

Annual Report on Postpartum Health

Substitute Senate Bill 5068; Section 2(8); Chapter 90; Laws of 2021

January 1, 2026

Legislative summary

The Health Care Authority (HCA) submits this report as required by Senate Bill (SB) 5068:

The managed care organizations contracted with the authority to provide postpartum coverage must annually report to the legislature on their work to improve maternal health for enrollees, including but not limited to postpartum services offered to enrollees, the percentage of enrollees utilizing each postpartum service offered, outreach activities to engage enrollees in available postpartum services, and efforts to collect eligibility information for the authority to ensure the enrollee is in the most appropriate program for the state to receive the maximum federal match.

Executive summary

The 2025 Annual Report on Postpartum Health is an improvement in the reporting structure from the 2024 report. This report is a baseline to monitor postpartum utilization of benefits for members in After-Pregnancy Coverage (APC).

We received data from managed care organizations (MCOs) that indicates:

- Increased efforts to monitor and track postpartum health
- New efforts to engage members in APC as well as efforts to provide additional support to members in the postpartum period by offering value-added benefits. These benefits include:
 - Baby items,
 - Meals,
 - Telehealth access to lactation consultants, and
 - Targeted care coordination.
- In 2024 versus 2023, all MCOs report higher service utilization of three measures that indicate a positive trend in APC utilization:
 - Postpartum Depression Screening and Follow-Up (PDS-CH/AD),
 - Postpartum Care (PPC2), and
 - Primary Care provider (PCP).

We also carefully monitor other important measures from the Healthcare Effectiveness Data and Information Set (HEDIS):¹

- Emergency Department Utilization (EDU),²
- Follow-Up After Emergency Department Visit for Substance Use (FUA- CH/AD),
- Follow-Up After Emergency Department Visit for Mental Illness (FUM- CH/AD), and
- Follow-Up After Hospitalization for Mental Illness (FUD-CH/AD).

Ideally, screening for mental health and/or substance abuse issues and general access to a PCP in the postpartum period will facilitate appropriate referrals and treatment and decrease emergency department visits and hospitalizations in the postpartum period. All the plans reported an increase in EDU in 2024 over 2023. For the remaining three measures, the plans reported a wide range of follow up percentages at 7 days versus 30 days in 2023, and in 2024. However, all plans noted an increase in follow-up percentages at 30 days for the 2024 report. A decrease in EDU, FUA-CH/AD, FUM-CH/AD, and FUD-CH/AD measures and a continued increase in the PDS-CH/AD, PPC2, and PCP measures would indicate that members' mental health and substance abuse issues are being addressed in the office versus during a crisis or a hospitalization.

HCA will continue to work with the MCOs to refine the Annual Postpartum Health report. HCA intends to meet with MCOs in 2026 to discuss the data received in this most recent reporting period to request more specific details in the MCOs outreach and a deeper analysis of what has been effective and what has not been effective in increasing postpartum utilization of APC.

HCA also intends to discuss recent research findings indicating increased rates of mental health issues for youth and continued disparities for suicide among American Indian/Alaskan Natives, non-Hispanic Whites, and non-Hispanic Asian and Pacific Islanders during the postpartum period.³ Washington State's Maternal Mortality Review Panel indicated that 82% of the pregnancy-related deaths that occurred in the postpartum period were preventable. Thus, focused interventions from the MCOs are warranted and needed to address these alarming trends and the opportunity that exists to prevent morbidity and mortality during the 12-month postpartum period.

Background

SB 5068 passed in the 2021 Legislative session, focused on improving maternal health outcomes, directed managed care organizations (MCO) to provide annual reports documenting quality improvement and health monitoring efforts for pregnant and postpartum persons. These MCO annual reports provide a summary of activities MCOs engaged in to improve health in the postpartum period.

¹ Healthcare Effectiveness Data and Information Set (HEDIS) measures are a standardized set of performance measures that health plans and providers use to assess performance, identify care gaps, and make comparisons.

² MCOs were instructed to use emergency department (ED) Value Set from FUM-CH/AD metric.

³ Policy Center for Maternal Mental Health. (2025, September). [Maternal Suicide in the U.S.: How the Government is Improving Data Collection and Continued Opportunities for Health Care System Change](#) [Issue Brief].

Twelve months of comprehensive Apple Health/Medicaid postpartum coverage was implemented in June of 2022. HCA named this coverage After-Pregnancy Coverage (APC).

In the summer of 2024, the Department of Health (DOH) held listening sessions with Apple Health (Medicaid) members to better understand barriers faced by clients and families in accessing services in the critical year post end of pregnancy. Global Perinatal Services, Ayan Maternity Healthcare Support, Hummingbird Indigenous Family Services, and WithinReach helped recruit participants and facilitated the listening sessions. The listening sessions revealed that many Apple Health MCO enrolled members who recently experienced a pregnancy did not know about the coverage, resources, and associated benefits provided with APC. The [DOH's report from the listening sessions](#) was shared with the MCOs to encourage efforts to increase awareness and wider utilization of APC for their members.

In 2025, HCA met internally and with MCOs to revise the Annual Postpartum Health Report to focus on the **mental health and substance abuse challenges** people face in the postpartum period. This revision establishes a baseline leveraging HEDIS measures that focus on mental and substance health care access and quality during APC coverage. The 2024 National Survey on Drug Use (NSDU) highlighted the prevalence of the co-occurrence of mental health challenges and substance abuse for both adults and adolescents along with a lack of access to care for those seeking treatment for mental health and substance abuse.⁴ The Washington State Maternal Mortality Review report indicated that 45% of pregnancy related deaths were attributed to behavioral health conditions, predominantly overdose deaths, most of which involved fentanyl.⁵ The availability and utilization of APC coverage during the postpartum period offer an opportunity to provide access points to screening, follow-up, and evidence-based treatment to reduce maternal mortality.

HCA worked with all five Washington State MCOs to collect standardized postpartum metrics of interest, where possible. Subject matter experts at HCA received and reviewed reporting templates from:

- [Coordinated Care of Washington Integrated Managed Care](#) and [Integrated Foster Care](#),
- [Community Health Plan of Washington](#),
- [Molina Healthcare of Washington](#),
- [UnitedHealthcare Community Plan](#), and
- [Wellpoint](#).

Those individual reports are included in the appendix. The key findings and recommendations are summarized below.

⁴ Substance Abuse and Mental Health Services Administration. (2025). [Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health](#) (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

⁵ Department of Health, Gardner, D. MFA, MPH, McHugh, A. MPH, Eilers, K. MPH, MSN, RN (2025). Washington State Mortality Review Panel: Maternal Deaths 2021–2022.

Findings from the five MCOs

MCO work to improve postpartum health

HCA asked MCOs: “How is the MCO monitoring and tracking postpartum health?” Here are selected highlights from the MCOs unique reports:

- **Coordinated Care** monitors and tracks postpartum health in several ways. Coordinated Care is using a combination of clinical data systems, telehealth tools, performance improvement frameworks, and outreach strategies to monitor postpartum health under APC. These efforts aim to improve maternal outcomes, reduce disparities, and ensure continuity of care.
- **Community Health Plan of Washington** monitors and tracks postpartum health through a combination of data-driven oversight, care management engagement, and collaborative provider and community partnerships. CHPW utilizes claims data, encounter reports, and internal dashboards to monitor postpartum visit completion rates, birth outcomes, and engagement in postpartum services. These data are reviewed to identify trends, disparities, and opportunities for improvement.
- **Molina Healthcare of Washington** monitors and tracks member postpartum health through its pregnancy dashboard which includes outcomes associated with pregnancy, birth, and postpartum health. Outcomes that Molina uses to track and monitor improvements in postpartum health include:
 - Members who have had a postpartum visit,
 - Members identified as high risk,
 - Members identified as high risk (HR) and have engaged in case management,
 - Infant weight,
 - Housing status,
 - Behavioral health (BH) experience,
 - Chronic disease diagnosis, and
 - Utilization of BH services postpartum.

For 2025 reporting, Molina includes metrics that more closely examine the utilization of health care services by the birthing member in the year after delivery. These metrics include postpartum depression (PDS) screening; PDS screening during well-child visit; social needs screening; and screening, brief intervention, and referral to treatment (SBIRT).

For 2025, Molina also includes APC members as a distinct population in the pregnancy database.

- **UnitedHealthcare** Community Plan monitors HEDIS measures relevant to the postpartum population, including:
 - Inpatient hospitalizations,
 - Emergency room visits,
 - Outpatient utilization, and
 - Select value-added benefit (VAB) vendor engagement.
- **Wellpoint Washington's Taking Care of Baby and Me** (TCOBAM) program provides a comprehensive approach to monitoring and tracking postpartum health. This program is structured around a whole health clinical model that emphasizes coordinated care management

throughout the prenatal and postpartum periods. Key aspects of the program and contributions to monitoring postpartum health include identification and risk screening, assessment and care planning, documentation, and communication.

Wellpoint Washington utilizes Health Equity Explorer as a tracking platform created to help understand its member population by offering the opportunity to explore key clinical indicators, health care outcomes and social drivers of health to develop insights stratified by demographics and geographical location. Maternal Child Health Informed contains analytical insights into Maternal Child Health measures, demographics and trends.

- The [Birth Keepers Doula Program with Fourth Plain Forward](#) represents a significant investment in maternal health, particularly for communities of Black, Indigenous, and other people of color (BIPOC) in Clark County, Washington. The program creates professional pathways for Clark County BIPOC residents to become certified birth doulas. Since implementation of the partnership in May 2024, the program trained 10 BIPOC doulas and five of those are fully licensed and operational, supporting 18 live births.

Enrollee utilization of postpartum services

Please see [HEDIS Measures Annual Postpartum Health Report - 2025](#) to review MCO data. The postpartum metrics included in the template are as follows:

- Postpartum Care (PPC2)
- Contraceptive Care Postpartum Women ages 21 to 44 (CCP-CH/AD)
- Postpartum Depression Screening and Follow-Up (PDS-CH/AD)
- Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)
- Antidepressant Medication Management (AMM-AD)
- Follow-Up After Hospitalization for Mental Illness (FUD-CH/AD)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM- CH/AD)
- Follow-Up After Emergency Department Visit for Substance Use (FUA- CH/AD)
- Plan All-Cause Readmissions (PCR-CH/AD)
- Emergency Department Utilization (EDU)
- Primary Care provider (PCP)
- Monthly data for the 12 months postpartum for WIC referrals for all eligible postpartum members

Outreach to engage members in APC/postpartum services:

MCOs reported engaged members in APC/postpartum services through various outreach activities.

Coordinated Care of Washington

Coordinated Care of Washington identified several outreach activities.

Coordinated Care Start Smart for Baby (SSFB) Team and CCW Quality Team attempt to telephonically contact all members identified through claims as pregnant and postpartum

Assessments, reminders and educational packet mailings are sent to pregnant and postpartum members. Educational flyers and links to resources are sent to members.

In 2023 and 2024, the Pacify Doula mobile application [Expert maternal health support: 24/7 doula & lactation consultants](#) was new outreach. The application gave access to Tele Doulas and Tele Lactation Consultants and will end January 1, of 2026 to change to promotion of the in-person Medicaid Doula

benefit. Additionally, CCW tables, presents, and sponsors at health fairs and other events throughout the state and the year.

Community Health Plan of Washington

Community Health Plan of Washington (CHPW) provides an overview of its Pregnancy Care support and benefits in the **CHPW Apple Health Welcome kits**, which go out by mail, email, and text to all new members. Welcome kits guide members to CHPW websites and the new [pregnancy resource online hub](#) launched in 2024.

In 2025, CHPW conducted a targeted outreach to Apple Health members as part of the **CHPW Be Well** series. This series highlights tips and resources for growing families. This outreach connected members with a pregnancy care blog series and the CHPW Pregnancy Care Resource Hub. Additional outreach and a continuation of the pregnancy care blog series are in development. This outreach was amplified with social media posts.

Healthy You, Healthy Baby is a care management program that supports pregnant and postpartum members. CHPW continues to be committed to offering individualized support during and after pregnancy. Members receive outreach from a case manager offering support to provide education on pregnancy care, postpartum care, and resources. Case managers continue to leverage field staff (case managers and community health workers) to meet with the member in the community or home as needed. Care management staff connect members to postpartum resources including women, infants, and children (WIC), maternal support services (MSS), and its [ChildrenFirst™ Postpartum Rewards program](#).

Care Management and Marketing teams have participated in community engagement events through community health centers and the Department of Health. This includes participation in community baby showers and other events to educate members on postpartum supports through CHPW and connect members to appropriate resources.

Transition of Care (TOC) conducts outreach calls to any member with a hospital stay, including delivery of a newborn, to assess needs. Members are referred to a case manager as needed to support coordination of identified postpartum needs and ongoing support. Case managers also support new parents during admission to the neonatal intensive care unit (NICU).

In 2025, CHPW field staff engaged with community health centers and community-based organizations to support or cohost 10 community baby showers across the state. The team provided a baby shower tool kit to members which included relevant materials regarding benefits and services available to members, along with support for participating organizations.

In late 2024 and early 2025, CHPW expanded contracting to community-based birthing providers. CHPW is now contracted with [Rainier Valley Midwives](#) and [Federal Way Birth Center](#) to ensure culturally appropriate and community-based doula and midwifery services are available to members. Through these provider relationships, the need for Fetal-Maternal medicine specialty access was identified. In 2025, CHPW contracted with Ouma Health to provide telehealth access to Fetal-Maternal medicine and behavioral health support for pregnant and postpartum members. CHPW continues to actively participate in the [Doulas for All \(D4A\)](#) collaborative meetings and support and advocate for Washington doulas. CHPW is engaging with D4A as they transition their role from advocacy to a state Doula Hub.

CHPW staff partner with community health center staff through the [Community Transformation Incentive Program](#), where five CHCs have developed projects focused on prenatal and postpartum care. They also shared their experiences and insights.

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan reported that for both CY 2023 and CY 2024, UnitedHealthcare outreached all pregnant enrollees.

Members identified as having rising risk or high-risk pregnancies are offered enrollment in its [Health First Steps](#) case management program, which provides support throughout pregnancy and to one year postpartum. UnitedHealthcare sends an after-delivery letter and brochure to all postpartum members. Live outreach calls are completed to members for postpartum appointment reminders and scheduling.

UnitedHealthcare collaborates with external partners like WIC and other community-based organizations.

Additionally, its community outreach team participates in numerous local events, including health and community fairs, to promote services and offerings to community members, including pregnant and postpartum individuals.

All pregnant UnitedHealthcare members are eligible to download the [Babyscripts app](#), which offers milestone-based rewards. For example, members who complete a postpartum visit may receive a gift card.

Molina Healthcare

Molina Healthcare reported that all members who have delivered but have not engaged with their pregnancy care provider for postpartum follow-up are identified for outreach by a Molina team member who can support them in accessing care postpartum through personalized calls or mailings. These members are also flagged with an alert so if the member reaches out to any Molina team, Molina is able to respond to their immediate need. Molina then connects the member with someone who can support them in navigating access to postpartum care resources.

The Molina Care Connections team can also support members in the postpartum period who need care through telehealth services, even if the care needed is not associated with pregnancy.

Molina also educates members on rewards they can access with postpartum follow-up care and other health care activities, such as getting vaccinated during flu season.

Molina's community engagement team worked in collaboration with community-based organizations across the state to **share information about Medicaid coverage**. In 2022 and 2023, Molina partnered in organizations serving pregnant people and families with young children to facilitate community baby showers and health fairs.

Molina hosts regular **Community Conversations** with Molina members as well as community partners who support its members, specifically focusing on the experience of members in accessing care during and within the year after pregnancy. These conversations take place in small groups, and in partnership with a trusted community partner. Feedback received in these sessions has been used to support the increased utilization of care within the year postpartum for pregnancy and non-pregnancy related services.

Providers are given information about assigned members who are due for postpartum follow-up visits on a bi-weekly basis, and there is additional monthly reporting to groups who have prioritized postpartum

care through a value-based agreement. A percentage of its provider groups have the postpartum measure as a performance goal within their contract. Additionally, Molina shares provider educational materials to support high-quality interactions with members to encourage completion of postpartum care.

Members who are experiencing barriers associated with health-related social needs (HRSN) can receive support, including referrals and resource navigation support from a **Molina Community Connector**. This support can include (but is not limited to) assistance for members with housing instability, food insecurity, childcare, parenting resources, or other services needed to support the overall health and wellness of members.

Wellpoint

Wellpoint reported outreach to members is multidirectional. Wellpoint utilizes interactive voice response for outbound calls, text campaigns through mPulse, Taking Care of Baby and Me, case managers, value-added benefits, and supplying smartphones to high-risk members if needed.

Wellpoint identified provider interventions as well to help increase knowledge about APC, including:

- Customized monthly estimated due date report of pregnant members to enhance coordination of prenatal and postpartum follow-up for primary care providers and obstetric providers
- Monthly Gap-in-Care enrollment roster delivered via secure file transfer protocol (SFTP) to provider contacts
- Monthly provider report cards delivered via SFTP to provider contacts
- Bimonthly provider HEDIS training with continuing medical education provided
- HEDIS coding and desktop reference guides distributed to providers
- Quality management/Provider Success team monthly/quarterly conversations about month-over-month reporting in real time to ID key metrics needing improvement
- Obstetric practice consultant provider education and training
- Obstetric quality incentive programs (OBQIP) contracts- obstetrics practice consultants and provider contracting continuing to explain OBQIP among providers
- Monthly provider newsletter article highlighting HEDIS measures with tips to improve compliance
- Current procedural terminology II coding incentives and incentives for completion of notification of pregnancy form

Efforts to collect eligibility information for the HCA

MCOs reported efforts to collect eligibility information and ensure the enrollee is in the most appropriate program for the state to receive the maximum federal match:

- **Coordinated Care** of Washington reported a small number of members were eligible for APC in calendar year 2023 and calendar year 2024.
 - 2023: 96 members
 - 2024: 109 members
- **Community Health Plan of Washington** has reported eligibility (address updates) for the following members with HCA reported pregnancy indicators and which was also confirmed via claims billing codes:

- 2023: 115 members
- 2024: 221 members
- **United Healthcare** Community Plan reported zero members with a change in address or moving out of state and 48 members where the member was pregnant or reported an estimated due date.
- **Wellpoint** shared 2,734 eligibility updates in 2024 regarding pregnant and postpartum members. Multiple channels help identify pregnant members, including state enrollment files, claims data, medical management data, and manual referrals. Most members are identified through state enrollment and claims data.
 - State enrollment data: Members flagged for pregnancy are referred for risk screening and OB Case Management.
 - Claims data: Nightly queries search for pregnancy-related codes.
 - Continuous case finding: Daily evaluations of the Medicaid member population identify candidates for obstetric management via targeted International Classification of Diseases-10 and Current Procedural terminology codes along with authorization data.
 - Predictive modeling: Monthly, the Chronic Illness Intensity Index (CI3) uses demographic and claims data to create individualized risk profiles, helping direct and support case management efforts. Members identified through CI3 are referred to the OB Case Management program if deemed appropriate.

Appendix: Access report templates and data

- [HEDIS Measures Annual Postpartum Health Report - 2025](#)
- [Community Health Plan of WA Annual Postpartum Health Report - IMC - 2025](#)
- [Coordinated Care Annual Postpartum Health Report - IMC - 2025](#)
- [Coordinated Care Annual Postpartum Health Report - IFC - 2025](#)
- [Molina Healthcare Annual Postpartum Health Report - IMC - 2025](#)
- [UnitedHealthcare Annual Postpartum Health Report - IMC - 2025](#)
- [Wellpoint Annual Postpartum Health Report - IMC - 2025](#)

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