Final Report on Opportunities for Strengthening Maternal and Infant Health in Texas' Medicaid Managed Care Environment

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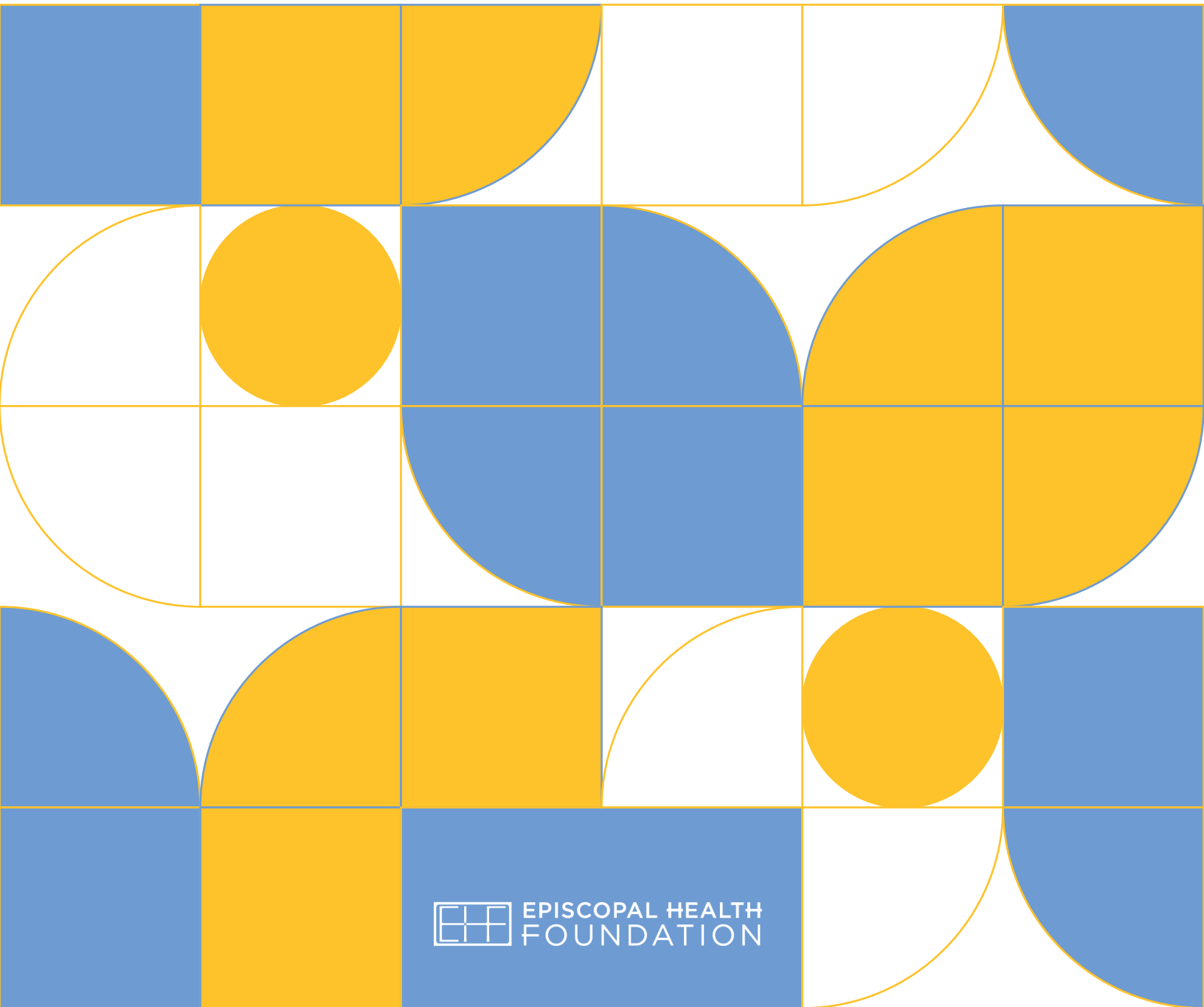

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Texas families currently experience higher birth rates, preterm births, and maternal mortality as compared to the rest of the US.[1] The weight of these experiences are disproportionately felt by the state's underserved communities - including low-income families and families of color - and it is anticipated that disparities will only worsen in the context of Texas' deepening maternity care "deserts" and mounting restrictions on reproductive healthcare.[2] [3] Indeed, as stressors on Texas' maternity care services continue to stack up, ensuring high-quality maternity care for the state's underserved communities is absolutely essential.

Medicaid is Texas' primary vehicle for providing maternity care for underserved communities – providing coverage for half of all Texas mothers.[4] Moreover, Texas is unique in that nearly 100% of Medicaid beneficiaries are enrolled in Medicaid *managed care*.[5] Medicaid managed care therefore emerges as an extremely powerful tool in Texas for improving maternal and infant health.

In this context, The Geiger Gibson Program (GGP) in Community Health at George Washington University and the Episcopal Health Foundation (EHF) partnered to explore *the extent to which Texas' Medicaid managed care program addresses key aspects of maternity care*.[6] Building on a study conducted with The Commonwealth Fund,[7] the GGP team conducted an extensive review of Texas' standard managed care contracts, analyzing the contractual requirements Medicaid health plans are held to by the state across 35 key maternity topics. (See Appendix for further details.) The team compared Texas' contractual language to the contractual requirements in the 38 other states and DC using Medicaid managed care as of 2022.[8]

In discussion with the Texas Association of Community Health Centers, and in light of more recent policy developments (identified below), the GGP conducted focus group with key health center representatives to assess their concerns, knowledge of maternity payment modalities, and thoughts about opportunities for strengthening maternity care.

The following highlight key opportunities and challenges from the contract reviews and focus group discussions.

Contract Review: Key Findings and Opportunities

There are several areas where Texas' contracts include strong expectations for maternity care. For example, Texas' contracts require Medicaid health plans to ensure that mothers can access prenatal care within two weeks of their request for a visit, and within five days in their third trimester. The contracts also impose strong access requirements for complex maternity care – for example, health plans are required to include complex maternity care facilities in their provider networks. Additionally, unlike most states, Texas requires that Medicaid health plans ensure that mothers receive risk assessments not only during their prenatal period, but also during the postpartum period.

However, there are numerous areas where Texas' managed care expectations are very limited and can be strengthened - such as its expectations for prenatal and postpartum care, perinatal case management, coverage of key maternity providers (such as midwives, maternal-fetal medicine specialists, community health workers, and doulas), and maternal mental health services and substance use disorder (SUD) care. Moreover, Texas' Medicaid managed care contracts are completely silent on several other key aspects of maternity care, such as maternity performance measures and payment reform.

Several opportunities to leverage current Texas policy developments and *strengthen* maternity services in Medicaid managed care are proposed below.

1) **Expanding and leveraging the perinatal workforce:** Texas HB 1575 expands access to perinatal case management services by allowing provision of these services by community health workers (CHWs) and doulas.[9] Texas can leverage this new requirement by requiring Medicaid health plans to include CHWs and doulas in their networks, looking to states such as Nevada and Michigan for this language. Moreover, Texas can include more robust perinatal case management requirements in their contracts, as required in Missouri, Mississippi, and Tennessee contracts.

2) **Enhancing perinatal risk assessment services:** HB 1575 also requires Texas Health and Human Services Commission (HHSC) to submit an annual report

detailing the nonmedical or social health-related needs of pregnant persons. Texas can use this opportunity to enhance contractual requirements for perinatal risk assessments, ensuring multiple, timely assessments that are highly inclusive of SDH screening. Texas can look to Missouri and Mississippi for examples of perinatal risk assessment requirements.

3) **Enhancing postpartum care:** Texas has joined 44 other states that have elected to extend postpartum coverage of Medicaid beneficiaries to one year postpartum.[10] This policy change provides an opportunity to implement more comprehensive postpartum requirements, such as more detailed contractual expectations for the content and frequency of postpartum visits and case management, as in Illinois.

4) **Developing maternity payment models to improve performance:** As of 2018, Texas' Medicaid health plans have been required to shift toward value-based payment for care. The shift to value-based payment often includes the development of alternative payment methods (APMs) linked to performance on key health service measures.[11] Although health plans have begun experimenting with APMs for a variety of services, few have developed maternity APMs.[12] Texas contracts are silent regarding maternity payment reform and maternity performance measures. Therefore, to encourage development of maternity APMs, Texas could explore requiring maternity payment reforms and maternity performance measures, such as those demonstrated in other state contracts (for example, Arizona, Florida, Indiana, Louisiana, New Mexico, and Nevada).

5) **Ensuring implementation of key maternity guidelines, consistent with Texas' Maternal Mortality and Morbidity Review Committee (MMMRC) recommendations.** Although Texas' contracts currently require its Medicaid health plans to use maternity care guidelines, these guidelines are not current.[13] Texas could require health plans and providers to adopt current maternity guidelines such as those put forth by the American College of Obstetricians and Gynecologists (ACOG), as well as those recommended by Texas' MMMRC and the DSHS as of their 2022 MMMRC report.[14] This report recommended the uptake of several key guidelines to improve access to high-quality maternity care in the state, including the Texas' Alliance for Innovation on Maternal Health (TexasAIM) maternity safety bundles,[15] the Maternal Early Warning Signs (MEWS) protocols,[16] the American Heart Association (ACA) maternal guidelines,[17] and more.

Focus Groups: Operational Opportunities and Challenges to Strengthen Maternity Care

In further discussion with the Texas Association of Community Health Centers (TACHC), the GGP team conducted a focus group to assess Texas community health center (CHC) interest in taking part in alternative payment models (APMs) to strengthen maternity care. EHF and TACHC have been seeking this input given that Texas has begun requiring MCO utilization of APMs, and in the context of the creation of Texas' health centers Clinically Integrated Network (CIN).

The focus group included seven individuals from five CHCs, representing perspectives from major urban cities, their surrounding areas, and the Texas-Mexico border. The key findings from this structured discussion can be found below.

- **CHC maternity provider shortages are the biggest challenge to strengthening maternity care.**
    - General workforce shortages were reported across all communities, but the rural and border CHC represented noted that maternity providers were particularly scarce. The lack of available maternity providers severely limits CHC capacity, especially to care for high-risk pregnancies, with some patients entering prenatal care late at CHCs and hospitals.
    - Inability to offer competitive salaries also presents a major challenge to attracting and retaining providers. Participants noted maternity care providers are generally not coming into their service area.
    - Participants noted the lack of maternity providers also affects their ability to attract and retain prenatal care patients, since patients want to see a prenatal care provider who will also deliver their babies.
    - Participants noted that CHCs (and hospitals) report increases in pregnancies post-Dobbs.

- **"Losing" patients to hospitals and not "getting them back"**
    - Participants noted that following hospital-based specialty care and/or delivery, patients are unlikely to return back to CHC for postpartum visit. Participants indicate that hospitals are incentivized to keep patients for postpartum visits because they get a bundled maternity payment.
    - However, participants were concerned that some patients may not be returning to **any** provider for postpartum care. In order to stress the

importance of returning for postpartum care, to any provider, CHCs try to inform patients during their prenatal care visit and also discuss the risk of postpartum mortality/morbidity.
    - Participants were also concerned that their patients can lose out on crucial wrap-around and SDoH supports provided at CHCs and opportunities for early identification/intervention.

- **Interest in APMs is low among CHCs**
    - Participants noted that current PPS rates are not sufficient to keep up with maternity care costs. They noted that PPS does not support current market salaries. While delays in wraparound payments are also a problem, CHCs are unclear how APMs will fix current PPS deficiencies.
    - Participants conveyed fear that APMs may lead to worse consequences and financial losses, especially for those CHCs already operating on thin margins. Fears include not being able to meet certain metrics or suffering financial penalties.
    - While they understand APMs can provide flexibility in care delivery, CHCs are unclear how APMs can incentivize more providers to join or contract with CHCs.
    - Size and scale are a consideration. Reluctant participants believed that they did not have sufficient number of Medicaid patients to move to an APM.
    - Participants also stated that they have little trust that MCOs can offer reasonable APMs for CHCs. In general, they have limited working relationships with MCOs and have not seen MCOs support case management, transportation, or other services to address social drivers of health. They also noted that MCOs have been absent during Medicaid redetermination.

- **CHCs still curious about how APMs might support them**
    - Participant interest in APMs largely centered on the advantages of greater flexibility in care delivery. They also believed that having the "right metrics" and incentives would make APM more attractive. However, they conveyed a "wait and see" approach to see how APMs develop.
    - When asked about CIN participation, some noted that they were also participating and acknowledged that the CIN was in the early stages. Those not yet participating in the CIN wanted to see how it would work to ensure that the APM covers the full cost of care.

Conclusion: Texas' Medicaid managed care contracts are limited or silent on many key aspects of maternity care. The state's contracts can and should be significantly strengthened to align with new legislation and address gaps with other state contractual terms. At the same time, CHCs require a more robust and flexible financial payment model to meet the increasing demand for maternity care. As the new workforce and postpartum legislation unfolds, it will be important to closely monitor and evaluate its performance in restoring and improving CHC maternity care capacity and access.

Appendix

This project included two major phases: review of Medicaid managed care contracts and focus group of CHCs.

Medicaid managed care contract reviews: From Fall 2022 to Winter 2023, the GGP research team conducted an extensive review of all standard state Medicaid managed care contracts in use in 2022. Specifically, GGP's analysis examined whether states address within their contracts *35 key maternity topics*, identified through a comprehensive literature review of maternity care "best practices".[1] If a state contract addressed a topic, the detailed contractual language was extracted and analyzed.

The key findings from this review are summarized in **Table 1.** As seen in this table, Texas' Medicaid managed care contracts currently contain language on topics that include:

- Coverage of the full continuum of maternity care (in other words, the contract specifies that care must occur along the continuum of family planning, preconception care, prenatal care, birth/delivery, and postpartum care)
- Maternal mental health and substance use disorder (SUD) services
- Maternity-specific case management and/or care coordination
- Maternity-specific access to care

Table 1 summarizes key language from GGP's detailed contractual review of states' 2022 Medicaid managed care contracts. An "X" denotes that the state contract included language specific to the topic. As seen in Table 2-87, Texas has implemented **several key approaches** to ensuring high-quality maternity care in Medicaid managed care.

[1] The George Washington University. (2023). Best Practices in the Coverage and Delivery of Maternal Health: A Review of the Literature. [Link forthcoming]

CHC focus group: To inform EHF and TACHC's work, the Geiger Gibson team conducted a focus group with eight individuals from five Texan CHCs on October 25th. The CHCs represented a mix of large and small practices and varied locations, including urban, rural, and border areas, and some were grantees of EHF's Clinics Pathway Approach. Per GW IRB (NCR234909), focus group participation and discussions were anonymized to safeguard candid responses; and participants also had the option to drop from the study or not respond to questions. Participating CHC representatives largely consisted of CEOs, administrative and clinical staff. Due to the small sample size of the participants, key findings may not be generalizeable. Due to this limitation, we presented on key themes that reflect CHCs' interest and perceived challenges to taking part in APMs, particularly those with a maternity care focus. Our findings were presented to TACHC representatives on December 12th. The focus group discussion guide included the following questions:

Question Set A: What are health centers' experience with and appetite for APMs?

1) Are you familiar with APMs and their purpose?
2) Is your CHC taking part in any APMs with your health plans and partners? If so, what kinds of services/programs do they cover? What's your sense of how it is going?
3) If not currently participating, is your CHC interested in taking part in APMs? If so, what would your team need to take part? What are the benefits and barriers you foresee?

Question Set B: What services are essential for high-quality maternity care, and should be included in an APM? What challenges do CHCs face in providing this high-quality care, and how can MCOs support CHCs in overcoming these challenges?

In designing new maternity APMs, there are at least two important considerations. First, APMs must identify and target those services that are essential for high-quality maternity care. Second, MCOs must support CHCs in overcoming their greatest challenges in providing this care, so that CHCs can benefit from APMs.

4) What maternity services are essential for high-quality maternity care? For example:
    - Provision of timely prenatal and postpartum care
    - Use of the latest perinatal guidelines
    - Use of Maternal Early Warning System (MEWS) protocols
    - Use of TX DSHS-recommended perinatal outreach programs and engagement tools

- Established CHC-hospital partnerships to ensure access to maternal-fetal medicine specialists, complex care facilities, maternal mental health providers, etc?
- Regular screening for maternal mental health disorders during the prenatal and postpartum periods
- Regular screening for SDH needs during the prenatal and postpartum periods
  - Provision of care via CHWs, peer supports, doulas, etc
- Provision of maternity care in rural/shortage areas

5) What are the greatest challenges organizations face in providing this comprehensive range of maternity services? So that CHCs can benefit from APMs, how can MCOs support CHCs in overcoming their greatest maternity care challenges? For example:

- *Patient engagement:* Would CHCs benefit from enhanced MCO case management support to ensure that perinatal persons can achieve timely access to prenatal and postpartum visits?
- *Workforce:* Would CHCs benefit from additional MCO efforts to create robust networks of maternity providers, such as maternal-fetal medicine providers, midwives, CHWs, maternal mental health providers, etc?
- *Keeping up with maternity guidance:* Would CHCs benefit from MCOs providing easy access & training on the latest maternity guidelines

Table 1. Maternity Provisions Within State Medicaid Managed Care Contracts

State	Early Identification of Pregnancy	Full Maternal Health Continuum of Care[2]	Specialized Maternal-Fetal Medicine[3]	Doula Services[4]	Maternity-Related MH/SUD Services[5]	Maternity Case Management & Care Coordination[6]*	Transport[7]	Community Health Workers[8]	Oral Health[9]	Lactation Supports[10]	Maternity-Specific Access[11]	Maternity-Specific Performance Improvement Activities[12]	Maternity-Specific Payment Reform[13]	Mate Spe Perfor Measu
MN				X	X	X*	X	X	X		X	X	X	X
LA		X	X		X	X*				X	X		X	X
NH			X		X	X*	X			X	X		X	X
PA				X	X	X*	X	X			X		X	X
AZ	X	X			X		X				X		X	X
IL		X	X		X	X*				X	X			X
IN	X				X	X*	X		X				X	X
NV				X	X	X*		X			X	X	X	
VA				X	X	X				X	X		X	X
FL	X			X		X*					X		X	X
GA	X	X						X			X		X	X
HI			X		X	X*		X		X	X			
MO					X	X*	X		X		X			X

[2] The contract includes care specifications along the "full maternal health continuum of care", including family planning, preconception/interconception care, prenatal care, birth/delivery, and postpartum care.
[3] The contract includes network requirements or other practice-related provisions for maternal-fetal medicine providers (i.e., requirements for in-network inclusion or referral to these specialists without utilization management).
[4] The contract includes network requirements or other practice-related provisions for doulas.
[5] The contract explicitly mentions maternity-specific mental health and/or substance use disorder (SUD) services.
[6] The contract explicitly mentions maternity-specific care management and/or care coordination. States marked with an asterisk (*) have contracts that require MCOs to assess maternity patients' "risk" levels to determine their level of case management and/or care coordination need.
[7] The contract requires transportation services for maternity patients.
[8] The contract includes network requirements or other practice-related provisions for community health workers.
[9] The contract explicitly mentions maternity-related oral health services.
[10] The contract requires coverage of lactation services or devices (including lactation nurses, breast feeding courses, or breast pump coverage).
[11] The contract contains any of the following requirements: perinatal-specific travel time and distance requirements, perinatal-specific appointment wait times requirements, telehealth rules for maternity visits, or special access rules/network composition requirements for perinatal persons with high medical or social risk.
[12] The contract requires MCOS to implement maternity-related performance improvement activities.
[13] The contract explicitly mentions maternity-related payment reform approaches, including: bundled payments (e.g., what is in bundle, what period of care covered, who are providers), value-based payments (e.g., linked to performance measures), or in-lieu-of and value-added services (i.e., not covered in the contract).
[14] The contract explicitly names maternity-specific performance measures that MCOs must report on. All states marked with an "X" require maternity-specific performance measures from the CMS Core Set or HEDIS, except for those marked with a ¥; these states do not explicitly require maternity-specific CMS or HEDIS measures, but do require maternity-specific performance measures from other stewards. States marked with "X+" are those that require maternity-specific performance measures from the CMS Core Set or HEDIS plus maternity-specific performance measures from other stewards.

State	Early Identification of Pregnancy	Full Maternal Health Continuum of Care[2]	Specialized Maternal-Fetal Medicine[3]	Doula Services[4]	Maternity-Related MH/SUD Services[5]	Maternity Case Management & Care Coordination[6]*	Transport[7]	Community Health Workers[8]	Oral Health[9]	Lactation Supports[10]	Maternity-Specific Access[11]	Maternity-Specific Performance Improvement Activities[12]	Maternity-Specific Payment Reform[13]	Mate Spe Perfor Measu
MS					X	X*	X				X		X	X
NJ			X	X	X						X		X	X
OR				X	X			X	X			X	X	
WI			X		X	X*		X		X	X			
DE						X*		X			X		X	X
MI						X*	X	X	X					X
NE					X	X*			X				X	X
NM					X	X*		X				X		X
UT		X			X	X*					X			X
WA					X			X		X	X			X
MD				X	X	X					X			
OH					X			X					X	X
TX		**X**			**X**	**X***					**X**			
CO					X						X			X
KS					X						X		X	
KY			X										X	X
MA					X					X	X			
NY					X	X*					X			
RI				X		X					X			
TN					X	X*								X
DC					X						X			
IA					X						X			
ND											X			
SC						X*								
WV											X			
CA														
Total	**4**	**6**	**7**	**9**	**29**	**24**	**8**	**12**	**6**	**8**	**29**	**4**	**18**	**2**

Table 2: State Coverage of the Full Continuum of Maternity Services

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCOs are required to use specific maternity guidelines	**YES**[18]	Does not include updated guidelines	**YES**	6	IL,[19] MD[20]	IL & MD require use of current ACOG and UPSTF guidelines
2) MCO contracts include preconception care expectations	**YES**[21]	Current language is limited	**UNKNOWN**	7	AZ,[22] GA[23]	AZ requires that preconception care cover specific topics; GA requires use of a preconception toolkit
3) MCO contracts include early ID of pregnancy expectations	**NO**	Silent on approach	**UNKNOWN**	4	FL,[24] IN[25]	FL requires MCOs to have a plan for pregnancy identification; IN has a "notification of pregnancy" program with provider & plan incentives
4) MCO contracts include prenatal care expectations	**YES**[26]		**YES**	35	LA[27]	LA requires: MCOs partner with community groups to provide

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
		Current language has good stipulations, but could be more comprehensive				prenatal outreach, use ACOG guidelines, demonstrate adequate maternal-fetal medicine specialists & perinatal mental health providers, and use maternal engagement tools to supplement office care
5) MCO contracts include birth/delivery care expectations	**YES**[28]	Current language has good stipulations, but could be more comprehensive	**UNKNOWN**	17	AZ[29]	AZ clarifies the coverage of low-risk home births from licensed professionals
6) MCO contracts include postpartum care expectations	**YES**[30]	Current language is limited; does include good stipulation about postpartum risk assessment	**YES**	16	IL[31]	IL includes: detailed expectations for the content and frequency of postpartum visits, requires mechanisms to ensure postpartum mothers have direct contact with her care team & case manager for referrals, requires high-risk postpartum mothers are closely followed

Table 3: State Augmentations to Medical Maternity Care

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCO contracts include expectations for perinatal case management	**YES**[32]	Current language is very limited	**YES**	**24**	MO,[33] NM,[34] TN[35]	TN and MO include detailed expectations for low-risk and high-risk maternity case management; NM provides detailed expectations for high-risk cases
2) MCOs are required to use screening tools to identify high-risk maternity patients	**YES**[36]	Current language is very limited; does include good stipulation about postpartum risk assessment	**UNKNOWN**	**19**	MO,[37] MS[38]	MO requires MCOs to screen all pregnant members within 15 days of notice of pregnancy or enrollment & to file their risk assessment; MS requires clear risk stratification levels (low, medium, and high) based on the screening tool
4) MCO contracts include maternal mental health service expectations	**YES**[39]		**YES**	**22**	AZ[40]	

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
		Current language is very limited				AZ requires mental health screening & follow-up during the prenatal and postpartum visit
5) MCO contracts include maternal SUD service expectations	**YES**[41]	Current language is very limited	**YES**	**22**	AZ,[42] KS[43]	AZ requires SUD screening once per trimester and appropriate follow-up; KS requires that pregnant persons with SUD receive care within 48 hours of contact
6) MCO contracts include lactation support expectations	**NO**	Silent on approach	**UNKNOWN**	**8**	HI[44]	HI requires coverage of lactation support for 6 months and breastfeeding education
7) MCO contracts include oral health expectations for maternity patients	**NO**	Silent on approach	**UNKNOWN**	**6**	MI,[45] MO[46]	MI and MO require coverage or oral health services for pregnant persons
8) MCO contracts include expectations for addressing housing needs for maternity patients	**NO**	Silent on approach	**UNKNOWN**	**3**	MO[47]	MO requires that health plans support housing insecure mothers with

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
						alternate arrangements within 24 hours

Table 4: State Maternity Workforce Policies

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCO contract provides expectations for doula coverage	**NO**	Silent on approach	**YES**	**9**	MN,[48] NV[49]	MN specifies coverage of doula services; NV requires plans to allow doulas as care coordinators
2) MCO contract provides expectations for community health worker or peer support specialist coverage	**NO***	No contractual language despite coverage*	**YES**	**12**	MI,[50] NV[51]	NV requires plans to allow CHWs and peer support specialists as care coordinators; MI requires plans to partner with community-based organizations to create CHW programs to address SDH and provide care coordination

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
3) MCO contract provides coverage of midwives	**YES**[52]	Current language is limited	**UNKNOWN**	**35**	AZ[53]	AZ specifies expectations for midwives, including that certified nurse midwives can act as primary care providers (PCPs)
4) MCO contract includes coverage of Maternal Fetal Medicine specialists	**NO***	Silent on approach	**UNKNOWN**	**7**	LA[54]	LA requires available and accessible maternal fetal specialists in the MCO network
5) MCO contract provides coverage of care within free-standing birth centers	**NO***	No contractual language despite coverage*	**UNKNOWN**	**13**	KS[55]	KS requires that plans include at least one free-standing birth center in their networks
6) Implicit bias trainings required of providers	**NO**	Silent on approach	**YES**	**0** (No states include this in MCO contracts, but 5 require training by state law)	MI, MN	5 states, including MI and MN, have signed legislation into law requiring at least some healthcare workers to take implicit bias training, some as a prerequisite for professional licensure or renewal[56]

** While no specific language was included in the MMC contracts, these services ARE covered under Medicaid managed care.*

Table 5: State Maternity Care Access Policies

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCO contract specifies appointment wait times for perinatal care appointments, including high-risk pregnancies	**YES**[57]	Current language has good stipulations, but could be more comprehensive	**YES**	**16**	AZ,[58] LA[59]	AZ & LA specifies wait times for a prenatal appointment in each trimester
2) MCO contract requires the inclusion of facilities that can handle more complex conditions	**YES**[60]	Current language is very comprehensive, but do not require use of TX's complex-care tools (see below)	**YES**	**9**	-	-
3) MCO contract references maternity-specific transport	**NO**	Silent on approach	**YES**	**8**	MO,[61] MS[62]	MO requires health plans to provide assistance to patients in making transportation arrangements for all maternity care; MS requires health plans to create processes for last-minute maternity care transport issues

Table 6: State Performance Measurement & Performance Improvement Policies

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCOs required to report CMS maternal health performance measures	**NO**	Silent on approach	**UNKNOWN**	**19**	FL,[63] LA[64]	FL& LA require MCOs to collect and report on several CMS maternity measures
2) MCOs required to report additional maternal health performance metrics	**NO**	Silent on approach	**YES**	**7**	IN[65]	IN requires MCOs to collect and report on the HEDIS maternal mental health screening and follow-up measure
3) MCOs required to collect race-stratified data	**NO**	Silent on approach	**YES**	**3**	CO[66]	CO requires that health plans stratify all performance measures by race/ethnicity
4) MCOs take part in a maternity PIP/QIP	**NO**	Silent on approach	**YES**	**4**	NM,[67] NV[68]	NM and NV require that all health plans conduct a maternity PIP

Table 7: State Texas' Payment Reform Policies

	Does TX Use this Approach?	Limitations to Current TX Approach	Has TX Made Progress on the Approach?	# States Using Approach	Other State Approaches to Consider	Details of Other State(s) Approaches
1) MCOs required to take part in perinatal payment reform initiatives	**NO**	Silent on approach	**YES**	**18**	AZ,[69] FL,[70] KS[71]	AZ withholds 20% of payment if prenatal and postpartum visits timeliness targets are not met; FL requires health plans to pay a fine if prenatal and postpartum visit timeliness targets are not met; KS requires MCOs to pay a fine if maternity patients with SUD do not receive care within 48 hours of contact; KY requires health plans to pay a fine if prenatal care is not received within the timeline required

[1] https://www.kff.org/statedata/
[2] https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf
[3] https://www.washingtonpost.com/politics/2023/06/21/obgyn-abortion-poll/
[4] https://files.kff.org/attachment/fact-sheet-medicaid-state-TX
[5] https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[6] https://www.commonwealthfund.org/sites/default/files/2023-05/Rosenbaum%20Appendix%202%20-%20A%20Review%20of%20the%20Literature%20-%20Best%20Practices%20in%20the%20Coverage%20and%20Delivery%20of%20Maternal%20Health.pdf
[7] https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care#:~:text=The%20Road%20to%20Maternal%20Health%20Runs%20Through%20Medicaid%20Managed%20Care,-Ariel%20Zetina%2C%20who&text=We%20face%20a%20maternal%20mortality,based%20on%20race%20and%20ethnicity.
[8] https://www.commonwealthfund.org/sites/default/files/2023-05/Rosenbaum_Appendix%201_Tables.pdf
[9] https://www.episcopalhealth.org/news-release/texas-legislature-takes-monumental-step-to-improve-health-not-just-health-care-in-addressing-maternal-health-crisis/
[10] https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/
[11] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/alternative-payment-models-texas-medicaid.pdf
[12] https://www.hhs.texas.gov/sites/default/files/documents/2021-apm-summary.xlsx
[13] https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=37&rl=253
[14] https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Joint-Biennial-MMMRC-Report-2022.pdf
[15] https://www.dshs.texas.gov/maternal-child-health/programs-activities-maternal-child-health/texasaim
[16] https://www.tchmb.org/mews
[17] https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Joint-Biennial-MMMRC-Report-2022.pdf
[18] 8.1.22.4. Perinatal Services.... The MCO's perinatal health care system **must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M**. (p. 163, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions, Texas)
[19] 3.1.3.13 Maternity care: At a minimum, Contractor shall provide the following services: 3.1.3.13.1 **a comprehensive prenatal evaluation, examination, testing, and care in accordance with the latest standards recommended by ACOG, USPSTF and other leading academic and national clinical or specialty based organizations**…3.1.3.13.3.4 **routine laboratory screening per ACOG and USPSTF recommendations**….1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities **in accordance with ACOG guidelines**.. (pp. 309-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)
[20] G. **An MCO shall follow, at a minimum, the American College of Obstetricians and Gynecologists (ACOG) guidelines for pregnant and postpartum women**. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)
[21] 8.1.22.4. Perinatal Services… The MCO must have a perinatal health care system in place that, at a minimum, provides the following services: **1. Pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents; 2. Perinatal risk assessment of non-pregnant women**, pregnant, and postpartum women, and infants up to one year of age; Access to appropriate levels of care based on risk assessment, including emergency care. (p. 163, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions, Texas)
[22] … The well-woman preventive care visit is inclusive of a minimum of the following:… **x. Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes**: (a) Reproductive history and sexual practices, (b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake, (c) Physical activity or exercise, (d) Oral

health care, (e) Chronic disease management, (f) Emotional wellness, (g) Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and (h) Recommended intervals between pregnancies... (p. 3, Effective February 2021, AMPM Policy 411, AHCCS Medical Policy Manual, Chapter 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

[23] 3. Education and Training... **The Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at:** http://fpm.emory.edu/preventive/research/projects/index.html. (p. 74, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)http://fpm.emory.edu/preventive/research/projects/index.html. (p. 74, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

[24] (e) The Managed Care Plan shall **implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant**. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

…Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care. (p. 29, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

[25] 3.4 Pregnancy Coverage under HIP… **The Contractor shall develop policies and procedures for quickly identifying pregnant HIP members. The Contractor shall notify the State's fiscal agent within one (1) business day of confirming a member's pregnancy. The notice shall include the pregnancy start date as well as the expected delivery date. Date of confirmation for purposes of this Section 3.4 shall mean the date the Contractor receives notification of member pregnancy from the provider, whether through the official NOP form described in Section 9.2.3 or otherwise. In the event the Contractor discovers member pregnancy prior to provider confirmation, such as through claims data, the Contractor shall confirm member pregnancy with the provider within three (3) business days of discovery, provided the member has engaged with a provider… The Contractor shall have policies and procedures in place for quickly identifying pregnant members and suspending all cost-sharing. The Contractor is responsible for informing the member of their HIP Maternity coverage**. This information shall, at minimum, be included in the Contractor's Member Handbook, as described in Section 7.4.1. The Contractor shall also work closely with its providers to complete the Notification of Pregnancy risk assessment on all pregnant members, as detailed in Section 9.2.3. (p. 36, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.3 Notification of Pregnancy (NOP) Incentives. OMPP has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., a NOP form) for pregnant members. The Contractor shall comply with the policies and procedures set forth in the IHCP Provider Bulletin regarding the NOP process dated May 22, 2014 (BT201425), and any updates thereto. **The provider shall be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health risk assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider.** Only one assessment should be completed per member per pregnancy, regardless of whether the member receives pregnancy services through the Presumptive eligibility for pregnant women program. To be eligible for the provider incentive payment, the NOP form shall be submitted by providers via the Portal within five (5) calendar days of the visit during which the NOP form was completed. **The State shall reimburse the Contractor for NOP forms submitted according to the standards set forth in the HIP MCE Policies and Procedures Manual. This reimbursement amount shall be passed on to the provider who completed the NOP form. An additional amount will be transferred to a bonus pool. The Contractor shall be eligible to receive bonus pool funds based on achievement of certain maternity-related targets.** See Exhibit 4 for further detail regarding the NOP incentives and maternity-related targets. The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in a prenatal case management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p.144, Amendment #14, Effective, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential… b. Additional Maternity Payments and Incentives. **FSSA will reimburse Contractor $60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire $60 payment to the physician that completed the NOP form on behalf of the pregnant member**. (p. 193, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

[26] 8.1.22.4 Perinatal Services… The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... **2. Perinatal risk assessment of… pregnant women**; **3. Access to appropriate levels of care based on risk assessment, including emergency care**; **4. Transfer and care of pregnant women… to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent**

preterm birth, such as hydroxyprogesterone caproate. … **The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births**. **….MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born**... (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms &

[27] 6.11. Prenatal Care Services. 6.11.1. The MCO shall ensure Medicaid members under its care who are pregnant, **begin receiving care within the first trimester or within seven (7) days after enrolling in the MCO.** (See Attachment C.) **The MCO shall provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services, including specialized behavioral health services that are incidental to a pregnancy (in accordance with 42 CFR Part 440, Subpart B,) to all members.** As noted in the Women's Health Services subsection**, the pregnant member shall be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP**. 6.11.2. **The MCO shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members.** 6.11.3. **The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth**. 6.11.4. **The MCO shall ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to the MCO as well as appropriate referrals to the WIC program for nutritional assistance.** (A sample WIC Referral Form may be found at this link). 6.11.5. **The MCO shall develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to LDH for approval.** Some goals of this program would be to: 6.11.5.1. Improve overall engagement in the maternity population and help women keep appointments and educate them about needed health screenings throughout pregnancy; 6.11.5.2. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources; and 6.11.5.3. Improve health decisions across the pregnant population based on available Statebased and MCO-based programs and services. (pp. 79-80, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.13. Perinatal Services 6.13.1. MCO shall maintain a plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following: 6.13.1.1. **Routine cervical length assessments for pregnant women; 6.13.1.2. Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy.** The MCO shall not require prior authorization of progesterone for the prevention of premature birth unless written approval from the Medicaid Medical Director is obtained. The MCO will provide progesterone access to eligible members in a timely fashion. (p. 81, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

[27] 6.12. Maternity Services. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both mother and newborn child. All medically necessary procedures listed on the claim are the responsibility of the MCO regardless of primary or secondary mental health diagnosis appearing on the claim. (p. 81, Effective 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

[28] 8.1.22.4. Perinatal Services... **The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the Newborn Member, and may not place limits on the duration of such care.** (p. 164, Effective March 1, 2022, Document Revision V1.39, Attachment B-2 – STAR+PLUS, Dallas and Tarrant Service Areas RFP, STAR+PLUS, Covered Service, Texas)

[29] Maternity Services: …**Members anticipated to have a low-risk delivery, may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services**. **Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services.** The Contractor shall allow women and their newborns to receive no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with an agreement by the mother, may discharge the mother or newborn prior to the minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the minimum 48 or 96 hour stay, whichever is applicable. (p. 81, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (p. 172, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

[30] 8.1.22.4 Perinatal Services… The MCO's perinatal health care services must **ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life...** The MCO must have a perinatal health care system in place that, at a minimum, provides the following services**… 2. Perinatal risk assessment of postpartum women, and infants up to one year of age; 3. Access to appropriate levels of care based on risk assessment, including emergency care; 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems…** (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions, Texas)

[31] 3.1.3.13.5 **Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services:** …. 3.1.3.13.5.1 **postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective Family Planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials and WIC; 3.1.3.13.5.2 postpartum depression screening during the one (1)–year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). After delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)–week postpartum visit; 3.1.3.13.5.3 Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if Medically Necessary, to avoid interruption of care; 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease; and 3.1.3.13.5.5 Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery**. (pp. 312-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)
3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items…3.1.3.13.3.5 visits close to the third (3rd) trimester should include**… options for postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated…. transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy**. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

[32] 8.1.24.4 Perinatal Services.... The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... **2. Perinatal risk assessment of pregnant and postpartum women**;… **7. Education and care coordination for Members who are at high-risk for preterm labor**. (pp. 8-157 to 8-158, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

[33] **The health plan shall screen all pregnant members for care management needs and offer care management to all pregnant members. The health plan shall offer care management within fifteen (15) business days of date effective with the health plan of newly eligible members or within fifteen (15) business days of notice of pregnancy for currently eligible members. The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs and must be completed within fifteen (15) business days form the date effective with the health plan for newly eligible members or within fifteen (15) business days of notice of pregnancy for currently eligible members**... e. Care Plans... 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women: **A risk appraisal form must be a part of the member's record**. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd. **Intermediate referrals to substance-related treatment services if the member is identified as being a substance user**. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. **Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in care management; Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment; Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21); Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in care management; Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation; Assistance in making transportation arrangements for prenatal care, delivery, and postpartum care; Referrals to prenatal or childbirth education where available; Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment; Assistance to the mother in enrolling the newborn in**

ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed; Assistance in identifying and selecting a medical care provider for both the mother and the child; Identification of feeding method for the child; Notifications to current health care providers when care management services are discontinued; Referrals for family planning services if requested; and Directions to start taking folic acid vitamin before the next pregnancy. (pp. 71, 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

[34] **Based on the Comprehensive Needs Assessment, the CONTRACTOR shall assign care coordination level 2, at a minimum, to Members with one of the following:… 4.4.6.1.7 High risk pregnancy including pregnant members who are eighteen (18) years and younger**…4.4.6.3 Care coordinators for Members in care coordination level 2 shall provide and/or arrange for the following care coordination services: 4.4.6.3.1 **Development and implementation of a CCP; 4.4.6.3.2 Monitoring of the CCP to determine if the CCP is meeting the Member's identified needs; 4.4.6.3.3 Assessment of need for assignment to a Health Home; 4.4.6.3.4 Targeted Health Education, including disease management, based on the Member's individual diagnosis (as determined by the Comprehensive Needs Assessment); 4.4.6.3.5 Annual Comprehensive Needs Assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed; 4.4.6.3.6 Semi-annual in-person and in-home visits with the Member; 4.4.6.3.7 Two telephonic contacts shall occur as follows: (1) 60-90 Calendar Days, and (2) 240-270 Calendar Days, from the most recent CNA** (pp. 53-54, no date, New Mexico Amended Version Sample RFP)

[35] 2**.8.4.2 Low Risk Maternity Program The CONTRACTOR shall provide a Low Risk Maternity Program** for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications. 2.8.4.2.1 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program. 2.8.4.2.1.**1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions: 1. Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract. 2. One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health. 3. Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management. 4. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. 5. Referrals to appropriate community–based resources and follow-up for these referrals.**

2.8.4.6 High Risk Maternity Program The CONTRACTOR shall provide a High Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. **2.8.4.6.1 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for the High Risk Maternity Program to inform the member about the program.** For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days. 2.8.4.6.2 **The CONTRACTOR shall provide to members enrolled in the High Risk Maternity Program the following minimum standard interventions: One interactive contact to the member per month of pregnancy to provide intense case management including the following: Development of member support relationship by face to face visit or other means as appropriate. Monthly interactive contacts to support and follow-up on patient self-management. If prenatal visits have not been kept more frequent calls are required. Comprehensive HRA to include screening for mental health and substance abuse. Development and implementation of individualized care plan to include information on pregnancy, newborn, and inter-conception health. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. Referrals to appropriate community–based resources and follow-up for these referrals. If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including Tennessee Tobacco QuitLine**. (pp. 9-11, 13, no date, Amendment 11, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

[36] 8.1.24.4 Perinatal Services.... The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... **2. Perinatal risk assessment of pregnant and postpartum women**. (pp. 8-157 to 8-158, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

[37] **The health plan shall screen all pregnant members for care management needs…The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs and must be completed within fifteen (15) business days form the date effective with the health plan for newly eligible members or within fifteen (15) business days of notice of pregnancy for currently eligible members**... e. Care Plans... 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women: **A risk appraisal form must be a part of the member's record**. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd. (pp. 71, 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

[38] 1. Assignment of Risk Levels. **The Contractor shall develop a Care Management program that addresses the varying needs and differing levels of Care Management needs for Members. Based on the Health Risk Screening, the Contractor's Care Management program must provide for the completion of a detailed health risk assessment for Members, which includes an assessment of and assignment to risk stratification levels (e.g., low, medium, rising, high) which determine the intensity of interventions and follow-up care that is required for each Member. The Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need**. Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to …. pregnant women under twenty-one (21), high risk pregnancies… shall be assigned to the medium or high risk level and receive Care Management services. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to high risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and shall have access to Care Management teams. (p. 118, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

[39] **The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC requires that the MCO designate Members in the following groups as MSHCN: . . . 8.1.12.1.2.Pregnant women identified as high risk, including: . . . 8.1.12.1.2.c. Pregnant Members with mental health . . . diagnoses.** (pp. 122, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

[40] The minimum requirements of the Contractor's maternity care program shall include:… **16. Identification of postpartum depression for referral of members to the appropriate health care providers. The Contractor shall require the use of any normally referenced validated screening tool to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the maternity care provider or subsequent referral to the plan/entity responsible for the provision of behavioral health services, if clinically indicated.** …C. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that providers adhere to the following maternity care requirements**:… 3. Maternity care providers shall ensure that:… g. Perinatal and postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service: i. Providers shall refer to any norm-referenced validated screening tool to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the Primary Care Provider (PCP) or subsequent referral to the plan/entity responsible for the provision of behavioral health services if clinically indicated**… (p. 5-7, Effective September 01, 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

[41] The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). **HHSC requires that the MCO designate Members in the following groups as MSHCN: . . . 8.1.12.1.2. Pregnant women identified as high risk, including: . . . 8.1.12.1.2.c. Pregnant Members with . . . substance use disorder diagnoses**. (p. 122, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

[42] Maternity care providers shall ensure that:… b**. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling shall be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment... e. All pregnant members shall receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed**... (p. 7, Effective September 01, 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

[43] **SUD Access to Care Standard:** CONTRACTOR(S) must comply with the contract provisions regarding priority access to care for pregnant women**. At minimum, pregnant women are to be placed in the urgent category. Members are assessed within 24 hours of initial contact and services delivered within 48 hours of initial contact. CONTRACTOR(S) must demonstrate performance at 100%. (Data source: KCPC.) Fine: $10,000 for each non-compliant finding/pregnant woman not assigned at minimum to urgent category, not assessed within 24 hours of initial contact, or not delivered services within 48 hours of initial contact.** Validation of metric will be completed by KDADS chart review prior to damages being assessed to the CONTRACTOR(S). (p. 9, no date, Attachment G, Liquidated Damages. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

[44] The following services are covered under pregnancy-related services:... **7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on... breastfeeding**... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

[45] **B. Services Covered Under This Contract… mm. Dental services for pregnant beneficiaries.** (p. 49, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

[46] In addition to the services listed in the comprehensive benefit package herein, **the health plan shall provide the following services to… pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98**.... **b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan**... (p. 58, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

[47] In addition to the requirements listed above, **the health plan shall include the following in the care plans of pregnant women:.. Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment**... (p. 75, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

[48] **6.1.35.2 Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered.** [Minnesota Statutes, §256B.0625, subd. 28b] (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

[49] 7.5.6.6.3. A Care Coordinator for purposes of this Contract is a para-professional, whose background is most frequently anchored in the disciplines of social work or community health systems to improve health outcomes. **Care Coordination services may be provided by non-licensed staff, including Community Health Workers, Promotores or Peer Support Specialists, and Doulas for Contractors who may offer this service as a Value Added Service**. (p. 148, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

[50] **Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience**. Examples of CHW services include but are not limited to: i. Conduct home visits to assess barriers to healthy living and accessing health care ii. Set up medical and behavioral health office visits iii. Explain the importance of scheduled visits to clients iv. Remind clients of scheduled visits multiple times v. Accompany clients to office visits, as necessary vi. Participate in office visits, as necessary vii. Advocate for clients with Providers viii. Arrange for social services (such as housing and heating assistance) and surrounding support services ix. Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care x. Help boost clients' morale and sense of self-worth xi. Provide clients with training in self-management skills xii. Provide clients with someone they can trust by being reliable, nonjudgmental, consistent, open, and accepting xiii. Serve as a key knowledge source for Services and information needed for clients to have healthier, more stable lives (pp. 71-72, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

[51] 7.5.6.6.3. A Care Coordinator for purposes of this Contract is a para-professional, whose background is most frequently anchored in the disciplines of social work or community health systems to improve health outcomes**. Care Coordination services may be provided by non-licensed staff, including Community Health Workers, Promotores or Peer Support Specialists, and Doulas for Contractors who may offer this service as a Value Added Service**. (p. 148, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

[52] **Services included under the MCO capitation payment. Prenatal care provided by a . . . certified nurse midwife (CNM)**. (pp. 7, 9, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

[53] Maternity Services: **Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant… Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice**… Refer to AMPM Policy 410. p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

[54] 6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and **have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists**. (p.80, Effective October 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

[55] CONTRACTOR(S) shall adhere to the following requirements and considerations for specific Provider types within its Provider network: … **4. Include at least one FQHC, RHC, and Free-Standing Birthing Center (FBC) in accordance with CMS' State Health Officials Letter #16-006**. (p. 70, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

[56] Ollove, M. (2022). Implicit Bias Hurting Patients, Some States Train Doctors. The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/04/21/with-implicit-bias-hurting-patients-some-states-train-doctors

[57] **8.1.3.1 Appointment Accessibility… 8. Pre-natal care must be provided within 14 Days for initial appointments, except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five Days, or immediately, if an emergency exists.** Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider (pp. 69-70, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

[58] **4. For Maternity Care Provider Appointments, initial prenatal care appointments with the provider for enrolled pregnant members shall be provided as follows: a. First trimester - within 14 calendar days of request, b. Second trimester within seven calendar days of request, c. Third trimester within three business days of request, and d. High risk pregnancies as expeditiously as the member's health condition requires and no later than three business days of identification of high risk by the Contractor or maternity care provider or immediately if an emergency exists**. (p. 417, Effective October 1, 2022, ACOM Policy 417, AHCCS Contractor Operations Manual Chapter 400 – Operations)

[59] Maternity Care Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. **The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy. •Within their first trimester within 14 days; •Within the second trimester within 7 days; •Within their third trimester within 3 days; •High risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists**. (p. 115, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

[60] The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:… **4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.** (p. 163, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

[61] **In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:.. Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care**;... (p. 75, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

[62] Because scheduling issues will occasionally occur, **the Contractor must develop processes for handling urgent trips, high risk trips, last minute requests from Members, their family members, guardians or representatives and Mississippi Medicaid Providers, scheduling changes and NET Providers who do not arrive for scheduled pick-ups. Trips considered "high risk" include but are not limited to the following types of requests:… high risk pregnancy, newborn check, prenatal appointment**... (p. 246, Effective July 2017, Exhibit E, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

[63] Section IX. Quality... B. Performance Measures (PMs) 1. Required Performance Measures a. The Managed Care Plan shall collect and report the performance measures in the Required Performance Measures Table, Table 6, below, certified via a qualified auditor. Table 6 Required Performance Measures Healthcare Effectiveness Data and Information Set (HEDIS)… **13. Prenatal and Postpartum Care - (PPC)… Child Core Set... 30. Contraceptive Care – Postpartum Women Ages 15-20 - (CCPCH) 31. Contraceptive Care – All Women Ages 15-20 (CCW-CH) 32. Elective Delivery – (PC-01) 33. Cesarean Section – (PC-02) Adult Core Set... 36. Contraceptive Care – Postpartum Women Ages 21-44 – (CCPAD) 37. Contraceptive Care – All Women Ages 21-44 (CCW-AD)** (pp. 72-74, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

[64] Performance Measures. Measure: **Prenatal and Postpartum Care -Timeliness of Prenatal Care. The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. Measure: Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2): The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery … Measure: Contraceptive Care-Postpartum: The percentage of women ages who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery.** Four rates are reported. (pp. 407-408, 417, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

[65] **Prenatal Depression Screening and Follow-Up (PND-E). The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. HEDIS measure (PND-E) using hybrid data.** Amount of Performance Withhold at risk: 5% If the Contractor timely and accurately reports this measure for the 2022 measurement year, in accordance with State expectations, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. (p. 196, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

[66] **The Contractor shall disaggregate their performance and utilization data at least by race and ethnicity, language, and disability status in strategic priority areas and make this information available to the department and stakeholders upon request**. (p. 120, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

[67] 4.**12.4.10 At a minimum the CONTRACTOR shall implement Performance Improvement Projects (PIPs) in the following areas: … one (1) Prenatal and Postpartum.** (p. 143, New Mexico Amended Version Sample RFP, 2022).

[68] **7.9.5.4. The Contractor will be required annually to conduct and report on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs.** Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, maternal and child health outcomes, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and Appeals and Grievances**. 7.9.5.5. The Contractor must participate in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by the State**. 7.9.5.6. The Contractor must select an additional two (2) projects from the list below, to serve as the Contractor's required PIPs in accordance with 42 CFR 438.330(a)(2) and 42 CFR 438.358: 7.9.5.6.1. Increasing access to and use of primary care and preventive services across the covered population; 7.9.5.6.2. Improving quality of and access

to Behavioral Health Services; 7.9.5.6.3. Reducing preventable thirty (30) day hospital readmissions; and 7.9.5.6.4. Social determinants of health and health equity. (p. 245, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

[69] Measure 3: **Prenatal and Postpartum Care: Timeliness of Prenatal Care Higher is Better; Percent of Withhold: 20%** (p. 1, Effective October 1, 2021, ACOM Policy 306, Attachment B – APM Quality Performance Measure Scores – ACC, For the Contract Year Ending 09/30/21)

[70] The Managed Care Plan **may receive a monetary sanction of up to ten thousand dollars ($10,000.00) for each performance measure group where the group score is below three (3). Performance measure groups are as follows: d. Prenatal/Perinatal (1) Prenatal and Postpartum Care (includes two (2) measures)** (p. 94, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

[71] Performance Guarantees. SUD Access to Care Standard: CONTRACTOR(S) must comply with the contract provisions regarding priority access to care for pregnant women. **At minimum, pregnant women are to be placed in the urgent category. Members are assessed within 24 hours of initial contact and services delivered within 48 hours of initial contact. CONTRACTOR(S) must demonstrate performance at 100%. (Data source: KCPC.) Fine: $10,000 for each non-compliant finding/pregnant woman not assigned at minimum to urgent category, not assessed within 24 hours of initial contact, or not delivered services within 48 hours of initial contact.** Validation of metric will be completed by KDADS chart review prior to damages being assessed to the CONTRACTOR(S). (p. 9, no date, Attachment G, Liquidated Damages. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)