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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of VHA Maternity Care Coordination and Women Veterans' Experience

National Review | **24-00818-208** | **August 10, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a national healthcare review to assess the Veterans Health Administration's (VHA) coordination of maternity care using standards set forth in VHA Directive 1330.03(2), *Maternity Health Care and Coordination*.[1] The OIG's review included access to prenatal care, compliance with VHA maternity care coordination services for pregnant and postpartum patients, and women veterans' experience. The review was initiated in August 2024 and concluded in April 2026.

In fiscal year 2025, over 740,000 women veterans used VHA for health care with approximately half being of reproductive age.[2] Maternity benefits are included in the VA medical benefits package for patients enrolled in VA's health care system, as mandated by federal regulation and required by VHA policy.[3] VHA provides most pregnancy-related care through community care.[4]

Review Results

The OIG found that VHA providers largely complied with requirements to refer patients to prenatal providers as early as possible after pregnancy was diagnosed. Seventy-seven percent of patients diagnosed in the first trimester attended their first prenatal appointment with a community maternity care provider during their first trimester, indicating that VHA providers and community care coordination of maternity care referrals generally aligned with the American Academy of Pediatrics and American College of Obstetricians and Gynecologists *Guidelines for Perinatal Care*.[5]

The OIG found that during the prenatal period, 88 percent of pregnant patients had contact attempts documented in the electronic health record by the maternity care coordinator at all required contact points with 73 percent being successfully contacted. However, during the postpartum period, the OIG found that only 51 percent of the patients had contact attempts

[1] VHA Directive 1330.03(2), *Maternity Health Care and Coordination*, November 3, 2020, amended February 7, 2025.

[2] VHA provided health care for 357,349 women veterans, ages from 18 to 50 years old in fiscal year 2025. "VA Maternity Outcomes – Quarterly Community Care Birth Report, FY 2025," VHA Support Service Center (VSSC), https://vssc.med.va.gov/VSSCMainApp. (This site is not publicly accessible.)

[3] 38 C.F.R. § 17.38. Veteran's Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, codified at 38 U.S.C. § 1705; VHA Directive 1330.03(2). The VA medical benefits package refers to the range of health care services that the VA covers and provides to eligible veterans. Maternity services have been included in the VA medical benefits package since 1999.

[4] PL 115-182, § 132 VA Mission Act (2018). Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VHA can authorize and pay community care providers for healthcare services when the necessary care, such as obstetric services, is not available at VHA.

[5] American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, 8th ed., 2017.

documented in the electronic health record, and 24 percent were successfully contacted by the maternity care coordinator at all required contact points the year following delivery. The OIG also found that required screenings for depression, relationship health and safety, housing and food security, and alcohol use were not consistently offered to patients successfully contacted by the maternity care coordinator during the postpartum period.

To ensure timely transition of care back to VHA, maternity care coordinators are required to ensure that a postpartum appointment is scheduled within three months of delivery. The OIG found that 35 percent of patients had a VHA primary care provider visit within three months of delivery as required. Given concerns for increased maternal mortality risk during the year following delivery, coordinating timely transition of ongoing care back to the patient's VHA primary care provider is important to promote overall health and ensure any needs are addressed timely during the postpartum period.

During postpartum contacts, maternity care coordinators documented patient reports of billing concerns for 25 percent of patients, and during the OIG's limited survey of women veterans, more than 1 in 3 patients reported billing and payment concerns. This highlights VHA's need to assess processes to resolve billing issues for patients receiving VA maternity care.

The OIG made four recommendations to the Under Secretary for Health related to maternity care coordinator compliance with requirements for postpartum care patient contacts and screenings, community care billing and billing resolution processes for patients, and the scheduling and completion of postpartum primary care appointments.[6]

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

[6] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

The Under Secretary for Health concurred with two recommendations and agreed to utilize the Maternal Mental Health Dashboard and create a formalized monitoring process for postpartum screening to strengthen accountability and continuous improvement. The Under Secretary for Health concurred in principle with the remaining two recommendations and reported that VA will conduct an independent analysis of community care maternity billing and incorporate evaluations of scheduling assistance, care coordination, outreach, and barriers to follow-up care into the maternity care coordinator oversight framework to reinforce compliance with postpartum primary care follow-up appointment requirements (see appendix B). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted a national healthcare review to assess the Veterans Health Administration's (VHA's) coordination of maternity care using standards set forth in VHA Directive 1330.03(02), *Maternity Health Care and Coordination*.[1] The review was initiated in August 2024 and concluded in April 2026. While VHA provides most maternity care through community providers, VHA has responsibility for coordination of care throughout the prenatal and postpartum period.[2] The scope of OIG's review included access to prenatal care, compliance with VHA maternity care coordination services for pregnant and postpartum patients, and patient experience.

Background

Women are the fastest-growing demographic in the veteran population.[3] In fiscal year 2025, over 740,000 women veterans used VHA for health care, of which 357,349 women veterans were of reproductive age, 18 to 50 years old.[4] Maternity benefits are included in the VA medical benefits package for patients enrolled in VA healthcare, as mandated by federal regulation and required by VHA Directive 1330.03(2), *Maternity Health Care and Coordination*.[5] The number of patients with obstetric deliveries paid for by VHA has steadily increased from approximately 6,100 in fiscal year 2020 to more than 10,700 in fiscal year 2025.[6]

VHA Maternity Care

VHA maternity benefits begin with the confirmation of pregnancy and continue through the postpartum period.[7] Clinical services covered under VHA maternity benefits include

- initial comprehensive medical assessment;

[1] VHA Directive 1330.03(2), *Maternity Health Care and Coordination*, November 3, 2020, amended February 7, 2025.

[2] VHA Directive 1330.03(2).

[3] VHA, Women Veterans Health Care, "Women Veterans in Focus," updated September 2025. VA's 2023 Veteran Population Projection Model estimated a population of 2,112,758 women veterans by the end of fiscal year 2025.

[4] "VA Maternity Outcomes – Quarterly Community Care Birth Report, FY 2025," VHA Support Service Center (VSSC), https://vssc.med.va.gov/VSSCMainApp. (This site is not publicly accessible.) A fiscal year is a 12-month period used for accounting purposes that in the federal government runs from October 1 through September 30. Public Law 93-344.

[5] 38 C.F.R. § 17.38. Veteran's Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, codified at 38 U.S.C. § 1705; VHA Directive 1330.03(2).

[6] "VA Maternity Outcomes-Quarterly Community Care Birth Report, FYs 2020, 2025," VHA Support Service Center (VSSC).

[7] VHA Directive 1330.03(2).

- evaluation and treatment consultations with clinically indicated specialist(s) and subspecialist(s);
- laboratory tests;
- prenatal screening for genetic disorders;
- diagnostic imaging;
- pregnancy-related education such as childbirth, parenting, nutrition, and breastfeeding classes;
- labor and delivery services;
- specified newborn care;
- pharmacy services;
- management of miscarriages; and
- postpartum contraception.[8]

Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VHA can authorize and pay community care providers for healthcare services when the necessary care, such as obstetric services, is not available at VHA, is not available in a timely manner at VHA, or certain eligibility criteria are met.[9] According to VHA policy, pregnancy-related care is typically provided through community care, however, VHA may continue to manage coexisting medical or mental health conditions, or maternity-related laboratory tests or medications.[10]

Maternity Care Coordination

Women veterans have unique medical and mental health conditions that can put them at higher risk for adverse pregnancy outcomes.[11] VHA implemented a maternity care coordination policy in 2012 to assist pregnant women veterans' navigation of VHA healthcare services and care received from community care providers.[12] Maternity care coordination improves access to essential health services, enhances maternal and birth outcomes, and reduces costs, particularly for women with chronic conditions, pregnancy-related complications, mental health needs, or social vulnerabilities. In response to the Protecting Moms Who Served Act of 2021, which

[8] VHA Directive 1330.03(2).

[9] PL 115-182, § 132 VA Mission Act.

[10] VHA Directive 1330.03(2).

[11] VHA Office of Women's Health, *State of Reproductive Health Report,* Volume II, January 2023.

[12] VHA Directive 1330.03(2). VHA Directive 1330.03(2) replaced VHA Handbook 1330.03, *Maternity Health Care and Coordination*, 2012.

highlighted concerns regarding maternal outcomes and health disparities, VHA implemented efforts to enhance support for pregnant and postpartum patients.[13] The VHA Under Secretary for Operations and Management memorandum, "Maternity Care Coordination (MCC) Program Expansion" required that every VHA facility expand maternity care coordination by the end of fiscal year 2023, with patient contacts occurring throughout pregnancy and continuing for one year following delivery.[14]

Prior OIG Reports

An OIG national healthcare review, published September 28, 2023, found VHA facilities generally reported providing reproductive health services through on-site and community resources. For maternity care specifically, leaders indicated services were largely available through community care, though some noted availability of specialists, such as obstetricians, in some areas could affect timeliness of access. The OIG made no recommendations.[15]

An OIG national healthcare review published June 27, 2024, highlighted VHA maternity care coordinators' perspectives on barriers in coordinating maternity care and included two recommendations related to maternity care coordinator staffing and timeliness of community care maternity care referrals. Both recommendations were closed as of November 13, 2025.[16]

Scope and Methodology

The OIG initiated this comprehensive review in August 2024 to assess VHA's provision of timely access to prenatal care and compliance with maternity care coordination guidance for pregnant and postpartum patients, and to seek the perspectives of women veterans who used VHA benefits for maternity care.[17] See Appendix A for a more detailed description of the data methodology.

To review access to prenatal care and postpartum primary care follow-up, the OIG used VHA administrative data to identify patients with paid claims for a delivery in fiscal year 2025. The OIG assessed the time between the entry of the VHA maternity care consult and the patient's first community care provider prenatal appointment, and the time from delivery to the patient's first postpartum appointment with a VHA primary care provider.

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[13] Protecting Moms Who Served Act, Pub. L. No. 117-69, 135 Stat. 1495 (2021).

[14] Assistant Under Secretary for Operations and Management, "Maternity Care Coordination (MCC) Program Expansion (VIEWS # 9248076)," memorandum to Veterans Integrated Service Network Directors (10N1-23), January 18, 2023.

[15] VA OIG, *Review of Veterans Health Administration Reproductive Health Services*, Report No. 22-03931-226, September 28, 2023.

[16] VA OIG, *Review of Perceived Barriers in Coordinating Veteran Maternity Care*, Report No. 22-00900-186, June 27, 2024.

[17] VHA Directive 1330.03(2).

To evaluate prenatal care coordination, the OIG identified a study population of women veterans with a pregnancy in fiscal year 2023 using VHA administrative data, including community care consults for maternity care and pregnancy log entries. The OIG reviewed electronic health records (EHRs) of a statistical sample of 400 patients to verify pregnancy, which resulted in a final sample of 294 patients. EHR reviews for prenatal care coordination encompassed the time frame from documentation of pregnancy through the first VHA primary care or women's health clinic visit.

To evaluate postpartum care coordination, the OIG identified a study population of women veterans who used VHA for maternity care and had a delivery in calendar year 2024 based on VHA administrative data. The time frame for review of postpartum care for the study population extends to December 31, 2025. The OIG reviewed EHRs for a statistical sample of 100 patients to evaluate postpartum care coordination from the date of delivery through one year postpartum.

To ensure the perspectives of women veterans who used VHA for maternity care were represented in the review, the OIG conducted an electronic patient experience survey. Using VHA administrative data, the OIG identified a study population of women veterans with a live birth between May 1, 2025, and July 12, 2025, using VA Community Care, and selected a statistical sample of 500 patients. Prior to initiating the survey, the OIG reviewed the EHR for each patient to confirm a live birth delivery, and excluded patients with a negative outcome during or shortly following delivery to avoid potential burden or distress that a survey might cause. Following the EHR review, 4 patients were excluded, resulting in a sample of 496 women veterans. The OIG initiated the survey on September 3, 2025, mailing letters with QR (quick response) code links to the survey, and sent two follow-up emails with survey links for patients who did not respond to the survey letter. The survey period concluded on October 20, 2025. A total of 131 (26 percent) patients responded to the survey. While this survey provides insights from patients' perspectives on the VHA maternity care services provided, given the low response rate (26 percent), the results have limited generalizability and are representative of those who responded to the survey only. The OIG also reviewed relevant VHA policies and guidance documents.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Coordination of Maternity Care

Maternity Care Referrals

VHA Directive 1330.03(2), *Maternity Health Care and Coordination*, specifies that a veteran's VHA provider is responsible for "referring the Veteran to an authorized routine or high-risk prenatal care provider (e.g., maternal fetal medicine) 'as early as possible' after the pregnancy is diagnosed."[18]

Generally, a VHA provider enters a community care consult for maternity care when pregnancy is diagnosed.[19] Facility community care staff send a referral to a community care provider, authorizing a standardized episode of care that includes a range of clinical services covered under VHA maternity care benefits.[20] An appointment can be scheduled by facility community care staff or scheduled directly by the patient with the community care provider.

Pregnancy Diagnosis to Maternity Care Referral

Time from pregnancy diagnosis to VHA provider entry of a consult for community maternity care

Average	6 days
Same Day	40%

Figure 1. *Maternity care referrals.*
Source: OIG review of patient EHRs (fiscal year 2023 prenatal sample).

The OIG found that VHA providers referred 40 percent (two in five) of patients to a community maternity care provider the same day pregnancy was diagnosed, with an average of six days from pregnancy diagnosis to referral. Twenty-four percent of the pregnant patients were identified as high risk, either by the VHA provider at the time of referral or subsequently by the community maternity care provider during the patient's pregnancy. Of the patients with a documented high-risk pregnancy, 100 percent were referred to a high-risk prenatal care provider either by a VHA provider or community maternity care provider, if indicated. These findings indicate VHA providers largely complied with VHA requirements to refer patients to prenatal providers as early as possible after the pregnancy was diagnosed.[21]

[18] VHA Directive 1330.03(2). Specific guidance regarding the requirement to refer the veteran 'as early as possible' is delineated in VHA Directive 1330.03(2) §5g(2).

[19] VHA Directive 1232, *Consult Management*, November 22, 2024.

[20] VHA Directive 1330.03(2).

[21] VHA Directive 1330.03(2).

American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, notes that "women who receive early and regular prenatal care are more likely to have healthy infants," and provides guidance that "the first visit for prenatal care typically occurs in the first trimester," with the frequency of follow-up visits "determined by the individual needs of the woman and an assessment of her risks."[22]

Maternity Care Referral to First Prenatal Appointment

Time from consult entry to first prenatal appointment with a community maternity care provider		
	Average	26 days
	Within 30 days	68%

Figure 2. *Maternity care referrals.*
Source: OIG analysis of VHA administrative data (fiscal year 2025 population data).

The OIG's analysis of fiscal year 2025 administrative data showed that 68 percent (approximately 2 in 3) of pregnant patients were seen by a community maternity provider within 30 days of the VHA provider entering a consult. The OIG's EHR review for prenatal care coordination found that, for patients identified with high-risk pregnancy, the average time from consult to the initial appointment with a high-risk community maternity care provider was 24 days, with 74 percent seen within 30 days.

Given the clinical importance of establishing prenatal care early, the OIG reviewed the stage of pregnancy when pregnancy was documented in the EHR and prenatal care was initiated. The 40-week span of a typical pregnancy is commonly grouped into three trimesters: first trimester (weeks 0–13), second trimester (weeks 14–27), and third trimester (weeks 28–40).[23]

[22] American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, 8th ed., 2017.

[23] "How Your Fetus Grows During Pregnancy," The American College of Obstetricians and Gynecologists, accessed March 19, 2025, https://www.acog.org/womens-health/faqs/how-your-fetus-grows-during-pregnancy. Pregnancy can be divided into weeks and sometimes days, with trimesters specified as follows: the first trimester spans from the first day of the last menstrual period to 13 weeks and 6 days; the second trimester spans from 14 weeks and 0 days to 27 weeks and 6 days; and the third trimester spans from 28 weeks and 0 days to 40 weeks and 6 days.

Pregnancy Trimester at Diagnosis

	1st Trimester	2nd Trimester	3rd Trimester
VA provider notified of pregnancy (or) diagnosed pregnancy	90%	8%	2%

Figure 3. *Pregnancy trimester at diagnosis.*
Source: OIG review of patient EHRs (fiscal year 2023 prenatal sample).

The OIG used information on gestational age from community care provider documentation to calculate the trimester when pregnancy diagnosis was identified by a VHA provider. The OIG found the majority (90 percent) of patients were diagnosed within the first trimester.

Pregnancy Trimester at First Prenatal Appointment

	1st Trimester	2nd Trimester	3rd Trimester
First prenatal appointment with community maternity care provider	77%	19%	4%

Figure 4. *Pregnancy trimester at first prenatal appointment.*
Source: OIG review of patient EHRs (fiscal year 2023 prenatal sample).

The OIG found that 77 percent (approximately 3 in 4) of patients diagnosed in the first trimester attended their first prenatal appointment with a VA community maternity care provider during their first trimester. The OIG further examined the timeline of referrals for the 13 percent whose first prenatal appointment occurred in the second trimester. The OIG found that the median number of days from maternity care referral to first prenatal appointment for these patients was longer (approximately 38 days) than those who were both diagnosed and had care initiated in the first trimester (approximately 23 days). The reason for the delayed prenatal care appointment was often not apparent from the EHR review; however, some cases had documented reasons including community provider scheduling availability, identification of a community provider for the referral, appointments canceled by the patient, or patient decided later in pregnancy to use VHA for maternity care.

The OIG concluded that VHA providers and community care coordination of maternity care referrals generally aligned with the *Guidelines for Perinatal Care* recommendation to initiate prenatal care in the first trimester.[24]

Maternity Care Coordinator Contacts and Screening

VHA Directive 1330.03(2), *Maternity Health Care and Coordination,* specifies that maternity care coordinators are responsible for "ensuring the effective coordination of care between VA and maternity care providers in the community, and all relevant VA and community specialist providers treating the pregnant Veteran." [25] Maternity care coordinators are required to make regular telephone contacts to assess and support the patient's pregnancy and postpartum needs and document the outcome of calls in the EHR.[26] While VHA Directive 1330.03(2) specifies that "the nature and frequency of calls are based on the Veteran's needs," the *VA Maternity Care Coordinator Program Manual* specifies expectations for prenatal telephone contacts to occur during the first, second, and third trimesters of pregnancy, and an immediate postpartum contact shortly following delivery.[27] The *VA Maternity Care Coordinator Program Manual* also provides guidance on screening for key health and social needs, including depression, alcohol use, relationship health and safety related to intimate partner violence, and housing and food insecurity during contacts with patients.[28]

In addition to prenatal contacts in each trimester and a post-delivery contact, the VHA Assistant Under Secretary for Operations and Management memorandum, "Maternity Care Coordination (MCC) Program Expansion" required facilities to extend postpartum contacts through one year following delivery by the end of fiscal year 2023 (September 30, 2023).[29] The *VA Maternity Care Coordinator Program Manual* provides guidelines on enhanced postpartum care coordination and requires patient contacts to include 3-, 6-, 9-, and 12-month postpartum calls.[30]

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[24] American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*.

[25] VHA Directive 1330.03(2).

[26] VHA Directive 1330.03(2).

[27] VHA Directive 1330.03(2); VA, VA MCC Telephone Care Program Manual, 2023, rescinded and replaced by VA, VA Maternity Care Coordinator (MCC) Program Manual, 2024, rescinded and replaced by VA, VA Maternity Care Coordinator Program Manual, V5ii, 2025. The manuals contain the same or similar language related to maternity care coordinator prenatal screening responsibilities.

[28] VA, *VA MCC Telephone Care Program Manual*, *VA Maternity Care Coordinator (MCC) Program Manual*, *VA Maternity Care Coordinator Program Manual,* V5ii. The manuals contain the same or similar language related to screening responsibilities.

[29] Assistant Under Secretary for Operations and Management, "Maternity Care Coordination (MCC) Program Expansion (VIEWS # 9248076)," memorandum.

[30] VA, *Maternity Care Coordinator (MCC) Program Manual*, *VA Maternity Care Coordinator Program Manual,* V5ii. The manuals contain the same or similar language related to maternity care coordinator postpartum screening responsibilities.

The OIG reviewed patient EHRs to evaluate maternity care coordinators' compliance with required prenatal and postpartum contacts.

Prenatal Contacts and Screening Compliance

Maternity Care Coordinator Prenatal Contacts

	Documented required contact attempts	Completed patient contacts
Overall *(all prenatal contact points)*	88%	73%
1st Trimester	95%	91%
2nd Trimester	91%	80%
3rd Trimester	92%	82%

Figure 5. *Maternity care coordinator prenatal contacts.*
Source: OIG review of patient EHRs (fiscal year 2023 prenatal sample).

The OIG found that most (88 percent) of the pregnant patients had contact attempts documented in the EHR by the maternity care coordinator across all prenatal contact points. The maternity care coordinators made successful contact with 73 percent (approximately 3 in 4) of pregnant patients at all of the required prenatal contact points. During patient contacts, maternity care coordinators must screen for depression and relationship health and safety during the first and third trimesters, and for alcohol use during the first trimester.[31] The OIG found that most pregnant patients had at least one of each type of screen completed during the prenatal period by either the maternity care coordinator or another provider. Ninety-two percent of the patients had at least one depression screening, 81 percent had at least one relationship health and safety

[31] VA, *VA MCC Telephone Care Program Manual Program Manual*, *VA Maternity Care Coordinator (MCC) Program Manual*, *VA Maternity Care Coordinator Program Manual,* V5ii.

screening, and 93 percent had at least one alcohol screening completed by a maternity care coordinator or other member of the patient's healthcare team.[32]

Postpartum Contacts and Screening Compliance

Maternity Care Coordinator Postpartum Contacts

	Documented required contact attempts	Completed patient contacts
Overall *(all postpartum contact points)*	51%	24%
Post-delivery	88%	79%
3 months	82%	63%
6 months	73%	44%
9 months	67%	46%
12 months	69%	41%

Figure 6. *Maternity care coordinator postpartum contacts.*
Source: OIG review of patient EHRs (calendar year 2024 postpartum sample).

The OIG found that only about half of the postpartum patients had contact attempts documented in the EHR by the maternity care coordinator at all required points during the year following delivery. Successful contacts across all postpartum contact points were documented for 24 percent of patients. At 6-, 9-, and 12-months postpartum, more than 1 in 4 patients lacked documentation of postpartum contact attempts by the maternity care coordinator. These findings indicate that facilities are not compliant with requirements for postpartum care coordination contacts for the year following delivery.

The *VHA Maternity Care Coordinator (MCC) Program Manual* requires maternity care coordinators screen for depression, relationship health and safety, and housing and food security at the post-delivery, 3-month, 6-month, 9-month, and 12-month postpartum and alcohol use at

[32] VA, *VA MCC Telephone Care Program Manual Program Manual*, *VA Maternity Care Coordinator (MCC) Program Manual*, *VA Maternity Care Coordinator Program Manual,* V5ii.

the 3-month postpartum contact. Recommendations for alcohol screening at other postpartum contact points are dependent on a patient's prior reported alcohol use.[33]

Adherence to Postpartum Screening for Contacted Patients

Depression Screen

Overall *(all postpartum contact points)*				**54%**
Post-delivery	3 months	6 months	9 months	12 months
68%	73%	81%	88%	89%

Relationship Health and Safety Screen

Overall *(all postpartum contact points)*				**40%**
Post-delivery	3 months	6 months	9 months	12 months
52%	60%	66%	72%	72%

Housing and Food Security Screen

Overall *(all postpartum contact points)*				**38%**
Post-delivery	3 months	6 months	9 months	12 months
48%	64%	78%	79%	81%

[33] VA, *VA Maternity Care Coordinator (MCC) Program Manual*, *VA Maternity Care Coordinator Program Manual,* V5ii.

Alcohol Use Screen

Overall *(all postpartum contact points)*				**65%**
Post-delivery	3 months	6 months	9 months	12 months
n/a	65%	n/a	n/a	n/a

Figure 7. *Maternity care coordinator adherence to postpartum screening for contacted patients.*
Source: OIG review of patient EHRs (calendar year 2024 postpartum sample).
Note: Maternity care coordinator adherence to postpartum screening guidance was assessed only for the contact points at which the maternity care coordinator successfully contacted the patient.
Maternity care coordinator notes documenting that screening was completed, the patient declined screening, or the screening was not completed due to the presence of another party at the appointment (e.g., the patient's significant other or a minor child age two or older) were considered compliant.

For the patients successfully contacted in the postpartum period, the OIG found gaps in the required screenings by the maternity care coordinator. During the postpartum period, the maternity care coordinator's completion of screenings varied across contact points and by type of screening, with the lowest screening compliance rates at the post-delivery contact point.

When screenings are positive, maternity care coordinators must ensure patients are referred for follow-up care with appropriate specialists.[34] This proactive approach helps identify risks early, connect patients to critical resources, and improve maternal health outcomes.[35] The OIG found that for patients who screened positive, the appropriate follow-up was documented for 100 percent of the positive postpartum screenings. This indicates that patients who were contacted and screened as positive were likely linked to appropriate services or resources for assistance when needs were identified. This further highlights the importance of maternity care coordination and adherence to screening guidance to address mental health risks, relationship health and safety concerns, and social determinants of health across the postpartum period.

The identified gaps in screening indicate opportunities to improve identification of at-risk postpartum patients to ensure they are offered appropriate services and resources to address mental health, safety, and health-related needs.

[34] VHA Directive 1330.03(2).

[35] VA, "VA expands maternity care coordination for Veterans," news release, September 29, 2023, https://news.va.gov/press-room/va-expands-maternity-care-coordination-for-veterans/.

Overall Postpartum Screening Completion Rates

In addition to assessing screening compliance rates for patients successfully contacted by the maternity care coordinator, the OIG evaluated screening rates for the entire postpartum sample, regardless of maternity care coordinator contact. The completion rate reflects screenings that were completed, regardless of who performed them.

Patients with Completed Postpartum Screenings

	Post-delivery	3 months	6 months	9 months	12 months
Depression Screen	56%	47%	41%	42%	44%
Housing and Food Security Screen	40%	42%	39%	40%	37%
Relationship Health and Safety Screen	35%	36%	27%	33%	25%
Alcohol Use Screen	n/a	50%	n/a	n/a	n/a

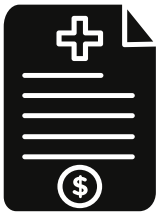
Figure 8. *Patients with completed postpartum screenings.*
Source: OIG review of patient EHRs (calendar year 2024 postpartum sample).
Note: Screening rates reflect completed screenings only.

Roughly 1 in 2 patients were screened for postpartum depression and alcohol use at each of the recommended screening points, while approximately 2 in 5 patients were screened for housing and food security. Relationship health and safety screening rates were lowest, with 1 in 3 to 1 in 4 patients completing screening at each recommended screening point.

Billing Concerns

Claims and payment for services provided through VHA community care, including maternity care, are managed directly by VHA or third party administrators that are under contract to manage portions of VHA's community care program.[36] VHA Directive 1003, *VHA Veteran Patient Experience*, outlines expectations for a customer service-focused culture within VHA, which includes a user-friendly process for patients to raise concerns and continuous process improvement to address reoccurring issues.[37] Of concerns raised by patients receiving maternity care, billing concerns were one of the most common.

Maternity Care Billing Concerns



Patients with billing concerns documented by maternity care coordinator 25%

Figure 9. *Patients with billing issues documented by maternity care coordinator.*
Source: OIG review of patient EHRs (calendar year 2024 postpartum sample).

Maternity care coordinators documented patient reports of billing concerns for 25 percent (1 in 4) of patients contacted during the year following delivery. These findings are consistent with patient responses during the patient experience survey discussed below, and a prior OIG report from 2024 in which approximately 80 percent of maternity care coordinators surveyed identified billing issues as an area for improvement.[38] This ongoing issue highlights VHA's need to improve processes for veterans to resolve billing issues for community maternity care.

Postpartum Primary Care Visit

VHA Directive 1330.03(2) *Maternity Health Care and Coordination*, requires maternity care coordinators to ensure that a postpartum appointment is scheduled with the patient's VHA primary care or women's health clinic within three months after delivery, or earlier if medically necessary.[39] The postpartum visit ensures transition of the patient's care from the community

[36] Veteran Community Care, *Billing and Payments* (fact sheet), August 30, 2019, accessed April 13, 2026, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-26.pdf. (Web page is no longer accessible.) Some veterans may have a copayment for services received from a community provider.

[37] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

[38] VA OIG, *Review of Perceived Barriers in Coordinating Veteran Maternity Care*.

[39] VHA Directive 1330.03(2). For the purposes of this report, the OIG considered visits in a primary care or women's health clinic as a visit with a VHA primary care provider.

maternity care provider back to the patient's VHA care team, who assumes primary responsibility for the patient's ongoing care.[40]

First Postpartum Visit with VHA Primary Care Provider

Within 3 months	35%
Average	174 days
Median	126 days

Figure 10. *First postpartum visit with VHA primary care.*
Source: OIG analysis of VHA administrative data (fiscal year 2025 population data).

The OIG's analysis of fiscal year 2025 administrative data found that 35 percent (approximately 1 in 3) of patients had a VHA primary care provider visit within the required time frame following delivery. This was consistent with findings from the OIG's EHR review assessing postpartum care coordination for women veterans with delivery in calendar year 2024, which found that, of the patients reviewed, 45 percent were scheduled and 34 percent completed a VHA primary care appointment within three months of delivery. For those not scheduled within three months, the OIG noted that 32 percent had attempted contacts for scheduling but were unsuccessful; 24 percent had no documented attempts to schedule; 23 percent had appointments scheduled beyond the required time frame; and 17 percent of patients canceled, did not show for the scheduled appointment, or declined the appointment.

These findings indicate opportunities to improve the scheduling timeliness for postpartum follow-up in primary care or women's health clinics. Given concerns for increased maternal mortality risk during the year following delivery, coordinating timely transition of ongoing care back to the patient's VHA primary care provider is important to promote overall health and ensure any needs are addressed timely during the postpartum period.[41]

2. Patient Experience

The OIG's survey of patients who used VHA maternity care services is intended to ensure that women veterans' perspectives were incorporated into this review and help inform VHA's ongoing care coordination efforts. While the survey offers insights into patients' experiences with VHA maternity care services, the 26 percent response rate presents risks for nonresponse

[40] American College of Obstetricians and Gynecologist Committee Opinion, No. 736, *Optimizing Postpartum Care,* May 2018. DOI: 10.1097/AOG.0000000000002633; VA and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Pregnancy*, v4.0, 2023.

[41] Assistant Under Secretary for Operations and Management, "Maternity Care Coordination (MCC) Program Expansion (VIEWS # 9248076)," memorandum.

bias and limits the generalizability of the findings.[42] As such, the results reflect only the views of those who responded.

Satisfaction with Community Care Prenatal Appointment Timeliness

First appointment with community maternity care provider received timely*

Yes	81%
No	14%
I don't recall	5%

Figure 11. *Satisfaction with community care prenatal appointment timeliness.*
Source: OIG analysis from patient experience survey.
**Maternity care providers include obstetrics/gynecologists (OB/GYN), certified nurse midwives, and family medicine providers.*

Most of the women veterans were satisfied with the timeliness of their first appointment with their community maternity care provider. Among those who were not satisfied, the most common reasons were inability to get an earlier appointment with the community care provider or delayed VA authorization.

Satisfaction with Maternity Care Coordinator

Satisfaction with support received from the maternity care coordinator

During pregnancy	95%
Following delivery	95%

Figure 12. *Satisfaction with maternity care coordinator.*
Source: OIG analysis of patient experience survey results.

Nearly all of the women veterans (99 percent) indicated having contact with a VHA maternity care coordinator, and most reported satisfaction with the support they received. Among those who provided additional feedback, many cited positive interpersonal interactions, accessibility, and assistance connecting to resources as key contributors to their satisfaction. Following childbirth, women veterans frequently noted the ongoing communication and resource assistance from the maternity care coordinator as beneficial.

[42] Robert T. Sataloff and Swetha Vontela, "Response Rates in Survey Research" *Journal of Voice* 35, no. 5 (2021): 683-684, DOI: 10.1016/j.jvoice.2020.12.043. While there is no consensus on acceptable minimum survey response rates, lower response rates increased risks for nonresponse bias, which occurs when there is a significant difference between survey responders and nonresponders. Nonresponse bias can result in survey data that is not representative of the surveyed group.

Satisfaction with the Availability of Pregnancy-Related Education

Satisfaction with the availability of pregnancy-related education.

Nutritional counseling	76%
Breastfeeding support following delivery	74%
Lactation classes	71%
Childbirth preparation classes	63%
Parenting classes	61%

Figure 13. *Satisfaction with the availability of pregnancy-related education.*
Source: OIG analysis of patient experience survey results.
Note: Analysis excludes patients who indicated that they did not want or need the specified pregnancy-related education.

Of those who expressed an interest or need for pregnancy-related information, approximately 1 in 4 patients provided additional feedback, with insufficient class availability and having to pay for classes provided in the community being the most frequently cited issues.[43] The survey responses, although limited, highlight opportunities to improve awareness of and access to pregnancy education resources and ensure processes for payment are clear when pregnancy education is provided through community partners.

Billing and Payment Concerns

Concerns related to billing or payment for the maternity care received through VA Community Care — 37%

Figure 14. *Billing and payment concerns.*
Source: OIG analysis of patient experience survey results.

[43] Interest was measured via the proportion of respondents who selected "I did not want/need" rather than "yes" or "no" when rating satisfaction with pregnancy related education.

Thirty-seven percent (approximately 1 in 3) of women veterans reported billing and payment concerns. Among those who provided additional feedback, the most common issues described were the burden associated with resolving billing issues and incorrect billing by community care providers. The survey responses, although limited, highlight opportunities for improvement to ensure clear, efficient processes are in place for patients to resolve billing concerns and enhance community care provider education to improve billing accuracy.

Conclusion

VHA providers largely complied with VHA requirements to refer patients to prenatal providers as early as possible after pregnancy was diagnosed. The OIG found that 77 percent of patients diagnosed in the first trimester attended their first prenatal appointment with a community maternity care provider during their first trimester, indicating that VHA providers and community care coordination of maternity care referrals generally aligned with the American Academy of Pediatrics and American College of Obstetricians and Gynecologists *Guidelines for Perinatal Care* for many patients.[44] Additionally, most of the women veterans surveyed were satisfied with the timeliness of their first appointment with their community maternity care provider.

The OIG found that 88 percent of the pregnant patients reviewed had contact attempts documented in the EHR by the maternity care coordinator across all required prenatal contact points. Seventy-three percent of pregnant patients were successfully contacted by the maternity care coordinator at all required prenatal contact points. However, the OIG found that only about half of the postpartum patients had contact attempts documented in the EHR by the maternity care coordinator at all required points for the year following delivery. Additionally, the OIG found gaps in documentation of efforts by the maternity care coordinator to complete required screenings across the postpartum contacts. These findings indicate that facilities are not yet compliant with requirements for postpartum care coordination contacts for the year following delivery.

The OIG found that 35 percent of patients had a visit with their VHA primary care provider within 3 months of delivery, indicating opportunities for improvement to ensure coordination of timely transition of ongoing care back to the patient's VHA primary care provider.

Nearly all the women veterans surveyed had contact with a VHA maternity care coordinator, and the great majority reported satisfaction with the support they received. However, satisfaction ratings in the limited number of survey responses received highlighted opportunities to improve awareness of and access to pregnancy education resources and ensure the process and

[44] American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*.

responsibility for payment is clear when pregnancy education is provided through community partners.

Maternity care coordinators documented patient reports of billing concerns for 25 percent of patients contacted during the year following delivery. The billing concern was mirrored in the results of the OIG's patient experience survey. This highlights VHA's need to streamline administrative processes to resolve billing issues for community maternity care.

The Under Secretary for Health concurred with two recommendations and agreed to utilize the Maternal Mental Health Dashboard and create a formalized monitoring process for postpartum screening to strengthen accountability and continuous improvement.[45] The Under Secretary for Health concurred in principle with the remaining two recommendations and reported that VA will conduct an independent analysis of community care maternity billing and incorporate evaluations of scheduling assistance, care coordination, outreach, and barriers to follow-up care into the maternity care coordinator oversight framework to reinforce compliance with postpartum primary care follow-up appointment requirements. The OIG will follow up on the planned actions until they are completed.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–4

1. The Under Secretary for Health reviews Veterans Health Administration's compliance with requirements for postpartum care coordination contacts by the maternity care coordinator and implements an action plan to ensure sustained compliance.

2. The Under Secretary for Health reviews Veterans Health Administration maternity care coordinators' compliance with requirements for postpartum screenings and implements an action plan to ensure sustained compliance.

3. The Under Secretary for Health evaluates concerns regarding community care billing and billing resolution processes for maternity care and implements an action plan as warranted.

4. The Under Secretary for Health evaluates the scheduling and completion of postpartum primary care appointments within three months of delivery and implements an action plan to ensure sustained compliance.

[45] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Data Methodology

Patient Sampling and Data Methodology for EHR Reviews

Prenatal

During fiscal year 2023, there were 667,550 female veterans between the ages of 18 and 50 enrolled and eligible for VHA benefits, including maternity care. Using VHA administrative and claims data, a total of 18,773 of this population were identified as having at least one VHA visit during fiscal year 2023 or had a paid claim during fiscal year 2023 through VHA and being pregnant during fiscal year 2023. Pregnancy was determined by identifying the first occurrence of either women veterans being identified as pregnant with an initial estimated delivery date or pregnancy end date from the pregnancy logs during fiscal year 2023 or women veterans with an initial maternity care consult using stop code 339 or claims referral with a maternity care category of care during fiscal year 2023. The criteria to define the pregnancy population resulted in three mutually exclusive groups, where patients were identified as pregnant by both pregnancy log and consults, pregnancy log only, and consults only.

A stratified random sample of 400 patients from the fiscal year 2023 pregnancy study population was generated for EHR review to estimate prenatal care coordination review points. The sample consisted of three strata: stratum one had 200 patients identified by both pregnancy log and consults, stratum two had 100 patients identified by pregnancy log only, and stratum three had 100 patients identified by consult only.

During the EHR review, the team confirmed a pregnancy within fiscal year 2023 for 294 of the 400 women veterans across three strata. Following the initial EHR reviews, 75 percent of the *consult only* stratum, 27 percent of the *pregnancy log* only stratum, and 2 percent of the *pregnancy log and consult* stratum were excluded. The majority of patients excluded were due to absence of pregnancy within the time frame of the review, including: identified consults were for general gynecology services not pregnancy (75 patients), pregnancy log entries did not indicate current pregnancy (27 patients), pregnancy loss documented concurrent with the pregnancy diagnosis (3 patients), or the referral was for nonviable or ectopic pregnancy (1 patient).

Following the EHR review, data analysis was performed using a stratified bootstrap of 10,000 replicates with replacement to provide estimates and background information for the fiscal year 2023 pregnancy study population.

Postpartum

Using VHA administrative data, the OIG identified 7,662 women veterans who used VHA for maternity care, with a professional paid claim for a diagnosis of delivery during calendar year

2024. Delivery diagnosis was identified via International Classification of Diseases (ICD), Tenth Revision, diagnostic codes.

A simple random sample of 100 patients from the 2024 delivery population was generated and provided for EHR review to produce estimates for the study population on VHA postpartum care coordination. To evaluate maternity care coordinator contacts and patient screenings across the year following delivery, the OIG separated the postpartum period into five mutually exclusive time frames corresponding to the required contact points as follows: post-delivery (delivery date through 45 days after delivery), 3-month postpartum (46 through 135 days after delivery), 6- month postpartum (136 through 225 days after delivery), 9-month postpartum (226 through 315 days after delivery), 12-month postpartum (316 through 405 days after delivery). The OIG also assessed timeliness of the patient's first VHA primary care or women's health clinic visit following delivery.

Following the EHR review, data analysis was performed using a bootstrap of 10,000 replicates with replacement to provide estimates and background information for the 2024 deliveries study population.

Patient Sampling and Data Methodology for the Patient Experience Survey

Claims administrative data were used to identify women veterans who had a paid claim for a recent ICD 10 diagnosis of delivery during calendar year 2025, for four separate monthly and sequential waves, with overlapping intervals every two weeks, to capture and evaluate patient responses within a similar time window of delivery during May 1 to July 12, 2025. To prevent potential bias, the OIG used a sequential overlapping sampling strategy to achieve a similar time from delivery to survey among participants.

Table A.1. Patient Experience Survey Sampling Waves

Waves	Time Window of Delivery	Sample Size
Wave 1	May 1, 2025, through May 31, 2025	125
Wave 2	May 15, 2025, through June 14, 2025	125
Wave 3	May 29, 2025, through June 28, 2025	125
Wave 4	June 12, 2025, through July 12, 2025	125

Source: OIG survey sampling methodology.

For each wave, a simple random sample without replacement of 125 patients was generated with sample weights for a total of 500 patients for the total survey effort. The waves were sequentially built and patients selected for prior waves were excluded to ensure samples were mutually exclusive and there is only one response per patient.

Prior to initiating the survey, the OIG reviewed EHRs for each patient to confirm a live birth delivery and verify or update mailing addresses and email addresses for the survey methods. The OIG excluded patients with a negative outcome during or shortly following delivery to avoid potential burden or distress that a survey might cause. From the EHR review, the team excluded 4 patients, leaving a total sample of 496 patients eligible to be surveyed. Reasons for exclusion included: potential burden or distress due to infant health concerns (1), service provided was for miscarriage management (1), no evidence of referral for VHA maternity care or VHA care within the specified time frame (1), and no evidence or documentation of pregnancy (1).

Table A.2. Patient Experience Survey Response Rate

	Number of patients surveyed	Response Rate	95% Confidence Interval
Patient Experience Response Rate	496	26.34%	(22.21%, 30.51%)

Source: OIG analysis of survey response data.

After the survey response data collection, data analysis was performed using a bootstrap of 10,000 replicates with replacement to provide estimates for patients responding to the survey. Given the low response rate (26 percent), the analysis did not extrapolate/generalize beyond those who responded to the survey.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 13, 2026

From: Office of the Under Secretary for Health (10)

Subj: Healthcare Review—Review of VHA Maternity Care Coordination and Women Veterans' Experience

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of VHA Maternity Care Coordination and Women Veterans' Experience. Attached is the Veterans Health Administration's (VHA) action plan.
2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.
3. Comments regarding the contents of this memorandum may be directed to GAO OIG Accountability Liaison Office.

(Original signed by:)

John Figueroa
Acting Under Secretary for Health

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health reviews Veterans Health Administration's compliance with requirements for postpartum care coordination contacts by the maternity care coordinator and implements an action plan to ensure compliance.

_X__Concur

____Nonconcur

Target date for completion: April 2027

Under Secretary for Health Comments

Office of Women's Health (OWH) will continue to utilize the existing Maternity Care Coordinator (MCC) Maternal Mental Health Dashboard to monitor required postpartum mental health screening completion associated with designated MCC postpartum contacts. Required postpartum mental screenings are associated with designated MCC postpartum contacts at 3, 6, 9, 12 months postpartum and are reflected in dashboard measures. Dashboard data are reviewed through established MCC oversight processes and may be used to identify performance trends, support monitoring of postpartum contact completion, and inform targeted improvement activities.

The OWH will produce two key deliverables: the MCC Maternal Mental Health Dashboard and a formalized oversight process to support ongoing monitoring and accountability.

Sustainability will include monitoring of required postpartum mental health screening completion at designated postpartum contact intervals, reviewing the MCC dashboard, conducting oversight activities to continue to support identification of performance trends and identifying opportunities for improvement.

Recommendation 2

The Under Secretary for Health reviews Veterans Health Administration maternity care coordinators' compliance with requirements for postpartum screenings and implements an action plan to ensure compliance.

_X__Concur

____Nonconcur

Target date for completion: April 2027

Under Secretary for Health Comments

The MCC Program's performance monitoring and oversight approach is built on four interconnected components:

1. MCC Competency Framework (under development)
   The MCC Competency Framework establishes the knowledge, skills, abilities, and performance expectations required of Maternity Care Coordinators. The framework defines the activities MCCs are expected to perform, including postpartum care coordination contacts, required screenings, transition support activities, care coordination, documentation, and identification of barriers to care.
2. MCC Supervisory Chart Review Tool (under development)
   The MCC Supervisory Chart Review Tool operationalizes the competency framework by providing a standardized method to evaluate whether MCC Program expectations are being implemented and documented in practice. Review criteria are aligned to established MCC competencies and program requirements.
3. MCC Annual Review Reporting Template (under development)
   The MCC Annual Review Reporting Template provides a standardized mechanism for facilities to report annual MCC Program review findings to the Office of Women's Health. The template supports reporting of review results, identified gaps, corrective actions, and program improvement activities and provides a mechanism for national-level oversight, trend analysis, and program monitoring.
4. MCC Program Performance Monitoring and Oversight Framework (under development)
   The MCC Program Performance Monitoring and Oversight Framework establishes the structure for monitoring program implementation, evaluating findings, identifying recurring gaps, supporting accountability, and informing continuous program improvement activities.

Together, these components establish a standardized approach in which MCC competencies define expected performance, the supervisory review tool evaluates implementation of those expectations, the oversight framework establishes monitoring and accountability processes, and the annual reporting template supports national oversight, trend analysis, and continuous program improvement.

OWH will establish a standardized oversight approach for required postpartum screening activities through implementation of the MCC Competency Framework, MCC Supervisory Chart Review Tool, MCC Annual Review Reporting Template, and MCC Program Performance Monitoring and Oversight Framework. Facilities will conduct standardized reviews of required postpartum screening activities and report findings to OWH through an annual review process. Review findings will be used to identify

recurring gaps, support corrective actions, and inform continuous program improvement.

Deliverables will include: MCC Program Performance Monitoring and Oversight Framework finalized and implemented; MCC Supervisory Chart Review Tool finalized and implemented; Standardized review criteria established for required postpartum screenings; and MCC Annual Review Reporting Template finalized and implemented.

Recommendation 3

The Under Secretary for Health evaluates concerns regarding community care billing and billing resolution processes for maternity care and implements an action plan as warranted.

_X__Concur in Principle

____Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

VA is committed to ensuring accurate and timely billing resolution for all community care services, including maternity care. Because the full scope of billing concerns related to VA maternity care remains unquantified, VA is concurring in principle and will conduct an independent analysis of community care maternity care billing. This analysis will assess the scope and frequency of any identified billing concerns. Upon completion of the analysis, VHA will review findings and implement an action plan as warranted.

Recommendation 4

The Under Secretary for Health evaluates the scheduling and completion of postpartum primary care appointments within three months of delivery and implements an action plan to ensure compliance.

__X_Concur in Principle

____Nonconcur

Target date for completion: April 2027

Under Secretary for Health Comments

OWH concurs with the importance of bringing Veterans back into primary care after pregnancy ends. VHA policy requires that a visit with primary care be scheduled within the first 3 months after pregnancy ends but does not specify that such visits be completed in the same timeframe. Using the aforementioned MCC Program

Performance Monitoring and Oversight Framework, VHA will ensure that sites are compliant with required scheduling mandates.

OWH acknowledges that Veterans' self-determination (to return for care or not within 3 months) is a factor in appointment completion, particularly if there are other psychosocial factors impacting their decision-making and ability to engage in care. Therefore, the MCC Program Performance Monitoring and Oversight Framework will include review of scheduling assistance, care coordination activities, documented outreach efforts, and identified barriers to follow-up care.

Deliverables will include: MCC Program Performance Monitoring and Oversight Framework finalized and implemented; MCC Supervisory Chart Review Tool finalized and implemented; Standardized review criteria established for required postpartum screenings; and MCC Annual Review Reporting Template finalized and implemented.

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