Table 1. Coverage

This table presents information on the coverage of family planning as a state plan benefit, including states that operate Medicaid as a 1115 demonstration for populations beyond those who may be eligible under a family planning demonstration alone. It also indicates if coverage is required coextensive with state plan coverage, as well as whether family planning is specified as a pregnancy-related service for postpartum women. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.[*]

State	Identifies family planning as a covered benefit‡		Contract is explicit on coverage of all FDA-approved family planning methods†		Contractors are required to cover family planning services coextensive with state plan coverage		Contractors are required to cover family planning as a pregnancy-related service for postpartum women		Contractors are required to cover a defined list of "family planning related" services		Contractors are required to cover quick start prescribed contraceptives without a visit (applicable to general plans that cover Rx) ¥	
	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)
AZ	Y	X[1]	N				Y	X[2]	N		N	
CA	Y	X[3]	Y	X[4]			N		N		N	
CO	Y	X[5]	N				N		N		N	
DC	Y	X[6]	N		Y	X[7]	N		N		N	
DE	Y	X[8]	N		Y	X[9]	N		N		N	
FL	Y	X[10]	N				Y	X[11]	N		N	
GA	Y	X[12]	N		Y	X[13]	N		N		N	
HI	Y	X[14]	N				N		N		N	

[*] All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

† Managed care contract explicitly mentions the coverage of all FDA-approved family planning methods; the state plan may provide additional clarity on coverage of FP methods if contractors are required to cover family planning services coextensive with state plan coverage.

‡ The contract requires the MCO to provide family planning services, unless alternative arrangements are made for religious or moral accommodations.

Includes states operating their state plans under 1115 authority for beneficiary populations beyond those eligible under a family planning demonstration alone.

¥ Four states (MO, TN, WI, and WV), according to KFF, currently carve out some or all prescription drug coverage from their MCO contracts. As such, this may create additional utilization management issues.

State	Identifies family planning as a covered benefit‡		Contract is explicit on coverage of all FDA-approved family planning methods†		Contractors are required to cover family planning services coextensive with state plan coverage		Contractors are required to cover family planning as a pregnancy-related service for postpartum women		Contractors are required to cover a defined list of "family planning related" services		Contractors are required to cover quick start prescribed contraceptives without a visit (applicable to general plans that cover Rx) ¥	
	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)
IA	Y	X[15]	N		N		N		N		N	
IL	Y	X[16]	Y	X[17]	Y	X[18]	Y	X[19]	N		N	
IN	Y	X[20]	N		N		N		N		N	
KS	Y	X[21]	N		N		N		N		N	
KY	Y	X[22]	N		N		N		N		N	
LA	Y	X[23]	Y	X[24]	N		Y	X[25]	N		N	
MA	Y	X[26]	N		N		N		N		N	
MD	Y	X[27]	Y	X[28]	Y	X[29]	N		N		N	
MI	Y	X[30]	N		Y	X[31]	N		N		N	
MN	Y	X[32]	N		N		N		N		N	
MO ¥	Y	X[33]	N		N		Y	X[34]	N		N	
MS	Y	X[35]	N		Y	X[36]	N		N		N	
ND	Y	X[37]	N		N		N		N		N	
NE	Y	X[38]	Y	X[39]	N		N		N		N	
NH	Y	X[40]	N		Y	X[41]	N		N		N	
NJ	Y	X[42]	N		N		Y	X[43]	N		N	
NM	Y	X[44]	N		Y	X[45]	N		N		N	
NV	Y	X[46]	N		N		N		N		N	
NY	Y	X[47]	Y	X[48]	N		N		N		N	
OH	Y	X[49]	N		N		N		N		N	
OK	Y	X[50]	N		N		Y	X[51]	N		N	

State	Identifies family planning as a covered benefit‡		Contract is explicit on coverage of all FDA-approved family planning methods†		Contractors are required to cover family planning services coextensive with state plan coverage		Contractors are required to cover family planning as a pregnancy-related service for postpartum women		Contractors are required to cover a defined list of "family planning related" services		Contractors are required to cover quick start prescribed contraceptives without a visit (applicable to general plans that cover Rx) ¥	
	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)
OR	Y	X[52]	N		N		N		N		N	
PA	Y	X[53]	N		Y	X[54]	N		N		N	
RI	Y	X[55]	Y	X[56]	N		N		N		N	
SC	Y	X[57]	N		N		N		N		N	
TN ¥	Y	X[58]	N		N		N		N		N	
TX	Y	X[59]	N		Y	X[60]	N		N		N	
UT	Y	X[61]	N		Y	X[62]	N		N		N	
VA	Y	X[63]	N		N		Y	X[64]	N		N	
WA	Y	X[65]	Y	X[66]	N		N		N		N	
WI ¥	Y	X[67]	N		N		Y	X[68]	N		N	
WV ¥	Y	X[69]	N		N		N		N		N	
Total	**Y = 40 N = 0**		**Y = 8 N = 32**		**Y= 12 N= 28**		**Y= 9 N= 31**		**Y= 0 N= 40**		**Y= 0 N= 40**	

[1] Family Planning Services: The Contractor shall provide family planning services in accordance with the AMPM, and consistent with the terms of the Section 1115 Waiver Demonstration, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, are also included. If the Contractor does not provide family planning services due to moral and religious objections, it must contract for these services through another health care delivery system or have an approved alternative in place. The Contractor shall submit a Sterilization Report as specified in APMPM Policy 420 and Section F, Attachment F3, Contractor Chart of Deliverables. (Amendment #14, pp. 50-51, October 2019, Arizona Medicaid Managed Care Contract)

[2] The Contractor must monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries, utilization of Long Acting Reversible Contraceptives (LARC), prenatal, and postpartum visits (p. 92)
CMS CHILD CORE MEASAURES** Maternal and Perinatal Health: Contraceptive Care – Postpartum Women (CCP) (Attachment FR, p. 222, October 2019, Arizona Medicaid Managed Care Contract)

[3] 9. Access to Services with Special Arrangements A. Family Planning - Members have the right to access family planning services through any family planning Provider without Prior Authorization. Contractor shall provide family planning services in a manner that protects and enables Member freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. Contractor shall inform its Members in writing of their right to access any qualified family planning Provider without Prior Authorization in its Member Services Guide. (Attachment 13, Exhibit A, p. 66, 2017, California GMC Non-CCI Boilerplate Contract)

[4] Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement: Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. (p. 125, 2017, California GMC Non-CCI Boilerplate Contract).

[5] 2.1.26. Comprehensive Risk Contract – A risk contract between the Department and an MCO that covers comprehensive services that includes […] family planning services […] (p. 4, July 2019, Region 1, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract)

[6] Table A: Medicaid Covered Services: Family planning services and supplies (p. 77, April 2019, District of Columbia Medicaid Managed Care Model Contract)

[7] Contractor shall furnish services in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries through a FFS arrangement, in accordance with 42 C.F.R. § 438.210(a)(2), as a requirement of the State Plan. (p. 75, April 2019, District of Columbia Amerigroup Medicaid Managed Care Contract)

[8] The Contractor shall provide the following DSHP benefit package services as Medically Necessary (as defined in Section 3.4.5 of this Contract, below) and subject to the listed limitations herein. Family planning services (including voluntary sterilization if consent form is signed after member turns age 21) (p. 55, 2018, Delaware Medicaid Managed Care Model Contract)

[9] The Contractor shall furnish Covered Services in an amount, duration and scope that is no less than the amount, duration and scope for the same benefit/service as specified in Delaware's Medicaid State Plan (for Medicaid members) or CHIP State Plan (for DHCP members) (see 42 CFR 438.210). (p. 52, December 2017, Delaware Medicaid Managed Care Contract)

[10] TABLE 2A: REQUIRED MMA SERVICES: Family Planning Services and Supplies (Attachment I, p. 3).
(7) Family Planning Services and Supplies (a) The Managed Care Plan shall furnish family planning services on a voluntary and confidential basis. (Attachment II, Exhibit II-A, p. 14, July 2020, Florida Medicaid Managed Care Contract)

[11] (d) The Managed Care Plan shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling, and services for family planning to all women and their partners. The Managed Care Plan shall direct providers to maintain documentation in the enrollee records to reflect this provision. (Section 409.967(2), F.S.) (Exhibit II, p. 14, July 2020, Florida Medicaid Managed Care Contract)

[12] 4.6.4 Family Planning Services: 4.6.4.1 The Contractor shall provide access to Family Planning Services within the network to Members and P4HB Participants. (p. 86, Georgia CareSource Medicaid Managed Care Contract)

[13] 2.6.1 For Medicaid and PeachCare for Kids®, Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid and CHIP State Plans and the Georgia Medicaid Policies and Procedures Manuals are covered. Such Medically Necessary Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition. (p. 61, 2019, Georgia CareSource Medicaid Managed Care Contract)

[14] Primary and Acute Care Services- Physical Health The health plans shall provide the following services to all its members including those enrolled in the health plan during prior period coverage. Services shall be provided if medically necessary in the amount and duration listed below. The scope of services is defined in Section 40.740. : Outpatient medical or behavioral health visits to include: family planning. (pp. 171-172)

f. Family Planning Services - The health plan shall provide access to family planning services within the network. However, member freedom of choice may not be restricted to in-network providers. (p. 183, 2014, Hawaii Medicaid Managed Care Contract RFP)

[15] Family Planning Network: Members enrolled in the Iowa Family Planning Network are eligible for services that are either primary or secondary to family planning services as described in the Iowa Family Planning Network 1115 waiver. The Contractor shall provide these benefits to eligible and enrolled members (p. 33, January 2016, Iowa Amerigroup Medicaid Managed Care Contract)

[16] Family Planning and reproductive healthcare. Contractor shall ensure 3.1.3provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy or to improve maternal health and birth outcomes. Contractor must ensure that nationally recognized standards of care and guidelines for sexual and reproductive health are followed, and drugs and devices are prescribed or placed in accordance with guidance from the USPSTF, Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA) in its approved product information label (also called PI or package insert) or the American College of Obstetricians and Gynecologists (ACOG). Compliance with the requirements of the Affordable Care Act, and other applicable federal and State statutes is also required. (p. 308)

Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: 3.1.3.2 all safe, effective and clinically appropriate contraceptive methods, with emphasis on the most effective methods first. and encourage use of long-acting reversible contraceptives (LARCS), such as IUDs and implants when clinically appropriate, and consistent with FDA approved product information label; 3.1.3.3 contraceptive methods must also include over-the-counter and prescription emergency contraception, if indicated; 3.1.3.4 permanent methods of birth control, including tubal ligation, transcervical sterilization, and vasectomy, if clinically appropriate and desired by the patient […] (p. 308, January 2018, Illinois Medicaid Managed Care Model Contract)

[17] Contractor shall cover and offer all Food and Drug Administration (FDA)–approved birth control methods with education and counseling on the safest and most effective methods, if clinically appropriate for a particular patient. (p. 308, January 2018, Illinois Medicaid Managed Care Contract)

[18] Contractor shall comply with the terms of 42 CFR §438.206 (b) and (c) and provide, or arrange to have provided, to all Enrollees the services described in 89 Ill. Adm. Code, Part 140, 59 Ill. Adm. Code, Part 132, the State Plan and related waivers, as amended from time to time and not specifically excluded therein in accordance with the terms of this Contract. (p. 64, January 2018, Illinois Medicaid Managed Care Model Contract)

[19] 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 labor preparation, education regarding preeclampsia, warning signs of miscarriage, fetal movements/kick count, preterm labor and labor, options for intrapartum care, including options for anesthesia, breastfeeding encouragement, postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated. (p. 310, January 2018, Illinois Medicaid Managed Care Model Contract)

[20] Under the Contractor's HIP line of business, the Contractor shall provide all covered family planning services and supplies. (Amendment #7, Exhibit 2.E, p. 65, January 2018, Indiana Anthem Medicaid Managed Care Contract)

[21] 2.0 Medical Services - The following services and scope of these services as described in the Medicaid Provider Manuals are reflective of current State FFS limitations and must be covered under the terms of this contract. Covered services include but are not limited to the following: 2.32 Reproductive Services: The CONTRACTOR(S) is required to provide freedom of choice for family planning and reproductive health services, which may be out of the CONTRACTOR(S)' network. (Attachment C, p. 10, 2018 Kansas Medicaid Managed Care Contract)

[22] The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by an Enrollee for the following services within the Contractor's Network: Voluntary family planning in accordance with federal and state laws and judicial opinion. (pp. 95-96)
Contractor Covered Services […] J. Family Planning Services in accordance with federal and state law and judicial opinion. (Appendix H, p. 221, 2020, Kentucky Aetna Medicaid Managed Care Contract)

[23] 6.1.4. The MCO shall provide core benefits and services to Medicaid members. The core benefits and services that shall be provided to members are: … Family Planning Services (not applicable to MCO operating under Section 2.4 of this Contract). (p. 59, December 2019, Louisiana Aetna Better Health Medicaid Managed Care Contract)

[24] 6.14.1.5. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; (p. 82, December 2019, Louisiana Aetna Better Health Medicaid Managed Care Contract)

[25] 6.1.12. The MCO shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning services for pregnant women in accordance with 42 CFR Part 440, Subpart B. (p. 61, December 2019, Louisiana Aetna Better Health Medicaid Managed Care Contract)

[26] Services for Specific Populations - The Contractor shall provide or arrange health care services to MassHealth Standard and CommonHealth Enrollees under the age of 21, in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements at 42 CFR 441.56(b) and (c), and 130 CMR 450.140 et seq., as those regulations may be amended, ensuring that its Providers do the same. In addition, the Contractor shall: […] Provide or arrange family planning services. (Attachment A, pp. 128-135, September 2017, Massachusetts Medicaid Managed Care RFR Amendment)

[27] .19 Benefits — Family Planning Services - A. An MCO shall provide to its enrollees comprehensive family planning services, including but not limited to medically necessary office visits and laboratory tests, all FDA-approved contraceptive devices, methods, and supplies, and voluntary sterilizations. (p. 170, January 2020, Maryland Medicaid Managed Care Contract)

[28] .19 Benefits — Family Planning Services - A. An MCO shall provide to its enrollees comprehensive family planning services, including but not limited to medically necessary office visits and laboratory tests, all FDA-approved contraceptive devices, methods, and supplies, and voluntary sterilizations. (p. 170, January 2020, Maryland Medicaid Managed Care Contract)

[29] 1. To cover, for Enrollees: a. In accordance with COMAR 10.09.67 and as defined in COMAR 10.09.62.01B (Appendix N), medically necessary covered services under the Maryland Medicaid State Plan (State Plan) in the amount, duration and scope set forth in the State Plan and in accordance with 42 CFR 438.210 and 42 CFR 440.230. (p. 7, January 2020, Maryland Medicaid Managed Care Contract)

[30] VI. Covered Services B. Services Covered Under this Contract 1. Contractor must provide the full range of Covered Services listed below and any outreach necessary to facilitate Enrollees use of appropriate services. Contractors may choose to provide services over and above those specified. Covered Services provided to Enrollees under this Contract include, but are not limited to, the following: l. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis). (p. 48, January 2016, Michigan Medicaid Managed Care Contract)

[31] 1. Contractor must have available and provide, at a minimum, the appropriate Medically Necessary Covered Services. Contractor's standards for determining Medically Necessary Services must not be more restrictive than standards used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes, regulations, the State Plan, Medicaid Provider Manual and other State policy and procedures. (p. 47, January 2016, Michigan Medicaid Managed Care Model Contract)

[32] ARTICLE. 6 BENEFIT DESIGN AND ADMINISTRATION. All terms of Article 6 apply to Medical Assistance, MinnesotaCare, and MinnesotaCare Child Enrollees, unless otherwise stated. 6.1 MEDICAL ASSISTANCE (PMAP) COVERED SERVICES. 6.1.15 Family Planning Services. (pp. 81-88, January 2020, Minnesota Medicaid Managed Care Contract).

[33] 2.4 Health Plan Provider Networks: 2.4.1 General: 2.4.10 Family Planning and Sexually Transmitted Disease (STD) Treatment Providers: The health plan shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The health plan shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures. The health plan shall allow for full freedom of choice for the provision of these services. (Amendment #5, pp. 26-29, July 2018, Missouri Medicaid Managed Care RFP)

[34] 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women: […] Referrals for family planning services if requested; […] (pp. 73-74, July 2018, Missouri Medicaid Managed Care RFP)

[35] SECTION 5 – COVERED SERVICES AND BENEFITS … 7. Family Planning - The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services. (Exhibit A, pp. 104-107, July 2019, Mississippi Medicaid Managed Care Contract)

[36] The Contractor shall comply with all applicable policies and procedures of the Division, such as Mississippi Administrative Code, Title 23, specifically including without limitation all policies and procedures applicable to each category of covered services for the MississippiCAN Program, which are also covered by the State Plan, all of which are hereby incorporated into this Contract by reference and form an integral part of this Contract. In no instance may the limitations or exclusions imposed by the Contractor with respect to covered services be more stringent than those permitted in the applicable laws, policies and procedures. Changes in applicable policies and procedures can be made via updates to the Administrative Code, Provider Reference Guide, State Plan, or through written communication from the Division to the Contractor. (Amendment #4, p. 23, Mississippi Medicaid Managed Care Contract)

[37] Article 4: Benefits 4.1 General Provisions 4.1.1 Basic Standards - (G) MCO shall, pursuant to the 1915(b) Waiver, provide: (2) Family Planning Services - MCO shall assure access to family planning services per Section 1905(a)(4)(C) of the Social Security Act (42 U.S.C. § 1396d(a)(4)(C)) and 42 CFR § 431.51(b). (Amendment M, Attachment B, pp. 36-37, January 2020, North Dakota Stanford Health Plan Medicaid Managed Care Contract).

[38] Family Planning Services - Family planning services are a mandatory Medicaid benefit (p. 63, January 2017, Nebraska Total Care Medicaid Managed Care Contract).

[39] At a minimum, the MCO must provide coverage for the following family planning services: […] Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration. (p. 63, January 2017, Nebraska Medicaid Managed Care Contract)
[40] The MCO shall provide access to Family Planning Services to […] 4.7.6.2 Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network (Appendix C, p. 152).
Services: Family Planning Services: MCO Covered (Appendix C, Exhibit A, p. 71, 2019, New Hampshire Medicaid Managed Care Contract)
[41] The MCO shall provide, at a minimum, the services identified in the following matrix, and in accordance with CMS-approved Medicaid State Plan, to its members, reflecting the planned phase-in. (Appx. C, p. 49, 2019, New Hampshire Medicaid Managed Care RFP)
[42] 4.1.2 BENEFIT PACKAGE A. 1. The following categories of services shall be provided by the Contractor for all Medicaid and NJ FamilyCare A, B, C, D and ABP enrollees, except where indicated. See Section B.4.1 of the Appendices for complete definitions of the covered services … 10. Family Planning Services and Supplies. (Art. 4, pp. 10-11, January 2020, New Jersey Medicaid Managed Care Contract)
[43] Core Set Measure(s) […] CCP: Contraceptive Care – Postpartum women […] (Art. 4, p. 80-81, January 2020 New Jersey Medicaid Managed Care Contract)
[44] 4.5 Benefits/Service Requirements and Limitations - 4.5.8 Family Planning […] The family planning policy shall ensure that Members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: 4.5.8.1.2 Birth control pills and devices (including Plan B) […] (p. 122, April 2020, New Mexico BCBS Medicaid Managed Care Contract)
[45] 1.9 The CONTRACTOR shall provide the Alternative Benefit Plan (the "ABP") in accordance with the State's approved Medicaid State Plan and this Agreement. Unless explicitly stated otherwise, all provisions of this Agreement shall apply to the Alternative Benefit Plan and to categories of eligibility that are covered under the Alternative Benefit Plan. (p. 17, April 2020, New Mexico BCBS Medicaid Managed Care Contract)
[46] 4.2.2 Vendor Covered Services … At a minimum, the Vendor must provide directly, or by subcontract, all covered medically necessary services, which shall include, but may not be limited to, the following: 4.2.2.13 Family Planning Services. (pp. 44-45, July 2013, Nevada Medicaid Managed Care RFP)
[47] a) Nothing in this Agreement shall restrict the right of Enrollees to receive Family Planning and Reproductive Health services, as defined in Appendix C of this Agreement, which is hereby made a part of this Agreement as if set forth fully herein. (pp. 10-7 – 10-8, March 2019, New York Medicaid Managed Care Draft Contract)
[48] Planning and Reproductive Health visit for the purpose of: A) contraception, including all FDA-approved birth control methods and devices, including diaphragms, insertion/removal of an intrauterine device (IUD) or insertion/removal of contraceptive implants, and injection procedures involving pharmaceuticals such as Depo-Provera (FHPlus does not cover OTC products such as condoms and contraceptive foam); … E) medically-necessary induced abortions, which are procedures, either medical or surgical, that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration. In addition, if the pregnancy is the result of an act of rape or incest, the abortion is covered. (Appendix C, p. C-2, March 2019, New York Medicaid Managed Care Draft Contract)
[49] COVERAGE AND SERVICES 1. Basic Benefit Package. […] Services covered by the MCP benefit package shall include: […] g. Family planning services and supplies (p. 81, July 2020, Ohio Medicaid Managed Care Contract)
[50] Family planning services: Covered (p. 123, October 2020, Oklahoma Medicaid Managed Care RFP)
[51] Physical Health Performance Measures: Maternal and Perinatal Health […] Contraceptive Care – Postpartum Women Ages 21 to 44 […] (p. 180, October 2020, Oklahoma Medicaid Managed Care RFP)
[52] Covered Service Components […] d. Family Planning Services - Members may receive Covered Services for Family Planning from any OHA Provider as specified in the Social Security Act, Section 1905 [42 U.S.C. 1396d], 42 CFR 431.51 and defined in OAR 410-130-0585. To the extent the Member chooses to

receive such services without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor is not responsible for payment, Case Management, or Record Keeping. (p. 31, January 2020, Oregon Medicaid Managed Care Contract)

[53] Comprehensive Risk Contract — A risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: […] (7) Family planning services. (p. 14)
The PH-MCO may not restrict the right of a Member to choose a Health Care Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Members may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F, Family Planning Services Procedures. (p. 49, January 2020, Pennsylvania Medicaid Managed Care Contract)

[54] At a minimum, the PH-MCO must provide In-Plan Services in the amount, duration and scope set forth in the MA FFS Program and be based on the Recipient's benefit package, unless otherwise specified by the Department. This includes quantitative and non-quantitative treatment limits (QTL) (NQTL) as indicated in state statutes and regulations, the Medicaid state plan and other state policies and procedures. (p. 46, January 2020, Pennsylvania Medicaid Managed Care Contract)

[55] SERVICE: Family planning Services; SCOPE OF BENEFIT: Enrolled female members have freedom of choice of providers for family planning services. Covered to receive three hundred sixty-five (365) days of prescription contraception of FDA approved drugs and devices which will require a prescription dispensed as a single prescription. (Amendment 3, pp. 269, July 2019, Rhode Island Medicaid Managed Care Contract)

[56] SERVICE: Family planning Services; SCOPE OF BENEFIT: Enrolled female members have freedom of choice of providers for family planning services. Covered to receive three hundred sixty-five (365) days of prescription contraception of FDA approved drugs and devices which will require a prescription dispensed as a single prescription. (Amendment 3, Attachment A, pp. 269, July 2019, Rhode Island Medicaid Managed Care Contract)

[57] 4.2.12. Family Planning Services - Family Planning Services include traditional contraceptive drugs, supplies, and preventive contraceptive methods. These include, but are not limited to the following: (1) examinations, (2) assessments, (3) diagnostic procedures, and (4) health education, prevention and counseling services related to alternative birth control and prevention as prescribed and rendered by various Providers. The CONTRACTOR: 4.2.12.1. Shall be responsible for reimbursement for Family Planning Services. (Amendment IV, p. 56, July 2018, South Carolina Medicaid Managed Care Contract)

[58] A.2.7.5 Preventive Services 2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. (Amendment 12, p. 84, July 2020, Tennessee Medicaid Managed Care Contract)

[59] 8.2.2.2 Family Planning - Specific Requirements The MCO must provide access to confidential family planning services. (p. 8-165, March 2020, Texas Medicaid Managed Care Contract)

[60] Medicaid MCOs are responsible for providing all services and benefits available to clients of the Medicaid Fee-for-Service (FFS) Program to the MCO's Medicaid Members, in the same amount, duration, and scope as is available through FFS as reflected in the state plan under Title XIX of the Social Security Act Medical Assistance Program. (Att. B-1, Sec. 8, p. 8-55, March 2020, Texas Medicaid Managed Care Contract)

[61] 1.3.24 Family Planning Services (A) Family Planning Services are covered Services (Attachment C, p. 9, January 2019, Utah Medicaid ACO Model Contract)

[62] (A) The Contractor shall administer Covered Services, when Medically Necessary, in a manner that is no more restrictive than the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other state policies, procedures, and administrative rules. (Att. B, p. 33, January 2019, Utah Medicaid ACO Model Contract)

[63] 8.2.P Family Planning - The Contractor shall cover all family planning services which include services and supplies for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. Contractor shall provide education on available family planning services. Covered services include family planning services, including drugs, supplies, and devices by network and out-of-network providers provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 CFR § 441.20. (p. 168, July 2020, Virginia Medicaid Managed Care Contract)
[64] Immediate Post-Partum Coverage - The Contractor must provide reimbursement for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor shall also reimburse practitioners for the post-partum insertion of the LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule. (p. 168, July 2020, Virginia Medicaid Managed Care Contract)
[65] 17. Contract Services […] Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals… 17.1.10.6 Family planning services provided or by referral from a Participating Provider or practitioner. (p. 304, July 2020, Washington Apple Health Integrated Managed Care Contract)
[66] All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. (p. 321, July 2020, Washington Apple Health Integrated Managed Care Contract)
[67] b. The member may choose to receive family planning services at any Medicaid-enrolled family planning clinic. Family planning services provided at non-network Medicaid-enrolled family planning clinics are paid FFS for HMO members including pharmacy items ordered by the family planning provider. (p. 85, January 2020, Wisconsin Medicaid Managed Care Contract)
[68] The HMO must have strategies in place for post-partum care, including depression screening and family planning services. Contraception options should be explored and the initial appointment for post-partum care should be made prior to discharge. (p. 186, January 2020, Wisconsin Medicaid Managed Care Contract)
[69] 1.2.4 Family Planning - The MCO must ensure that its network includes sufficient family planning providers to ensure timely access to covered family planning services for enrollees. Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a FFS basis. (p. 55, 2020, West Virginia Medicaid Managed Care Contract)

Table 2. Access to Coverage/Provider Networks

This table presents information regarding contract specifications governing accessibility of family planning and family planning-related services,* as well as family planning provider networks. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.**

State	Contractors required to pay for all family planning services when furnished by a qualified Medicaid provider, regardless of provider's network status		Contractors required to pay for family planning-related services when furnished by a qualified Medicaid provider, regardless of network status and without prior authorization for out-of- network care		Contractors required to offer network contracts to all qualified Medicaid family planning providers in their plan service area		Contractors barred from using prior authorization or other utilization management methods for family planning services	
	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)
AZ	N		N		N		N	
CA	Y	X[1]	Y	X[2]	N		Y	X[3]
CO	N		N		N		Y	X[4]
DC	Y	X[5]	N		N		Y	X[6]
DE	Y	X[7]	N		N		Y	X[8]
FL	N		N		N		N	

*No federal law or regulation defines "family planning," but CMS specifies that 90% matching is available for "counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals" as well as sterilization services, which requires extra assurances of beneficiary consent. Family planning related services are "services provided in a family planning setting as part of or as follow-up to a family planning visit. Such services are provided because they were identified, or diagnosed, during a family planning visit." Examples of family planning related services include diagnosis and treatment of sexually transmitted infections, vaccination for human papilloma virus, treatment of urinary tract and lower genital trac infections, and treatment of complications from the use of prescribed contraceptives.

** All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

¥ Four states (MN, TN, WI, and WV), according to KFF, currently carve out some or all prescription drug coverage from their MCO contracts. As such, this may create additional utilization management issues.

State	Contractors required to pay for all family planning services when furnished by a qualified Medicaid provider, regardless of provider's network status		Contractors required to pay for family planning-related services when furnished by a qualified Medicaid provider, regardless of network status and without prior authorization for out-of- network care		Contractors required to offer network contracts to all qualified Medicaid family planning providers in their plan service area		Contractors barred from using prior authorization or other utilization management methods for family planning services	
	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)
GA	N		N		Y	X[9]	Y	X[10]
HI	N		N		N		N	
IA	N		N		Y	X[11]	N	
IL	Y	X[12]	N		N		Y	X[13]
IN	N		N		N		N	
KS	Y	X[14]	N		N		N	
KY	N		N		Y	X[15]	N	
LA	Y	X[16]	N		Y	X[17]	Y	X[18]
MA	N		N		N		Y	X[19]
MD	Y	X[20]	N		N		Y	X[21]
MI	Y	X[22]	N		N		Y	X[23]
MN	N		N		N		N	
MO ¥	Y	X[24]	N		N		Y	X[25]
MS	Y	X[26]	N		N		Y	X[27]
ND	N		N		N		Y	X[28]
NE	N		N		N		N	
NH	N		N		N		Y	X[29]
NJ	Y	X[30]	N		N		Y	X[31]
NM	Y	X[32]	N		N		N	
NV	N		N		N		Y	X[33]
NY	Y	X[34]	Y	X[35]	N		Y	X[36]
OH	N		N		N		N	

State	Contractors required to pay for all family planning services when furnished by a qualified Medicaid provider, regardless of provider's network status		Contractors required to pay for family planning-related services when furnished by a qualified Medicaid provider, regardless of network status and without prior authorization for out-of- network care		Contractors required to offer network contracts to all qualified Medicaid family planning providers in their plan service area		Contractors barred from using prior authorization or other utilization management methods for family planning services	
	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)	Incl. in Contract Y/N/Unclear	Relevant provision(s)
OK	N		N		N		N	
OR	N		N		N		Y	X[37]
PA	Y	X[38]	Y	X[39]	N		Y	X[40]
RI	N		N		N		Y	X[41]
SC	Y	X[42]	N		N		Y	X[43]
TN ¥	N		N		N		Y	X[44]
TX	Y	X[45]	N		N		Y	X[46]
UT	N		N		N		Y	X[47]
VA	Y	X[48]	N		N		Y	X[49]
WA	N		N		Y	X[50]	N	
WI ¥	N		N		N		N	
WV ¥	Y	X[51]	Y	X[52]	Y	X[53]	Y	X[54]
Total	**Y= 18 N= 22**		**Y= 4 N= 36**		**Y= 6 N= 34**		**Y= 26 N= 14**	

State	Contract incentivizes or requires same-day walk-ins		Contract specifies the maximum wait time for in-network family planning visits		Contract specifies the maximum travel time or distance for family planning visits		Contract specifies family planning provider/patient ratios		Contract specifies use of telehealth for family planning		Contractors required to offer non-emergency transportation services for all covered family planning services regardless of provider network status	
	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)
AZ	N		N		N		N		N		Y	X[55]
CA	N		N		N		N		N		Y	X[56]
CO	N		N		Y	X[57]	N		N		Y	X[58]
DC	N		N		N		N		N		Y	X[59]
DE	N		N		N		N		N		Y	X[60]
FL	N		N		Y	X[61]	Y	X[62]	Y	X[63]	Y	X[64]
GA	N		N		Y	X[65]	N		Y	X[66]	N	
HI	N		N		N		N		Y	X[67]	Y	X[68]
IA	N		Y	X[69]	Y	X[70]	N		N		Y	X[71]
IL	N		N		Y	X[72]	N		N		Y	X[73]
IN	N		N		Y	X[74]	N		N		N	
KS	N		N		N		N		N		Y	X[75]
KY	N		N		N		N		N		Y	X[76]
LA	Y	X[77]	Y	X[78]	N		N		N		Y	X[79]
MA	Y	X[80]	N		Y	X[81]	Y	X[82]	N		N	
MD	N		N		Y	X[83]	N		N		Y	X[84]
MI	N		Y	X[85]	Y	X[86]	N		N		Y	X[87]
MN	N		N		N		N		N		N	
MO[†]	N		N		N		N		N		Y	X[88]
MS	N		N		Y	X[89]	N		N		Y	X[90]
ND	N		N		N		N		N		Y	X[91]
NE	N		Y	X[92]	Y	X[93]	N		N		Y	X[94]

State	Contract incentivizes or requires same-day walk-ins		Contract specifies the maximum wait time for in-network family planning visits		Contract specifies the maximum travel time or distance for family planning visits		Contract specifies family planning provider/patient ratios		Contract specifies use of telehealth for family planning		Contractors required to offer non-emergency transportation services for all covered family planning services regardless of provider network status	
	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)	Incl. in Contract Y/N/ Unclear	Relevant provision(s)
NH	N		N		Y	X[95]	N		N		Y	X[96]
NJ	N		N		N		N		Y	X[97]	Y	X[98]
NM	N		N		N		N		N		Y	X[99]
NV	Y	X[100]	N		N		N		N		Y	X[101]
NY	N		Y	X[102]	N		N		N		Y	X[103]
OH	N		N		Y	X[104]	N		N		Y	X[105]
OK	Y	X[106]	N		Y	X[107]	N		N		Y	X[108]
OR	N		N		N		N		N		Y	X[109]
PA	N		N		Y	X[110]	N		N		Y	X[111]
RI	N		N		Y	X[112]	N		N		Y	X[113]
SC	Y	X[114]	N		N		N		N		N	
TN[†]	N		N		N		N		N		Y	X[115]
TX	N		N		Y	X[116]	N		Y	X[117]	N	
UT	N		N		N		N		N		N	
VA	N		N		N		N		Y	X[118]	N	
WA	N		N		N		N		N		N	
WI[†]	Y	X[119]	Y	X[120]	Y	X[121]	Y	X[122]	N		Y	X[123]
WV[†]	N		N		Y	X[124]	Y	X[125]	N		Y	X[126]
Total	**Y= 6 N= 34**		**Y= 6 N= 34**		**Y= 19 N= 21**		**Y= 4 N= 36**		**Y= 6 N= 34**		**Y= 31 N= 9**	

[1] 9. Non-Contracting Family Planning Providers' Reimbursement Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning Providers for services listed in Exhibit A, Attachment 9. Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy. (Ex. A, Att. 8, p. 54)

2) Out-Of-Network Family Planning Services Members of childbearing age may access the following services from out-of-Network family planning Providers to temporarily or permanently prevent or delay pregnancy: a) Health education and counseling necessary to make informed choices and understand contraceptive methods. b) Limited history and physical examination. c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse Out-of-Network Providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines. d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted disease, if medically indicated. e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment. f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider. g) Provision of contraceptive pills, devices, and supplies. h) Tubal ligation. i) Vasectomies. j) Pregnancy testing and counseling. B. Sexually Transmitted Diseases (STDs) Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its Provider Network. Members may access out-of-Network STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service Providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community Providers other than LHD and family planning providers, out-of-Network services are limited to one office visit per STD episode for the purposes of: 1) Diagnosis and treatment of vaginal discharge and urethral discharge. 2) Those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale. 3) Evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care. C. HIV Testing and Counseling Members may access confidential HIV counseling and testing services through the Contractor's Provider Network and through the out-of-network local health department and family planning Providers. (Ex. A, Att. 9, pp. 64-65, 2017, California GMC Non-CCI Boilerplate Contract)

[2] 9. Non-Contracting Family Planning Providers' Reimbursement Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning Providers for services listed in Exhibit A, Attachment 9. Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy. (Ex. A, Att. 8, p. 54)

2) Out-Of-Network Family Planning Services Members of childbearing age may access the following services from out-of-Network family planning Providers to temporarily or permanently prevent or delay pregnancy: a) Health education and counseling necessary to make informed choices and understand contraceptive methods. b) Limited history and physical examination. c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse Out-of-Network Providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines. d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted disease, if medically indicated. e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment. f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider. g) Provision of contraceptive pills, devices, and supplies. h) Tubal ligation. i) Vasectomies. j) Pregnancy testing and counseling. B. Sexually Transmitted Diseases (STDs) Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its Provider Network. Members may access out-of-Network STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service Providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community Providers other than LHD and family planning providers, out-of-

Network services are limited to one office visit per STD episode for the purposes of: 1) Diagnosis and treatment of vaginal discharge and urethral discharge. 2) Those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale. 3) Evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care. C. HIV Testing and Counseling Members may access confidential HIV counseling and testing services through the Contractor's Provider Network and through the out-of-network local health department and family planning Providers. (Ex. A, Att. 9, pp. 64-65, 2017, California GMC Non-CCI Boilerplate Contract)

[3] H. Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. (Exhibit A, Attachment 5, p. 32).

9. Access to Services with Special Arrangements A. Family Planning: Members have the right to access family planning services through any family planning Provider without Prior Authorization. Contractor shall provide family planning services in a manner that protects and enables Member freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. Contractor shall inform its Members in writing of their right to access any qualified family planning Provider without Prior Authorization in its Member Services Guide (see Exhibit A, Attachment 13). (Exhibit A, Attachment 9, p. 63)

Contractors shall ensure that the Member Services Guide includes the following information: 18. Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement: Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get. (Exhibit A, Attachment 13, pp. 125-26, 2017, California GMC Non-CCI Medicaid Manage Care Boilerplate Contract)

[4] Member Handbook 7.3.8.1. The Contractor shall collaborate with the Department to create a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 C.F.R. § 438.10. The Member Handbook shall include, at a minimum, all of the following: 7.3.8.1.8. A statement that prior authorization is not required to receive services from family planning providers. (Amendment #4, p. 41 July 2020, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract)

[5] Out-of-network family planning providers should be paid directly by the Contractor for services provided to Enrollees and such payments should be at a rate no less than the Medicaid fee-for-service rate or in-network rates, whichever is greater. (p. 109, April 2019, District of Columbia Medicaid Managed Care Model Contract)

[6] C.5.29.11 Women's Health […] C.5.29.11.2 […] In addition, Enrollees do not need a referral to access family planning services. (p. 109, April 2019, District of Columbia Medicaid Managed Care Model Contract)

[7] 3.11.3.6.1 The Contractor must reimburse non-participating providers for family planning services rendered to members as long as the following conditions are met: 3.11.3.6.1.1 The family planning provider is qualified to provide family planning services based on licensed scope of practice and is a DMAP-enrolled provider; 3.11.3.6.1.2 The family planning provider submits electronic claims using HIPAA standard transactions; 3.11.3.6.1.3 The family planning provider provides medical records sufficient to allow the Contractor to meet its care coordination responsibilities; if a member refuses the release of medical

information, the non-participating provider must submit documentation of such refusal; and 3.11.3.6.1.4 The family planning provider obtains informed consent for all contraceptive methods, including sterilization, consistent with requirements of 42 CFR 441.257 and 42 CFR 258. (p. 220)

3.11.3.8.1 The Contractor shall make payments to non-participating providers for Medically Necessary Covered Services on the same timeliness standards as referenced in Section 3.18.1 of this Contract when the following criteria are met: … 3.11.3.8.1.2 Services were for family planning services; (p. 221, 2018, Delaware Medicaid Managed Care Model Contract)

[8] 3.9.15 Family Planning Providers 3.9.15.1 Per Section 1902(a)(23) of the Social Security Act, the Contractor must allow members freedom of choice of family planning providers, including access without referral or prior authorization, to non-participating family planning providers. (p. 195, December 2017, Delaware Medicaid Managed Care Model Contract)

[9] 4.8.13.1 The Contractor shall make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act. (p. 111)

In meeting this obligation, the Supplier shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. (p. 360)

13. Family Planning Clinics: The Supplier shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act. (p. 397, 2016, Georgia CareSource Medicaid Managed Care Contract)

[10] The Contractor shall not require a Referral if a Member or P4HB Participant chooses to receive Family Planning services and supplies from outside of the network. (p. 86)

The Supplier shall not require a Referral if a Member or P4HB participant chooses to receive Family Planning Services and supplies from outside of the network. (p. 361, 2016, Georgia CareSource Medicaid Managed Care Contract)

[11] . B. Specialty Care Access Standards a. Specialty Network: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of members are met within the Contractor's provider network. […] At a minimum, the Contractor shall have provider agreements with providers practicing the following specialties: […] (xi) obstetrics and gynecology; (Appendix I, pp. 211-212, 2016, Iowa Amerigroup Iowa, Inc. Medicaid Managed Care Contract)

[12] 5.20.1.3 Family-Planning services. Subject to sections 5.5 and 5.6, Contractor shall cover Family-Planning services for all Enrollees, whether the Family-Planning services are provided by a Network or a non-Network Provider. (p. 103)

5.29.3 Contractor shall pay for Family-Planning services, subject to sections 5.5 and 5.6 hereof, rendered by a non-Network Provider, for which Contractor would pay if rendered by a Network Provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments, unless a different rate was agreed upon by Contractor and the non-Network Provider. (p. 123, January 2018, Illinois Medicaid Managed Care Contract)

[13] 3.1.3 Family Planning and reproductive healthcare. […] Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. (p. 308, January 2018, Illinois Medicaid Managed Care Model Contract Draft)

[14] 2.32 Reproductive Services: The CONTRACTOR(S) is required to provide freedom of choice for family planning and reproductive health services, which may be out of the CONTRACTOR(S)' network. The CONTRACTOR(S) is responsible for payment of these services. (Att. C, p. 17, 2018, Kansas Medicaid Managed Care Contract)
[15] In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: […] family planning providers. (p. 85, July 2020, Kentucky Medicaid Managed Care Contract)
[16] 6.14.4. The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the fee-for-service rate in effect on the date of service. (p. 82, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[17] The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services. (p. 121, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[18] The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. (p. 130, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[19] The Enrollee Information, shall include, but not be limited to, a description of the following: […] 7) The MCO Covered Services, including Behavioral Health Services, that do not require authorization or a referral from the Enrollee's PCP, for example, family planning services or individual behavioral health outpatient therapy […] (Attachment A, pp. 57-58, September 2017, Massachusetts Medicaid Managed Care RFR Model Contract)

[20] (2) An MCO shall reimburse out-of-plan providers to whom enrollees have self-referred for school-based services as described in COMAR 10.09.68.03 and family planning services including office visits (CPT codes 99201—99205 and 99211—99215), preventive medicine office visits (CPT codes 99383—99386 and 99393—99396), and all FDA-approved contraceptive devices, methods and supplies, at the established Medicaid rates. (p. 125, January 2020, Maryland Medicaid Managed Care Contract)
[21] B. An MCO shall, at the time of enrollment, and anytime upon request, furnish each enrollee with a copy of the MCO's enrollee handbook that includes all language in the template provided by the Department and the following current information: […] 11) A statement that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider […] (Appendix N, p. 136, January 2020, Maryland Medicaid Managed Care Contract)
[22] 5. Contractor must pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service, at established Medicaid FFS rates in effect on the date of service. (p. 42, January 2016, Michigan Medicaid Managed Care Model Contract).
[23] G. Family Planning Services […] 5. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization. (p. 42, January 2016, Michigan Medicaid Managed Care Model Contract)
[24] j. Family Planning Services: The health plan shall be financially liable for payment to providers, whether in-network or out-of-network, in accordance with Federal freedom of choice provisions. (Addendum #5, p. 53, May 2017, Missouri HealthNet Medicaid Managed Care RFP)
[25] At a minimum, the member handbook shall include the information and items listed below. […] Information on maternity, family planning, and sexually transmitted diseases services. This information should include the extent to which, and how, members may obtain family planning services and supplies from out-of-network providers. It should also include an explanation that the health plan cannot require a member to obtain a referral before choosing a family planning provider. (Addendum #5, p. 85, May 2017, Missouri HealthNet Medicaid Managed Care RFP)
[26] Claims for Emergency Medical Services and Family Planning Services shall be paid at the applicable Medicaid Fee-for-Service rate in the absence of an agreement otherwise between the Contractor and the Out-of-network Provider. (p. 239, July 2019, Mississippi Magnolia Medicaid Managed Care Contract)

[27] Information about family planning services, including explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies and that each Member is free from coercion or mental pressure and free to choose the method of family planning to be used, in accordance with 42 C.F.R. § 441.20. The MCO must comply with section 42 C.F.R 438.10(g)(2)(vii), which specifies that members cannot be required to obtain a referral prior to choosing a family planning provider […] (Amendment 4, Exhibit A, p. 84, July 2019, Mississippi Magnolia Medicaid Managed Care Contract)
[28] In accordance with Sections 1905(a)(4)(C) and 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)) and 42 CFR § 431.51(b)(2), prior authorization of, or requiring the use of Network Providers for, family planning services is prohibited. (Attachment B, p. 36, January 2020, North Dakota Sanford Health Plan Medicaid Managed Care Contract)
[29] 4.7.6 Women's Health […] 4.7.6.2 The MCO shall provide access to Family Planning Services to Members without the need for a referral or prior authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network. (Appendix C, p. 152, 2019, New Hampshire Medicaid Managed Care Model Contract RFP)
[30] The DMAHS shall reimburse family planning services provided by non-participating providers based on the Medicaid fee schedule. (Art. 4, p. 29, January 2020, New Jersey Medicaid Managed Care Model Contract)
[31] Exception A: An enrollee shall not be required to obtain a referral or be otherwise restricted in the choice of the family planning provider from whom the enrollee may receive family planning services. (Article 1, p. 28, January 2020, New Jersey Medicaid Managed Care Model Contract)

[32] Family planning Providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services that are Covered Services, regardless of whether they are Providers for Centennial Care. Unless otherwise negotiated, the CONTRACTOR shall reimburse Providers of family planning services pursuant to the Medicaid fee schedule. (p. 155)

4.10.2.3 Family Planning Non-Contract Providers - The CONTRACTOR shall reimburse family planning Non-Contract Providers for the provision of services to Members at a rate set by HSD. (p. 169-70, April 2020, New Mexico BCBS Medicaid Managed Care Contract)
[33] The Vendor may not require family planning services to be prior authorized. (Amendment #8, p. 61, July 2013, Nevada Medicaid Managed Care RFP)
[34] The Contractor must notify its Participating Providers that all claims for Family Planning and Reproductive services must be billed to the Contractor and not the Medicaid fee-for-service program. The Contractor will be charged for Family Planning and Reproductive Health services furnished to MMC Enrollees by Medicaid Non-Participating Providers at the applicable Medicaid rate or fee. In such instances, Medicaid Non-Participating Providers will bill Medicaid fee-for-service and the SDOH will issue a confidential charge back to the Contractor. Such charge back mechanism will comply with all applicable patient confidentiality requirements. (Appx. C, p. C-4, March 2019, New York Medicaid Managed Care Draft Contract)
[35] b) When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit: … iii) Screening and treatment for sexually transmissible disease… a) Free Access means MMC Enrollees may obtain Family Planning and Reproductive Health services, and HIV testing and pre-and post-test counseling when performed as part of a Family Planning and Reproductive Health encounter, from either the Contractor, if it includes such services in its Benefit Package, or from any appropriate Medicaid health care provider of the Enrollee's choice. No referral from the PCP or approval by the Contractor is required to access such services. (Appx. C, p. C-3)

The Contractor must notify its Participating Providers that all claims for Family Planning and Reproductive services must be billed to the Contractor and not the Medicaid fee-for-service program. The Contractor will be charged for Family Planning and Reproductive Health services furnished to MMC Enrollees by

Medicaid Non-Participating Providers at the applicable Medicaid rate or fee. In such instances, Medicaid Non-Participating Providers will bill Medicaid fee-for-service and the SDOH will issue a confidential charge back to the Contractor. Such charge back mechanism will comply with all applicable patient confidentiality requirements. (Appx. C, p. C-4, March 2019, New York Medicaid Managed Care Draft Contract)

[36] d) Family Planning and Reproductive Health Services: Enrollees may self-refer to family planning and reproductive health services as described in Section 10.10 and Appendix C of this Agreement. (Appendix C, pp. 10-12, March 2019, New York Medicaid Managed Care Draft Contract)

[37] d. Family Planning Services Members may receive Covered Services for Family Planning from any OHA Provider as specified in the Social Security Act, Section 1905 [42 U.S.C. 1396d], 42 CFR 431.51 and defined in OAR 410-130-0585. To the extent the Member chooses to receive such services without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor is not responsible for payment, Case Management, or Record Keeping. (Appendix B, Exhibit B, p. 31, January 2020, Oregon Medicaid Managed Care Contract)

[38] The PH-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. The PH-MCO may not restrict the right of a Member to choose a Health Care Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Members may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F, Family Planning Services Procedures. The PH-MCO must pay for Out-of-Network Services. (p. 49, January 2020, Pennsylvania Medicaid Managed Care Contract)

[39] The PH-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. The PH-MCO may not restrict the right of a Member to choose a Health Care Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Members may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F, Family Planning Services Procedures. The PH-MCO must pay for Out-of-Network Services. (p. 49)

EXHIBIT F FAMILY PLANNING SERVICES PROCEDURES Procedures Which May Be Included with a Family Planning Clinic Comprehensive Visit, a Family Planning Clinic Problem Visit or a Family Planning Clinic Routine Revisit: … Culture, chlamydia, … Syphilis test; qualitative (e.g., VDRL, RPR, ART), Culture, bacterial, definitive; any other source … Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision … Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit), Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit) (pp. F-1 – F-3, January 2020, Pennsylvania Medicaid Managed Care Contract).

[40] The PH-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. (p. 49, January 2020, Pennsylvania Medicaid Managed Care Contract)

[41] 2.08.03.07 In-Network Self-Referrals: The Contractor agrees to have written policies and procedures that permit members at a minimum to self-refer for one annual and up to five (5) GYN/Family Planning visits annually and for sexually-transmitted (STD) services, without obtaining a referral from the Primary Care Provider. (Amendment #3, p. 107, July 2019, Rhode Island Medicaid Managed Care Contract)

[42] The CONTRACTOR: 4.2.12.1. Shall be responsible for reimbursement for Family Planning Services. 4.2.12.2. Shall allow Members the freedom to receive Family Planning Services from an appropriate Provider without restrictions. (p. 65, July 2018, South Carolina Medicaid Managed Care Contract)
[43] 3.13.2.5.13.1. The CONTRACTOR may not require an Enrollee to obtain a referral before choosing a Family Planning Provider. (Amendment IV, p. 38, July 2018, South Carolina Medicaid Managed Care Contract)
[44] This shall include an explanation that the CONTRACTOR may not require a member to obtain a referral before choosing a family planning provider. (Amendment #12, p. 349, July 2020, Tennessee Medicaid Managed Care Contract)
[45] The MCO will reimburse family planning agencies no less than the Medicaid fee-for service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and will reimburse Out-of-Network family planning providers in accordance with HHSC's administrative rules. (Att. B-1, Sec. 8, p. 8-166, March 2020, Texas Medicaid Managed Care Contract)
[46] The MCO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider. (Attachment B-1, Section 8, p. 1-166, March 2020, Texas Medicaid Managed Care Contract)
[47] (C) The Enrollee handbook shall contain information: […] (17) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider […] (Attachment B, pp. 24-25, January 2020, Utah Medicaid Managed Care Model Contract)
[48] b. The Contractor shall cover and pay for emergency and family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract. (p. 134, July 2020, Virginia Medicaid Managed Care Contract)
[49] c. An explanation that the Contractor cannot require a member to obtain a referral before choosing a family planning provider. [42 CFR § 438.10 (g)(2)(vii)] (p. 116)

The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. (p. 126, July 2020, Virginia Medicaid Managed Care Contract)
[50] 17.2.5: The Contractor shall make a reasonable effort to subcontract with all local health departments, school-based health centers, family planning agencies contracted with HCA, and IHCP Providers. (pp. 316, July 2020, Washington Medicaid Managed Care Contract)
[51] The MCO must make a reasonable effort to Subcontract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and must reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. (pp. 56-57, July 2019, West Virginia Medicaid Managed Care Draft Contract).
[52] The MCO must make a reasonable effort to Subcontract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and must reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. (pp. 56-57).

Family Planning Services – those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: health education and counseling necessary to make informed choices and understand contraceptive methods; limited history and physical examination; laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods; diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated; screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment; follow-up care for complications associated with contraceptive methods issued by the family planning provider; provision of

contraceptive pills /devices/supplies; tubal ligation; vasectomies; and pregnancy testing and counseling. (p. 8, July 2019, West Virginia Medicaid Managed Care Draft Contract)

[53] The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; (p. 55, July 2019, West Virginia Medicaid Managed Care Draft Contract)

[54] Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a fee-for-service basis. The MCO must give each enrollee, including adolescents, the opportunity to use his/her own primary care provider or go to any family planning center for family planning services without requiring a referral. (p. 56)

The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider. (p. 116, July 2019, West Virginia Medicaid Managed Care Draft Contract)

[55] Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. See AMPM Policy 310-BB. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment. For information regarding Contractor reimbursement of ground ambulance and emergency care transportation when a contract does not exist between the Contractor and the transportation provider, refer to ACOM Policy 205. (Amendment #14, p. 60)

32. Appointment standards […] For medically necessary non-emergent transportation, the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. (Amendment #14, p. 107, October 2019, Arizona Medicaid Managed Care Contract)

[56] H. Transportation Contractor shall cover transportation services as required in this Contract and directed in APL 17-010 to ensure Members have access to all Medically Necessary services. […] 2) Contractor shall cover NEMT services required by Members to access Medi-Cal services, as provided for in Title 22 CCR Section 51323, subject to Contractor's Physician Certification Statement form being completed by the Member's Provider. Contractor shall refer and coordinate NEMT for Medi-Cal services not covered in this Contract. 3) As provided for in W & I Code Section 14132(ad), Contractor shall authorize all NMT for Members to obtain Medically Necessary Covered Services in accordance with the requirements and guidelines set forth in APL 17-010. Nothing in this Provision should be construed to prohibit the Contractor from developing policies and procedures which may include Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through Medi-Cal FFS. (Exhibit A, Attachment 10, p. 98, 2017, California GMC Non-CCI Boilerplate Contract)

[57] PCMP NETWORK TIME AND DISTANCE STANDARDS… Gynecology, OB/GYN Urban County Maximum Time (minutes) 30 Maximum Distance (miles) 30 Rural County Maximum Time (minutes) 45 Maximum Distance (miles) 45 Frontier County Maximum Time (minutes) 60 Maximum Distance (miles) 60. (Amendment #4, p.73, July 2020, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract)

[58] 14.3.46 Transportation, non-emergent, to medical appointments. This is a Medicaid benefit provided through the client's local county Department of Social Services, for the purpose of receiving covered medical services (Amendment #3, Exhibit M-3, p. 101, July 2019, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract). 10.2.13 The Contractor shall establish relationships and communication channels with the entities administering the Department's Non-Emergency Medical Transportation benefit in order to ensure Members are able to attend their medical appointments on time. Members' health is often negatively impacted when they miss appointments, particularly with specialty care providers, and can result in over utilization of the emergency department. Strengthening the relationship of the Non-Emergency Medical Transportation administrative entities with members of the Health Neighborhood and implementing initiatives to increase efficiency can significantly improve provider satisfaction, Member experience, and Member health (Amendment #4, Exhibit M-4, p. 68, July 2020, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract)
[59] C.3.44 Covered Services The items and services, transportation, and case management services described herein that, taken together, constitute the services that Contractor must provide to Enrollees under District and federal law. The term also encompasses any additional items and services described by Contractor as being available to Enrollees (p. 15, April 2019, District of Columbia Amerigroup Medicaid Managed Care Contract)
[60] 3.8.9.5 Non-Emergency Medical Transportation 3.8.9.5.1 The Contractor shall coordinate non-emergency medical transportation for members to ensure that members receive nonemergency medical transportation as needed. At a minimum, this shall include providing information to members on how to access non-emergency medical transportation, referring members to the State's non-emergency medical transportation vendor, and providing information and assistance as necessary to ensure that members receive appropriate transportation to Covered Services (p. 166, December 2017, Delaware Medicaid Managed Care Contract)
[61] Obstetrics/ Gynecology Urban County Maximum Time (minutes) 50 Maximum Distance (miles) 35 Maximum Time (minutes) Rural County 75 Maximum Distance (miles) 60.(Exhibit II-A, p. 44, July 2020, Florida Medicaid Managed Care Contract)
[62] Obstetrics/ Gynecology 1:1,500 enrollees (Exhibit II-A, p. 44, July 2020, Florida Medicaid Managed Care Contract)
[63] 4. Telemedicine Coverage Provisions a. The Managed Care Plan shall provide coverage for services provided through telemedicine, when appropriate, for services covered under this Contract, to the same extent the services would be covered if provided through a face-to-face (in person) encounter with a practitioner […] b. The Managed Care Plan shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter. (Attachment II, p. 60, July 2020, Florida Medicaid Managed Care Contract)

The Managed Care Plan shall include the following information in provider handbooks: […] If the Managed Care Plan allows the use of telemedicine, telemedicine requirements for providers. (Exhibit II-A, pp. 59-60, July 2020, Florida Medicaid Managed Care Contract)
[64] 9. The Managed Care Plan shall provide transportation to the enrollee and/or, the enrollee's authorized representative upon request and if the enrollee has no other means of transportation to and from the nearest hearing call-in center in accordance with Section V., Enrollee Services, of this Contract and its Exhibits. (Attachment II, p. 80, July 2020, Florida Medicaid Managed Care Contract)

[65] Obstetric Providers Urban Two (2) within thirty (30) minutes or (30) miles Rural Two (2) within forty-five (45) minutes or forty-five (45) miles (p. 114, 2016, Georgia CareSource Medicaid Managed Care Contract)
[66] 4.8.12.2 The Contractor shall provide telemedicine services to increase access to primary and specialty care as appropriate. (p. 110, 2016, Georgia CareSource Medicaid Managed Care Contract)
[67] 40.740.1 Coverage Provisions for Primary and Acute Care Services The health plan shall provide the following primary and acute care services in accordance with the prescribed parameters and limitations as part of their benefit package as described in Section 40.710. The health plan shall comply with all State and

Federal laws pertaining to the provision of such services. The health plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable. (p. 184, 2014, Hawaii Medicaid Managed Care RFP)

[68] 40.220 Specific Minimum Requirements The health plan is solely responsible for ensuring it: (1) has the network capacity to serve the expected enrollment in the service area; (2) offers an appropriate range of services and access to preventive, primary, acute, behavioral health, and long-term services and supports (LTSS); and (3) maintains a sufficient number, mix, and geographic distribution of providers of covered services. The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add provider types, or the DHS may require that the health plan add providers as required based on the needs of the members or due to changes in Federal or State law. At a minimum, the network shall include the following medical care providers: […] Non-emergency transportation providers (both ground and air); (p. 124, 2014, Hawaii Medicaid Managed Care RFP)

[69] B. Specialty Care Access Standards a. Specialty Network: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of members are met within the Contractor's provider network. […] At a minimum, the Contractor shall have provider agreements with providers practicing the following specialties: […] (xi) obstetrics and gynecology; […] c. Appointment Times: Not to exceed thirty (30) days for routine care or one (1) day for urgent care. (Appendix I, pp. 211-212, 2016, Iowa Amerigroup Iowa, Inc. Medicaid Managed Care Contract)

[70] B. Specialty Care Access Standards a. Specialty Network: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of members are met within the Contractor's provider network. […] At a minimum, the Contractor shall have provider agreements with providers practicing the following specialties: […] (xi) obstetrics and gynecology; […] b. Time and Distance: i. Sixty (60) minutes or sixty (60) miles from the personal residence of members for at least seventy-five percent (75%) of non-dual members. Ii. Ninety (90) minutes or ninety (90) miles from the personal residence of members for ALL non-dual members. (Appendix I, pp. 211-212, 2016, Iowa Amerigroup Iowa, Inc. Medicaid Managed Care Contract)

[71] Exhibit D COVERED BENEFITS The Contractor shall provide medically necessary covered benefits as described in Section 3.2 of the scope of work (p. 219). NEMT (Appendix I, p. 223, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

[72] 5.8.9 Family Planning. Contractor shall demonstrate that its network includes sufficient Family-Planning Providers to ensure timely access to Covered Services as provided in 42 CFR §438.206. (p. 84, January 2018, Illinois Medicaid Managed Care Model Contract)

[73] 5.29.10 Contractor shall establish and follow a uniform process for post-authorization of, and payment for, non-Emergency transportation that is consistent with the procedures and requirement established by the Department and set forth in the Medicaid Managed Care Provider Manual (p. 125, January 2018, Illinois Medicaid Managed Care Model Contract)

[74] 8.2.14 OB/GYNs The Contactor shall establish a network of OB/GYNs for women's healthcare and maternity needs. The Contractor shall ensure the availability of at least two OB/GYNs practicing within sixty (60) miles of the member's residence. OMPP shall reserve the right to change this requirement at any time in accordance with Section 2.11. (Amendment #7, p. 123, January 2017, Indiana Anthem Medicaid Managed Care Contract)

[75] 5.5.5.5. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICE STANDARDS CONTRACTOR(S) shall adhere to the following requirements: A. A Member's transportation for physical, Behavioral Health, and LTSS services shall arrive at the Provider location: a. No sooner than one (1) hour before the Member's appointment. b. At least fifteen (15) minutes prior to the Member's appointment time. B. The Member shall not wait for more than one (1) hour after the appointment for return transportation. C. Non-Emergency Medical Transportation Providers shall communicate with the Member regarding the approximate arrival time and shall promptly notify the Member when the transportation Provider will arrive later than the scheduled pick-up time (p. 76, 2018, Kansas Medicaid Managed Care RFP). 2.36 Non-emergency medical transportation (NEMT) to medically necessary services listed in State Policy and State Provider manuals, in compliance with all Federal regulations, including but not limited to: […] 2.36.3 Transportation to family planning services even if these services are obtained from a Provider not participating in the CONTRACTOR(S)' network (Attachment 10, pp. 10-11, 2018, Kansas Medicaid Managed Care RFP)

[76] 33.7 Nonemergency Medical Transportation The Department contracts with the Office of Transportation and Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. Through the NEMT program, certain eligible Enrollees receive safe and reliable transportation to Medicaid covered services. The Department shall continue to provide NEMT services for Medicaid Enrollees except as provided in Section 42. The Contractor shall provide educational materials regarding the availability of transportation services and refer Enrollees for NEMT. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. Transportation of an emergency nature, including ambulance stretcher services is the responsibility of the Contractor (Appendix A, Version 7, p. 118, July 2015, Kentucky Aetna Better Health Medicaid Managed Care Contract)
[77] 7.2. Appointment Availability Access Standards 7.2.1. […] The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows: […] 7.2.1.11. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. (p. 115, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[78] 6.14 Family Planning Services […] 6.14.7. The MCO shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one (1) week. (p. 83, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[79] 6.14. Family Planning Services 6.14.1. Family planning services and supplies are available to help prevent unintended pregnancies. Family Planning shall be provided to MCO members as defined in the emergency rule published in the June 20, 2014 Louisiana Register. The MCO shall provide coverage for the following family planning services included here, but not limited to: […] 6.14.1.8. Transportation services to and from family planning appointments provided all other criteria for NEMT are met. (pp. 81-82, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[80] The Contractor shall: 1. Ensure that all Enrollees may access: […] b. Same-day appointments for certain services. (Attachment A, p. 72, September 2017, Massachusetts Medicaid Managed Care RFR Model Contract)
[81] C. Availability […] 3. Specialists […] b. For any part of the Region where the Contractor does not meet this standard, the Contractor must demonstrate to EOHHS that it meets this standard when factoring in Obstetricians/Gynecologists in a contiguous Region or Regions that are within 15 miles or 30 minutes travel time from the Enrollee's residence. (Attachment A, pp. 205-206, September 2017, Massachusetts Medicaid Managed Care RFR Model Contract)
[82] 3. Specialists a. The Contractor shall maintain an Obstetrician/Gynecologist-to female Enrollee ratio of one to 500, throughout the Region, provided that, EOHHS may approve a waiver of the above ratio in accordance with federal law. Such ratio should include female Enrollees age 10 and older. (Attachment A, p. 206, September 2017, Massachusetts Medicaid Managed Care RFR Model Contract)
[83] .06 Geographical Access. A. Except as provided in §C of this regulation, an MCO shall develop and maintain a provider network that meets the following time and distance standards: (1) For adult and pediatric primary care, pharmacy, diagnostic laboratory and x-ray, and gynecology: (a) In urban areas, within 15 minutes or 10 miles; (b) In suburban areas, within 30 minutes or 20 miles; and (c) In rural areas, within 40 minutes or 30 miles; (Appendix N, pp. 148-149, January 2020, Maryland Medicaid Managed Care Contract)
[84] .07 Access Standards: Clinical and Pharmacy Access. A. Appointments. […] (3) Appointment Guidelines. […] (ii) When needed, enrollees will be afforded assistance in securing transportation to and from appointments, which shall include, when appropriate, contacting the local transportation grantee agency on behalf of the enrollee for the purpose of securing the enrollee's access to these services (Appendix N, pp. 153-154, January 2020, Maryland Medicaid Managed Care Contract)
[85] GYN: non-rural – 30 minutes, 30 miles, rural – 40 minutes, 40 miles (Appendix 14, p. 219, January 2016, Michigan Medicaid Managed Care Contract)
[86] OB/GYN non-rural Maximum Time (minutes) 30 minutes Maximum Distance (miles) 30 miles Rural Maximum Time (minutes) 40 minutes Maximum Distance (miles) 40 miles (Appendix 14, p. 219, January 2016, Michigan Medicaid Managed Care Contract)
[87] VI. Covered Services […] B. Services Covered Under this Contract 1. Contractor must provide the full range of Covered Services listed below and any outreach necessary to facilitate Enrollees use of appropriate services. Contractors may choose to provide services over and above those specified. Covered Services

provided to Enrollees under this Contract include, but are not limited to, the following: […] w. Non-emergent medical transportation (NEMT) to medically-necessary, Covered Services (pp. 48-49). H. Transportation 1. Contractor must provide non-emergent medical transportation (NEMT), including travel expenses, to authorized, Covered Services (p. 57, January 2016, Michigan Medicaid Managed Care Contract)

[88] 2.7.5 The health plan shall include the following services within the comprehensive benefit package and as outlined in the MO HealthNet Managed Care Policy Statements located and periodically updated on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managedcare-2017/bidder-vendor-documents/): […] y. Transportation Services: […] The health plan shall provide non-emergency medical transportation to members except for children in ME Codes 73 – 75, and 97 (Refer to Category of Aid 5 in Attachment 1, MO HealthNet Managed Care and Related Eligibility Groups, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care2017/bidder-vendor-documents/), and children in State custody with the following ME Codes 08, 52, 57, and 64 (Refer to Category of Aid 4 in Attachment 1, MO HealthNet Managed Care and Related Eligibility Groups, and located on the MO HealthNet website at Bidder and Vendor Documents (http://dss.mo.gov/business-processes/managed-care-2017/bidder-vendor- documents/) who do not have the ability to provide their own transportation (such as their own vehicle, friends, or relatives) to and from services required herein as well as to and from MO HealthNet Fee-For-Service covered services not included in the comprehensive benefit package (Addendum #5, pp. 56-57, May 2017, Missouri HealthNet Medicaid Managed Care RFP)

[89] B. Provider Network Requirements 1. Geographic Access Standards In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the geographic access standards for all Members set forth in Table 6. […]; OB/GYN: Urban – One (1) within thirty (30) minutes or thirty (30) miles; Rural – One within sixty (60) minutes or sixty (60) miles (Amendment #4, Exhibit A, p. 104, July 2019, Mississippi Magnolia Medicaid Managed Care Contract)

[90] EXHIBIT E: NON-EMERGENCY TRANSPORTATION (NET) REQUIREMENTS The Contractor, in its delivery of NET services, shall comply with all requirements of Exhibit H, Reporting Requirements, of this Contract. The Contractor shall administer and provide NET services to Members, including but not limited to the establishment of a network of NET Providers, and authorization, coordination, scheduling, management, and reimbursement of NET service requests. The Contractor is required to provide NET services according to Division policies. […] [Included in the Contract for informational purposes: Not all Mississippi Medicaid enrollees are eligible for NET Services. The following eligibility groups are not eligible for NET transportation: Family Planning Waiver, […] (Amendment #4, Exhibit A, pp. 275-275, July 2019, Mississippi Magnolia Medicaid Managed Care Contract)

[91] Article 4: Benefits 4.1 General Provisions 4.1.1 Basic Standards […] (J) MCO shall, in accordance with 42 CFR § 431.53, ensure necessary transportation for nonemergency transportation services, including the reimbursement amount for providers, per best practice guidelines and standards it develops, as necessary to provide the covered service (Attachment B, pp. 36-37, January 2020, North Dakota Stanford Health Plan Medicaid Managed Care Contract)

[92] Family planning services must be available within seven calendar days. 5. Non-urgent, preventive care must be available within 4 weeks. (Attachment 39, p. 1, January 2017, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[93] 2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics. (Attachment 39, p. 1, January 2017, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[94] 28. Medical Transportation a. The MCO must provide emergency and non-emergency medical transportation (NMET) for its members. (p. 7, January 2017, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[95] MCOs are required to meet Statewide standards in federally required areas (e.g., time and distance standards for Primary Care Providers (PCPs), specialists, obstetrics and gynecology) and additional areas identified by New Hampshire, including for Substance Use Disorder treatment services and for Children with Special Health Care Needs (Appendix C, p. 14, 2019, New Hampshire Medicaid Managed Care Model Contract RFP)

[96] 4.1.9 Non-Emergency Medical Transportation The MCO shall arrange for the NEMT of its Members to 4.1.9.1 ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO. The MCO shall provide the most cost-effective and least expensive mode of transportation to its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements. (Appendix C, p. 83, 2019, New Hampshire Medicaid Managed Care RFP)
[97] X. Telemedicine and Telehealth […] 2. Contractors shall authorize and reimburse for any service provided by a health care provider who is validly licensed, certified, or registered with the Department of Health (annually) to provide such services in the State of New Jersey so long as either the provider or patient are located in New Jersey at the time the services were provided. Services must be provided in compliance with existing requirements under law or regulation. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate. (Article 4, pp. 8-9, January 2020, New Jersey Medicaid Managed Care Contract)
[98]4.1.3 A. SERVICES REMAINING IN FEE-FOR-SERVICE PROGRAM AND MAY NECESSITATE CONTRACTOR ASSISTANCE TO THE ENROLLEE TO ACCESS THE SERVICES The following services provided by the New Jersey Medicaid program under its State plan shall remain in the fee-for-service program but may require medical orders by the Contractor's PCPs/providers or transportation broker. These services shall not be included in the Contractor's capitation (Article 4 – p. 17)

[…] 2. Non-emergency transportation – including all non-emergency transportation, such as mobile assistance vehicles (MAVs), non-emergency basic life support (BLS) ambulance (stretcher) and livery transportation for any NJ FamilyCare/Medicaid service whether it is a Contractor-covered service or non-Contractor covered service is provided by the State transportation broker. (Article 4 – pp. 21-22, January 2020, New Jersey Medicaid Managed Care Contract)
[99]Alternative Benefit Plan Services Included Under Centennial Care […] Non-emergency transportation when necessary to secure covered medical services (Amendment #2, p. 398, April 2020, New Mexico BCBS Medicaid Managed Care Contract)
[100] B. PCP Appointments 1. Same-day, medically necessary, primary care provider appointments (Amendment #8, p. 92, July 2013, Nevada Medicaid Managed Care RFP)
[101]4.2.3 The following services are either excluded as a Vendor covered benefit or have coverage limitations. Exclusions and limitations are identified as follows: […] 4.2.3.2 Non-Emergency Transportation (NET) The DHCFP contracts with a NET Broker who authorizes and arranges for all covered medically necessary non-emergency transportation. The Vendor and its subcontractors shall coordinate with the NET Broker, if necessary, to ensure NET services are secured on behalf of enrolled recipients. The Vendor and its subcontractors must also verify medical appointments upon request by DHCFP or the NET Broker (Amendment #8, pp. 46-47, July 2013, Nevada Medicaid Managed Care RFP)
[102] 15. Access Requirements […] 15.2 Appointment Availability Standards […] xii) Initial family planning visits: within two (2) weeks of request (Section 15, p. 15-2, March 2019, New York Medicaid Managed Care Draft Model Contract)
[103] 23. Non-Emergency Transportation a) Transportation expenses are covered for MMC Enrollees when transportation is essential in order for a MMC Enrollee to obtain necessary medical care and services which are covered under the Medicaid program (either as part of the Contractor's Benefit Package or by Medicaid fee-for-service) (Appendix K, p. K-34, March 2019, New York Medicaid Managed Care Draft Contract)
[104] Gynecology, OB/GYN Large Metro Maximum Time (minutes) 30 Maximum Distance (miles) 15 Metro Maximum Time (minutes) 45 Maximum Distance (miles) 30 Micro Maximum Time (minutes) 80 Maximum Distance (miles) 60 Rural Maximum Time (minutes) 90 Maximum Distance (miles) 75 (Appendix H, p. 100, July 2020, Ohio Medicaid Managed Care Draft Model Contract)

[105] 17. Additional Benefits. […] a. The MCP is required to make transportation available to any member requesting transportation when the member shall travel 30 miles or more from his or her home to receive a medically necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5160-26-03 and Appendices G and H of this Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit. (pp. 23-24, July 2020, Ohio Medicaid Managed Care Draft Contract).

[106] Providing enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible (p. 221, October 2020, Oklahoma Medicaid Managed Care RFP)

[107] OB/GYN: Urban Distance - Within ten miles of a Health Plan Enrollee's residence; OB/GYN: Rural Distance - Within 45 miles of a Health Plan Enrollee's residence (p. 397, October 2020, Oklahoma Medicaid Managed Care RFP)

[108] 1.6.7. Non-Emergency Transportation […] 1.6.7.2 NEMT Covered Services The Contractor shall provide NEMT to Health Plan Enrollees to access all SoonerCare covered services in accordance with 42 C.F.R. § 440.170. This includes all benefits for which the Contractor is responsible, as well as benefits which are covered by SoonerCare but not the responsibility of the Contractor as outlined in Section 1.6.4: "Excluded Benefits" of this Model Contract. The Contractor, at its sole discretion, may offer additional NEMT services as a Value-Added Benefit. (p. 142, October 2020, Oklahoma Medicaid Managed Care RFP)

[109] 4. Covered Service Components Without limiting the generality of Contractor's obligation to provide integrated care and coordination for Covered Services, the following responsibilities are required by law, and must be implemented in conjunction with its integrated care and coordination responsibilities stated above. […] b. Non-Emergent Medical Transportation (NEMT) Contractor is responsible for ensuring members have access to safe, timely, appropriate Nonemergent Medical Transportation services. Contractor shall develop and implement systems supported by written policies and procedures to describe the process for receiving member requests, approving NEMT services, and scheduling, assigning, and dispatching providers. (Appendix B, Exhibit B, pp. 19-20, January 2020, Oregon Medicaid Managed Care Contract)

[110] c. Specialists i. For the following provider types, the PH-MCOs operating in Lehigh Capital, Southeast, and Southwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural): General Surgery Cardiology Obstetrics & Gynecology Pharmacy Oncology Orthopedic Surgery Physical Therapy General Dentistry Radiology Pediatric Dentistry PH-MCOs operating in Northeast and Northwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural): General Surgery Cardiology Obstetrics & Gynecology Pharmacy Orthopedic Surgery Pediatric Dentistry General Dentistry (p. AAA-2, January 2020, Pennsylvania Medicaid Managed Care Contract)

[111]15. Transportation The PH-MCO must provide for all Medically Necessary emergency ambulance transportation and all Medically Necessary nonemergency ambulance transportation. Any non-emergency transportation (excluding Medically Necessary non-emergency ambulance transportation) for Members to and from MA compensable services must be arranged through the MATP. A complete description of MATP responsibilities can be found in Exhibit L, Medical Assistance Transportation Program. (p. 55, January 2020, Pennsylvania Medicaid Managed Care Contract). *See* Exhibit L for more on NEMT policy

[112] Provider Type OB/Gyn specialty care Time and Distance Standard…forty-five (45) minutes or thirty (30) miles from the member's home (Amendment #3, p. 114, July 2019, Rhode Island Medicaid Managed Care Contract)

[113] 2.06.01.09 Enhanced Services One of the goals of EOHHS is to reduce barriers to care that exist in the fee-for-service delivery system. To accomplish this goal, the Contractor agrees to offer a schedule of enhanced services, as described below. […] Transportation EOHHS contracts with a non-emergency transportation broker for all members. Through this service, for medically necessary or behavioral health appointments members are offered bus passes and, when necessary, transport on other types of non-emergency medical vehicles (chair vans, ambulances, etc.). For its part, the Contractor agrees to coordinate the arrangement of

transportation for its members through the Broker when a means of transport other than by bus is required. (Amendment #3, pp. 75-75, July 2019, Rhode Island Medicaid Managed Care Contract)

[114] 6.2.2.3.5. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures. (p. 91)

D.2.1.17 If the Subcontractor is a PCP, the Provider shall have an appointment system for covered core benefits and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements: […] D.2.1.17.5 Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. (Amendment IV, pp. 284-285, July 2018, South Carolina Medicaid Managed Care Contract)

[115] 2.6.1.3 CONTRACTOR Physical Health Benefits Chart for TennCare Members (Excluding CoverKids) […] Non-emergency Medical Transportation (including NonEmergency Ambulance Transportation) […] Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Division of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section A.1 of the Contract). (Amendment #12, pp. 48-50, July 2020, Tennessee Medicaid Managed Care Contract)

[116] OB/GYN Access: STAR and STAR+PLUS Program Networks must ensure that all female Members have access to an OB/GYN in the Provider Network within the following number of miles or travel time of the Member's residence. Members residing in a Metro County: 30 miles or 45 minutes; Members residing in a Micro County: 60 miles or 80 minutes; Members residing in a Rural County: 75 miles or 90 minutes. If an OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP. (Attachment B-1, Section 8, p. 8-61, March 2020, Texas Medicaid Managed Care Contract)

[117] Telemedicine, Telehealth, Telepharmacy, and Telemonitoring Access Telemedicine, Telehealth, Telepharmacy and Telemonitoring are Covered Services and are benefits of Texas Medicaid. MCOs are encouraged to contract with Providers offering these services to provide better access to healthcare for its Members. In addition, a Medicaid MCO must be able to accept and process Provider claims for these services in conformity with the Texas Medicaid benefit. MCOs are required to comply with Texas Government Code §531.0216. MCOs may not limit a physician's choice of platform for providing Telemedicine or Telehealth services by requiring the physician to use a particular platform to receive reimbursement for the service. MCOs must allow Members to receive Telemedicine or Telehealth services from providers other than the Member's PCP. (Attachment B-1, Section 8, p. 8-197, March 2020, Texas Medicaid Managed Care Contract)

[118] 8.2.MM Telemedicine Telemedicine is defined as the real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Telemedicine may also include 'store and forward' technology, where digital information (such as an X-ray) is forwarded to a professional for interpretation and diagnosis. The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions. The Contractor also shall encourage the use of telemedicine to promote community living and improve access to health services. (p. 218, July 2020, Virginia Medicaid Managed Care Contract)

[119] 5. Urgent Care Centers or Walk-in Clinics The HMO must have policies and procedures to provide members access to urgent care centers or walk-in clinics. The HMO must include in its network urgent care centers, walk-in clinics, or other medical facilities that are available to members for after-hours care from 5 p.m. to 7 p.m. during weekdays or open to members during weekends. A hospital emergency department may not serve to meet this requirement. All urgent care centers, walk-in clinics, and physician office open extended hours must accept and advertise that walk-in appointments are accepted. (p. 132, January 2020, Wisconsin Medicaid Managed Care Contract)

[120] OB/GYN Providers […] Wait times for an appointment shall be no more than 30 days. (p. 129, January 2020, Wisconsin Medicaid Managed Care Contract)

[121] OB/GYN Providers […] Counties Served Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha…. An OB/GYN must be within a 30 minute drive time of any member residing in these counties […] All other remaining counties […] An OB/GYN must be within a 60 minute drive time of any member residing in all other counties (p. 129, January 2020, Wisconsin Medicaid Managed Care Contract)

[122] OB/GYN Providers […] No standard (p. 129, January 2020, Wisconsin Medicaid Managed Care Contract)

[123]ARTICLE IV IV. SERVICES A. BadgerCare Plus and/or Medicaid SSI Services […] 1. Provision of Contract Services The HMO must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and Wis. Adm. Code ch. DHS 107 as applicable to the particular member and as further clarified in all Wisconsin Health Care Programs Online Handbook and HMO Contract Interpretation Bulletins, Provider Updates, through the interChange Portals, and as otherwise specified in this Contract except: […] a. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section A(6) (pp. 70-72, January 2020, Wisconsin Medicaid Managed Care Contract)

[124] OB/GYN OB/GYN or certified nurse midwife Two (2) providers within twenty-five (25) miles or thirty (30) minutes travel time (p. I-6, 2020, West Virginia Medicaid Managed Care Contract)

[125] OB/GYN or certified nurse midwife One (1) provider for every one thousand (1,000) enrollees per county (p I-4, July 2019, West Virginia Medicaid Managed Care Draft Contract)

[126] .3.1 Non-emergency Transportation Routine medical transportation to and from Medicaid-covered scheduled medical appointments is covered by the non-emergency medical transportation (NEMT) broker Medicaid program. This includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation by individuals. The NEMT broker must approve ambulance, multi-passenger van services, and transportation by common carriers. The MCO must inform enrollees of how to access non-emergency transportation as appropriate. (pp. 58-59, 2020, West Virginia Medicaid Managed Care Contract)

Table 3. Information for Plan Members

This table displays information on the extent to which states specify information transparency requirements for contractors related to family planning services. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.*

State	Contractors required to inform members regarding their free choice of provider from any qualified Medicaid provider, without pre-authorization†		Contractors required to inform female members of their right to direct access (without prior authorization) to women's health specialists within the network for routine and preventive health care‡		Contractors required to inform members regarding covered family planning services not available through their health plan, and where and how to obtain them§		Contractors required to inform members about confidentiality rights in connection with family planning		Contractors required to not disclose the family planning visit in the explanation of benefits	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
AZ	N		N		N		N		N	
CA	Y	X[1]	Y	X[2]	N		N		N	
CO	N		N		N	X[3]	N		N	
DC	N		N		Y	X[4]	N		N	
DE	N		N		Y	X[5]	N		N	
FL	Y	X[6]	N		N		N		N	
GA	N		N		N		N		N	
HI	N		N		Y	X[7]	N		N	

*All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

† In compliance with § 1902(a)(23) of the Social Security Act, codified at 42 U.S.C. § 1396a(a)(23) and implementing regulations at 42 C.F.R § 431.51

‡ In compliance with 42 C.F.R. § 438.206(b)(2)

§ In compliance with 42 C.F.R. § 438.10(g)(2)(ii)

¥ Four states (MN, TN, WI, and WV), according to KFF, currently carve out some or all prescription drug coverage from their MCO contracts. As such, this may create additional utilization management issues.

State	Contractors required to inform members regarding their free choice of provider from any qualified Medicaid provider, without pre-authorization[†]		Contractors required to inform female members of their right to direct access (without prior authorization) to women's health specialists within the network for routine and preventive health care[‡]		Contractors required to inform members regarding covered family planning services not available through their health plan, and where and how to obtain them[§]		Contractors required to inform members about confidentiality rights in connection with family planning		Contractors required to not disclose the family planning visit in the explanation of benefits	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
IA	N		N		N		N		N	
IL	N		Y	X[8]	Y	X[9]	N		N	
IN	N		N		N		N		N	
KS	N		N		N		N		N	
KY	N		N		N		N		N	
LA	N		N		N		N		N	
MA	Y	X[10]	Y	X[11]	N		N		N	
MD	N		N		N		N		N	
MI	Y	X[12]	Y	X[13]	Y	X[14]	N		N	
MN	Y	X[15]	N		N		N		N	
MO ¥	N		N		Y	X[16]	N		N	
MS	Y	X[17]	Y	X[18]	Y	X[19]	N		N	
ND	N		N		N		N		N	
NE	Y	X[20]	Y	X[21]	N		N		N	
NH	N		N		N		N		N	
NJ	Y	X[22]	Y	X[23]	Y	X[24]	N		N	
NM	N		N		N		N		N	
NV	N		Y	X[25]	N		N		N	
NY	N		Y	X[26]	Y	X[27]	N		N	
OH	N		Y	X[28]	N		N		N	
OK	Y	X[29]	Y	X[30]	N		N		N	

State	Contractors required to inform members regarding their free choice of provider from any qualified Medicaid provider, without pre-authorization[†]		Contractors required to inform female members of their right to direct access (without prior authorization) to women's health specialists within the network for routine and preventive health care[‡]		Contractors required to inform members regarding covered family planning services not available through their health plan, and where and how to obtain them[§]		Contractors required to inform members about confidentiality rights in connection with family planning		Contractors required to not disclose the family planning visit in the explanation of benefits	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
OR	N		N		N		N		N	
PA	N		N		N		N		N	
RI	N		N		Y	X[31]	N		N	
SC	N		N		N		N		N	
TN ¥	N		Y	X[32]	N		N		N	
TX	N		N		N		N		N	
UT	N		Y	X[33]	Y	X[34]	N		N	
VA	Y	X[35]	Y	X[36]	N		N		N	
WA	N		N		N		N		Y	X[37]
WI ¥	N		N		Y	X[38]	N		N	
WV ¥	Y	X[39]	Y	X[40]	Y	X[41]	N		N	
Total	**Y= 11 N= 29**		**Y= 15 N= 25**		**Y= 14 N= 26**		**Y= 0 N= 40**		**Y= 1 N= 39**	

[1] Contractor shall ensure that the Member Services Guide includes the following information: […] Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. (Exhibit A, Attachment 13, p. 128, California GMC Non-CCI Boilerplate Contract)

[2] Contractor shall ensure that the Member Services Guide includes the following information: […] Procedures for providing female Members with direct access to a women's health Specialist within the Network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health Specialist. (Exhibit A, Attachment 13, p. 128, California GMC Non-CCI Boilerplate Contract)

[3] 14.2.2.4.1. The Contractor shall communicate to its Network Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this Contract - Exhibit M but are available to Members under Medicaid fee for service (FFS). (Amendment #3, Exhibit M-3, p. 96, July 2019, Region 1, Colorado Rocky Mountain HMO Medicaid Managed Care Contract)

[4] C.5.17.5.8 In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees within 30 days: C.5.17.5.8.1 That the service is not covered by the Contractor; and C.5.17.5.8.2 How they can obtain information from the state about how to access those services. (p. 61, April 2019, District of Columbia Amerigroup Medicaid Managed Care Contract)

[5] 3.7.2.4.17.3 Identify non-Covered Services such as additional services, benefits/services provided through Medicaid FFS (see Section 3.4.10 of this Contract), another State program, or community resources. (p. 128, December 2017, Delaware Medicaid Managed Care Contract)

[6] (c) The Managed Care Plan shall allow each enrollee to obtain family planning services and supplies from any provider and shall not require a referral for such services. (Attachment II, Exhibit II-A, p. 14, July 2020, Florida Medicaid Managed Care Contract)

[7] Information on how to obtain services that the health plan does not cover because of moral or religious objections, if applicable; Benefits provided by the health plan not covered under the contract (p. 310, 2014, Hawaii Medicaid Managed Care RFP)

[8] At a minimum, the Enrollee handbook must contain: […] 5.21.5.7 how and the extent to which the Enrollee may obtain direct-access services, including Family-Planning services; 5.21.5.8 the policies and procedures for obtaining services, including clinical advice, self-referred services, services requiring prior authorization, and services requiring a Referral […] (p. 110, January 2018, Illinois Medicaid Managed Care Model Contract)

[9] Right of Conscience […] If Contractor chooses to exercise this right, Contractor must notify Potential Enrollees, Prospective Enrollees, and Enrollees that it has chosen not to render certain Covered Services […] (p. 74, January 2018, Illinois Medicaid Managed Care Model Contract)

[10] a. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services; (p. 135, September 2017, Massachusetts Medicaid Managed Care RFR Amendment)

[11] The Enrollee Information, shall include, but not be limited to, a description of the following: […] The MCO Covered Services, including Behavioral Health Services that do not require authorization or a referral from the Enrollee's PCP, for example, family planning services or individual behavioral health outpatient therapy […] (p. 58)

a. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services; (p. 135)

The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for MCO Covered Services necessary to provide women's routine and preventive health care services. This shall

include contracting with, and offering to female Enrollees, women's health specialists as PCPs. (p. 140, September 2017, Massachusetts Medicaid Managed Care RFR Amendment)

[12] xl. The extent to which, and how Enrollees may obtain benefits, including family planning services and supplies from Out-of-Network Providers. This includes an explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider. (p. 88, January 2016, Michigan Medicaid Managed Care Model Contract)

[13] At a minimum, the member handbook must include the following information as specified in 42 CFR 438.10(g)(2) and any other information required by MDHHS: … Enrollees' right to direct access to network women's health specialists and pediatric Providers for Covered Services necessary to provide routine and preventive health care services without a referral. (p. 86)

xl. The extent to which, and how Enrollees may obtain benefits, including family planning services and supplies from Out-of-Network Providers. This includes an explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider. (p. 88, January 2016, Michigan Medicaid Managed Care Model Contract)

[14] At a minimum, the member handbook must include the following information as specified in 42 CFR 438.10(g)(2) and any other information required by MDHHS: […] iii. Availability and process for accessing Covered Services that are not the responsibility of the Contractor, but are available to its Enrollees. (p. 86, January 2016, Michigan Medicaid Managed Care Model Contract)

[15] 3.10.3.3 The Handbook must include the following [42 CFR §438.10(g)]: […] (6) Notification of the open access of Family Planning Services and services prescribed by Minnesota Statutes, §62Q.14. (p. 44, January 2020, Minnesota Medicaid Managed Care Contract)

[16] At a minimum, the member handbook shall include the information and items listed below […] 8) A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package. (p. 80, July 2018, Missouri Medicaid Managed Care RFP)

[17] The Member Handbook must include at a minimum the following information: […] Information about family planning services, including explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies and that each Member is free from coercion or mental pressure and free to choose the method of family planning to be used, in accordance with 42 C.F.R. § 441.20. (Amendment #4, p. 84, Mississippi Medicaid Managed Care Contract)

[18] The Member Handbook must include at a minimum the following information: …. The MCO must comply with section 42 C.F.R 438.10(g)(2)(vii), which specifies that members cannot be required to obtain a referral prior to choosing a family planning provider […] (Amendment #4, p. 84, Mississippi Medicaid Managed Care Contract)

[19] The Member Handbook shall contain the list of services not covered by the MCOs because of moral or religious objections and how to obtain information from the State about how to access those services not covered. (Amendment #4, p. 84, Mississippi Medicaid Managed Care Contract)

[20] If you get care from a non-contracted provider… or outside of the Nebraska Total Care Service Area, you may be billed by the provider and you may have to pay, except for…family planning and sexually transmitted disease (STD) testing services (p. 16, January 2017, Sample Member Handbook, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[21] Women can go to any participating doctor, family practitioner, or nurse practitioner for routine and preventive OB/GYN care. You do not need approval from Nebraska Total Care or a referral from your PCP (p. 1087, Sample Member Handbook).

You do not need a referral for […] family planning. (p. 11, January 2017, Sample Member Handbook, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[22] The content and format of the handbook shall have the prior written approval of DMAHS and shall describe all services covered by the Contractor, exclusions or limitations on coverage, the correct use of the Contractor's plan, and other relevant information, including but not limited to the following: … 5. A notification of the enrollee's right to obtain family planning services from the Contractor or from any appropriate Medicaid participating family planning provider (42 C.F.R. § 431.51(b)); notification that enrollees covered under NJ FamilyCare shall not be required to obtain a referral or be otherwise restricted in the choice of the family planning provider from whom the enrollee may receive family planning services. (Art. 5, p. 12, January 2020, New Jersey Medicaid Managed Care Contract)

[23] The content and format of the handbook shall have the prior written approval of DMAHS and shall describe all services covered by the Contractor, exclusions or limitations on coverage, the correct use of the Contractor's plan, and other relevant information, including but not limited to the following: … 5. A notification of the enrollee's right to obtain family planning services from the Contractor or from any appropriate Medicaid participating family planning provider (42 C.F.R. § 431.51(b)); notification that enrollees covered under NJ FamilyCare shall not be required to obtain a referral or be otherwise restricted in the choice of the family planning provider from whom the enrollee may receive family planning services. (Art. 5, p. 12, January 2020, New Jersey Medicaid Managed Care Contract)

[24] The content and format of the handbook shall have the prior written approval of DMAHS and shall describe all services covered by the Contractor, exclusions or limitations on coverage, the correct use of the Contractor's plan, and other relevant information, including but not limited to the following: … A list of the Medicaid and/or NJ FamilyCare services not covered by the Contractor and an explanation of how to receive services not covered by this contract including the fact that such services may be obtained through the provider of their choice according to regular Medicaid program regulations. The Contractor may also assist an enrollee or, where applicable, an authorized person, in locating a referral provider. (Art. 5, p. 12, January 2020, New Jersey Medicaid Managed Care Contract)

[25] At a minimum, the information enumerated below must be included in the handbook. […] K. Procedures for obtaining benefits, including authorization requirements (p. 78, July 2013, Nevada Amerigroup Medicaid Managed Care Contract)

[26] If the Contractor includes Family Planning and Reproductive Health services in its Benefit Package (as per Appendix M of this Agreement), the Contractor must notify all Enrollees of reproductive age, including minors who may be sexually active, at the time of Enrollment about their right to obtain Family Planning and Reproductive Health services and supplies without referral or approval. (Appendix C, p. C-4, March 2019, New York Medicaid Managed Care Draft Contract)

[27] ii) If the Contractor does not include Family Planning and Reproductive Health services in its Benefit Package, the Contractor shall comply with the requirements of Part C.3 of Appendix C of this Agreement, including assuring that Enrollees are fully informed of their rights. (p. 10-8, March 2019)
b) Within ninety (90) days of signing this Agreement, the Contractor shall submit to the SDOH a policy and procedure statement that the Contractor will use to ensure that its Enrollees are fully informed of their rights to access a full range of Family Planning and Reproductive Health services, using the guidelines set forth below. The statement must be sent to the Director, Division of Health Plan Contracting and Oversight, NYS Department of Health, One Commerce Plaza, Room 1609, Albany, NY 12260. If the Contractor operates in New York City, an informational copy of the statement must also be sent to the NYC Department of Health & Mental Hygiene, Health Care Access and Improvement, Gotham Center, 42-09 28th Street, Long Island City, NY 11101-4132. (Appendix C, p. C-6, March 2019, New York Medicaid Managed Care Draft Contract)

[28] he MCP Member Handbook shall be clearly labeled as such and shall include: […] ii. Information regarding services excluded from MCP coverage and the services and benefits available through the MCP and how to obtain them, including at a minimum: […] 2. Self-referral services, including Title X services, and women's routine and preventative health care services provided by a woman's health specialist as specified in OAC rule 5160-26-03; (Appendix F, p. 76, July 2020, Ohio Medicaid Managed Care Contract)

[29] Pursuant to 42 C.F.R. § 438.10(c)(4)(ii), the Contractor shall use OHCA's model Health Plan Enrollee Handbook content in developing a Contractor-specific Handbook for OHCA's review and approval. The content of the Health Plan Enrollee Handbook shall include information that enables the Health Plan Enrollee to understand the MCO and SoonerSelect. This information shall include at a minimum: … The extent to which, and how, Health Plan Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers. This includes an explanation that the Contractor shall not require a Health Plan Enrollee to obtain a referral before choosing a family planning Provider […] (p. 196)

Family Planning In accordance with Section 1902(a)(23) of the Act and 42 C.F.R. § 431.51(b)(2), the Contractor shall not restrict the Health Plan Enrollee's free choice of Family Planning Services and Supplies Providers. (p. 151, October 2020, Oklahoma Medicaid Managed Care RFP)

[30] Pursuant to 42 C.F.R. § 438.10(c)(4)(ii), the Contractor shall use OHCA's model Health Plan Enrollee Handbook content in developing a Contractor-specific Handbook for OHCA's review and approval. The content of the Health Plan Enrollee Handbook shall include information that enables the Health Plan Enrollee to understand the MCO and SoonerSelect. This information shall include at a minimum: … … an explanation that the Contractor shall not require a Health Plan Enrollee to obtain a referral before choosing a family planning Provider […] (p. 196, October 2020, Oklahoma Medicaid Managed Care RFP)

[31] The member handbook will…contain at least the following: […] Information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement. (pp. 61-62, July 2019, Rhode Island Medicaid Managed Care Contract)

[32] 2.17.4.6.10 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to noncontract providers. This shall include an explanation that the CONTRACTOR may not require a member to obtain a referral before choosing a family planning provider. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider […] (p. 349, July 2020, Tennessee Medicaid Managed Care Contract)

[33] (C) The Enrollee handbook shall contain information: […] (17) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider. (Attachment B, p. 25, January 2019, Utah Medicaid ACO Model Contract)

5.1.2 Women's Health Specialists The Contractor shall provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist. (Attachment B, p. 53, Attachment B, January 2019, Utah Medicaid ACO Model Contract)

[34] (B) The Department shall notify Enrollees on how the Enrollees may obtain Covered Services that the Contractor has objected to providing on moral or religious grounds. Such services shall also be considered when calculating the Contractor's Capitation Rate. (Attachment B, p. 101, January 2019, Utah Medicaid ACO Model Contract)

[35] 7.10.G Member Services a. A description, including the amount, duration, and scope of all available covered services, as outlined in Section 8 of this Contract, including preventive services, and an explanation of any service limitations, referral and service authorization requirements, and any restrictions on the member's freedom of choice among network providers. The description shall include the procedures for obtaining benefits, including family planning services from out-of-network providers. [42 CFR § 438.10 (g)(2)(iii)-(iv)]. (p. 116, July 2020, Virginia Medicaid Managed Care Contract)

If the female member's designated primary care physician is not a women's health specialist, the Contractor is required to provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's care services. (p. 189, July 2020, Virginia Medicaid Managed Care Contract)

[36] 7.10.G Member Services a. A description, including the amount, duration, and scope of all available covered services, as outlined in Section 8 of this Contract, including preventive services, and an explanation of any service limitations, referral and service authorization requirements, and any restrictions on the

member's freedom of choice among network providers. The description shall include the procedures for obtaining benefits, including family planning services from out-of-network providers. [42 CFR § 438.10 (g)(2)(iii)-(iv)]. (p. 116)

If the female member's designated primary care physician is not a women's health specialist, the Contractor is required to provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's care services. (p. 189, July 2020, Virginia Medicaid Managed Care Contract)

[37] The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20). (p. 230, July 2020, Washington Apple Health Integrated Managed Care Contract)

[38] In written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the HMO because of an objection on moral or religious grounds. The HMO must inform members about how to access those services through the State. (p. 121, January 2020, Wisconsin Medicaid Managed Care Contract)

[39] Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a FFS basis. 4 The MCO must give each enrollee, including adolescents, the opportunity to use his/her own primary care provider or go to any family planning center for family planning services without requiring a referral….MCOs must provide their Medicaid enrollees with sufficient information to allow them to make an informed choice including: the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider both within and outside the MCO's network of providers. (p. 55)

Information on family planning services, including a discussion of enrollees' right to self-refer to in-network and out-of-network, Medicaid-participating family planning providers (p. 93, 2020, West Virginia Medicaid Managed Care Contract).

[40] Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a FFS basis. 4 The MCO must give each enrollee, including adolescents, the opportunity to use his/her own primary care provider or go to any family planning center for family planning services without requiring a referral. (p. 55)

Information on family planning services, including a discussion of enrollees' right to self-refer to in-network and out-of-network, Medicaid-participating family planning providers (p. 93, 2020, West Virginia Medicaid Managed Care Contract).

[41] Procedures for obtaining services covered under the Medicaid State Plan and not covered by the MCO (e.g., prescription drugs, non-emergency medical transportation […] (p. 93, 2020, West Virginia Medicaid Managed Care Contract).

Table 4. Payment Incentives

This table presents information on how states address the issue of payment incentives for plans and providers in the context of family planning. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.*

State	Contract specifies separate or add/on payments for family planning drugs or devices furnished as incident to a family planning visit (applicable to general plans that cover Rx) ¥		Contract specifies separate payment for postpartum LARC insertion		Contract encourages value-based incentives for primary or postpartum family planning	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
AZ	N		N		N	
CA	N		N		N	
CO	N		N		N	
DC	N		N		N	
DE	Y	X[1]	N		Y	X[2]
FL	N		N		N	
GA	N		N		N	
HI	N		N		Y	X[3]
IA	N		N		N	
IL	N		N		N	
IN	N		N		N	
KS	N		N		N	
KY	N		N		N	
LA	N		N		Y	X[4]
MA	N		N		N	

* All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

¥ Four states (MN, TN, WI, and WV), according to KFF, currently carve out some or all prescription drug coverage from their MCO contracts.

State	Contract specifies separate or add/on payments for family planning drugs or devices furnished as incident to a family planning visit (applicable to general plans that cover Rx) ¥		Contract specifies separate payment for postpartum LARC insertion		Contract encourages value-based incentives for primary or postpartum family planning	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
MD	N		N		N	
MI	N		N		N	
MN ¥	N		N		N	
MO	N		N		N	
MS	N		N		N	
ND	N		N		N	
NE	N		N		N	
NH	N		N		N	
NJ	N		N		N	
NM	N		N		N	
NV	N		N		N	
NY	N		N		N	
OH	N		N		N	
OK	N		N		N	
OR	N		N		Y	X[5]
PA	N		N		Y	X[6]
RI	N		Y	X[7]	N	
SC	N		N		N	
TN ¥	N		N		N	
TX	N		N		N	
UT	N		N		N	
VA	N		Y	X[8]	N	
WA	N		N		N	
WI ¥	N		N		N	

State	Contract specifies separate or add/on payments for family planning drugs or devices furnished as incident to a family planning visit (applicable to general plans that cover Rx) ¥		Contract specifies separate payment for postpartum LARC insertion		Contract encourages value-based incentives for primary or postpartum family planning	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
WV ¥	N		N		N	
Total	Y= 1 N= 39		Y= 2 N= 38		Y= 5 N= 35	

[1] 3.5.12 Claims Management […] 3.5.12.1.2.4.3 Ensuring that, for Long Acting Reversible Contraception (LARC) devices/drugs, the Contractor's reimbursement methodology will pay the provider (for example, a hospital or FQHC) separately at the claim detail level for these devises/drugs and not as part of any bundled rate. (p. 95, December 2017, Delaware Medicaid Managed Care Contract)

[2] APPENDIX 2: VALUE-BASED PURCHASING CARE INITIATIVE SECTION 6 PURPOSE a. The Department's value-based purchasing (VBP) care initiative applies to all Contractors. The purpose of this initiative is to accelerate the implementation of reforms/innovation within Delaware's health care delivery system to migrate the system away from traditional fee-for-service (FFS)/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures. Delaware seeks to align the incentives of the Contractor, providers and members through innovative VBP strategies. SECTION 7 TWO-PART STRATEGY a. To effectuate these changes, Delaware will hold the Contractor financially accountable to make meaningful progress on the Purpose through a two-part strategy: i. Quality Performance Measures (QPM): The Department will select measures that relate to any of the following domains: quality, access, utilization, long-term services and supports, provider participation, spending and/or member/provider satisfaction and assess a financial penalty for each measure if Contractor does not achieve performance levels defined in this Appendix. For purposes of this initiative, it is expected that the Department will select these measures as a sub-set of Delaware's Common Scorecard, but reserves the right to select other QPM that reflect the Department's goals/objectives and applicability to the Medicaid/CHIP population. […] SECTION 8 QUALITY PERFORMANCE MEASURES (QPM) a. QPM Performance/Measurement Year: For purposes of this Appendix, the Contractor's performance/measurement on each QPM will be evaluated on a calendar year basis unless a different performance/measurement period is otherwise required by the selected QPM. b. For the calendar year (CY) 2018 through CY 2020 performance/measurement year, the Department selected the following seven (7) QPM: […] vi. QPM #6: Prenatal and Postpartum Care (Timeliness of Prenatal Care) (HEDIS PPC) […] vi. QPM #6: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure. Contractor must be at or above the 66.67th percentile to achieve a satisfactory performance level on this QPM (pp. 391-394). […] [Note: Note: The contract provision does not explicitly include or exclude family planning services] SECTION 9 VALUE-BASED PURCHASING STRATEGIES (VBPS) […] b. The

Contractor is required to enter into payment arrangements/models with providers that align payment more directly to the quality and efficiency of care provided, by rewarding providers for their performance across different dimensions of quality and/or transferring the financial risk for member care to providers. The goal is to transition away from traditional FFS-based volume of care payment systems. […] e. VBPS Threshold Level: The Contractor is expected to achieve an annual threshold level for VBPS that will be measured as the portion of total medical/service expenditure to all providers for all members enrolled with the Contractor during the respective performance/measurement year that are associated with one or more of the acceptable VBPS arrangements/models. The same VBPS-related medical/service expenditures cannot be counted more than once for purposes of measuring against the respective threshold levels. The Department intends that the minimum threshold level will grow each year according to the following schedule: iii. Calendar Year 2020: A minimum of 40% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/3 of the 40% (i.e., 13%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department. iv. Calendar Year 2021: A minimum of 50% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/2 of the 50% (i.e., 25%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department. v. Calendar Year 2022: A minimum of 60% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 3/4 of the 60% (i.e., 45%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department. f. VBPS Penalty: For each performance/measurement year, the Contractor will be assessed a financial penalty if Contractor does not achieve performance levels specified in Section 4.e of this Appendix. (pp. 395-399, December 2017, Delaware Medicaid Managed Care Contract)

[3] 60.200 Incentives for Health Plan Performance The health plan shall be eligible for financial performance incentives or Pay for Performance (P4P) as long as the health plan is fully compliant with all terms of the contract. All incentives shall be in compliance with the Federal managed care incentive arrangement requirements set forth in 42 CFR Section 438.6 and the State Health Plan Manual. To qualify for receipt of a financial incentive that uses performance measurements as a performance indicator demonstrating improvement, a NCQA-licensed audit organization must have audited the reported rates for the measurements. […] Beginning in CY 2017 period, this PMPM withhold amount would be $2.00 PMPM for all members. The health plans' rates are actuarially sound with or without the refund of the PMPM P4P withhold. […] 60.245 Prenatal and Postpartum Care (PPC) - Postpartum Care The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows: 6.250% if the health plan has < 40.0% ABD, 3.750% if the health plan has >= 40.0% ABD This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate: Meets or exceeds the target HEDIS 75th percentile rate. (p. 453, 2014, Hawaii Medicaid Managed Care RFP)

[4] 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: […] 6.13.1.5. Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; (p. 81, December 2019, Louisiana Aetna Better Health Medicaid Managed Care Contract)

[5] Exhibit H – Value Based Payment Contractor shall demonstrate, as specified below, how it will use Value-based payment methodologies alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for Members. Contractor shall implement a schedule of Value-based payments, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery and the sustainability of care innovations across the care continuum. 1. VBP minimum threshold Starting on the effective date of this Contract, Contractor shall make at least 20% of its projected annual payments to its providers in contracts that include a value-based payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for

Performance LAN category 2C or higher. OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative/overhead expenses, profit/margin, and other non-service-related expenditures are excluded from the calculation. In addition to the LAN Framework, Contractor shall use the Value-based payment Roadmap for Coordinated Care Organizations and the OHA Value-based Payment Roadmap Categorization Guidance for Coordinated Care Organizations reports to enter the appropriate LAN VBP category for each payment model in the RFA VBP Data Template. 2. Expanding VBP beyond primary care to other care delivery areas a. Contractor shall develop new, or expanded from existing contract, VBPs in care delivery areas which include hospital care, maternity care, children's health care, behavioral health care, and oral health care. The term "expanded from an existing contract" includes, but is not limited to, an expansion of a CCO's existing contract such that more providers and/or members are included in the arrangement, and/or higher level VBP components are included. Prior to the effective date of this Contract, Contractor will receive final specifications of care delivery area VBPs, including required reporting metrics, from OHA. b. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher through the duration of the CCO 2.0 period. Contractor shall plan to implement care delivery area VBPs, according to the following schedule: In 2020, Contractor shall develop 2 new or expanded VBPs. The two new VBPs shall be in two of the listed care delivery areas, and one of the areas must be either hospital care or maternity care. Contractor may design new VBPs in both hospital care and maternity care. A VBP may encompass two care delivery areas; e.g. a hospital maternity care VBP that met specifications for both care delivery areas could count for both hospital care and maternity care delivery areas. (1) By 2021, Contractor shall implement two new or expanded VBPs, developed in previous years. (2) By 2022, Contractor shall implement a new VBP in one additional care delivery area. By the end of 2022, new VBPs in both hospital care and maternity care shall be in place. (3) By 2023 and 2024, Contractor shall implement one new VBP each year in each of the remaining care delivery areas. (4) By the end of 2024, Contractor shall implement new or expanded VBPs in all five care delivery areas (Appendix B, p. 148, January 2020, Oregon Medicaid Managed Care RFA).

[6] 8. Value Based Purchasing (VBP) […] a. Strategies The PH-MCO must enter into arrangements with Providers that incorporate VBP strategies, all of which must comply with the Physician Incentive Plan (PIP) requirements. The Department will accept any of the following arrangements as VBP strategies: […] The financial goals for the VBP strategies for each calendar year are based on a percentage of the PH-MCO's expenditures to the medical portion of the risk adjusted capitation and maternity revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments. These goals apply collectively to all HealthChoices Agreements between the PH-MCO and the Department in all HealthChoices Zones. For the purpose of this requirement, Capitation revenue is gross of premiums for risk sharing or risk pool arrangements without adjustment for risk sharing or risk pool results. The PH-MCO must achieve the following percentages through VBP arrangements: […] iv Calendar year 2020 – 50% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 50% must be from a combination of strategies iii. through v (pp. 149-152, January 2020, Pennsylvania Medicaid Managed Care Contract)

[7] 2.15.01.8 Hospital Services The Contractor will be required to implement reforms required by Rhode Island State Legislation (i.e., R.I. General Law Chapter 40-8, Section 40-8-13.4) which stipulates certain requirements for payments to hospitals. EOHHS recognizes that providing Long Acting Reversible Contraceptive Devices (LARCs) immediately post-partum in a hospital setting and prior to discharge has been shown to be effective in prolonging inter-birth intervals and preventing pre-term birth. The Contractor is required to reimburse providers for LARCs outside of the global fee for labor and delivery when the device is inserted post-partum in a hospital setting. The Contractor will reimburse separately for the LARC, outside of the global fee for labor and delivery. (Amendment #3, p. 153, July 2019, Rhode Island Medicaid Managed Care Contract)

[8] 8.2.P Family Planning […] a. Long Acting Reversible Contraception (LARC) Utilization and Reimbursement Appropriate family planning and/or health services shall be provided based on the member's desire for future pregnancy and shall assist the member in achieving her plan with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as service authorization shall not be required for approval. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral. In addition to a member's free choice of family planning provider, members are free to choose the method of family planning as provided in 42 CFR § 441.20. Immediate Post-Partum Coverage The Contractor must provide reimbursement for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less

than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor shall also reimburse practitioners for the post-partum insertion of the LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule. (p. 168, July 2020, Virginia Medicaid Managed Care Contract)

Table 5. Social Determinants of Health

This table presents information on how states address social determinants of health in the context of family planning services. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.*

State	Contract identifies family planning patients as a priority for social/health risk screening		Contract requires contractors to maintain referral relationships between their family planning network and social service agencies and agencies	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
AZ	N		N	
CA	N		N	
CO	N		N	
DC	N		N	
DE	N		N	
FL	N		N	
GA	N		N	
HI	N		N	
IA	N		N	
IL	N		Y	X[1]
IN	N		N	
KS	N		N	
KY	N		N	
LA	N		N	
MA	N		N	
MD	N		N	
MI	N		N	
MN	N		N	
MO	N		N	

* All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

State	Contract identifies family planning patients as a priority for social/health risk screening		Contract requires contractors to maintain referral relationships between their family planning network and social service agencies and agencies	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
MS	N		N	
ND	N		N	
NE	N		N	
NH	N		N	
NJ	N		N	
NM	N		N	
NV	N		N	
NY	N		N	
OH	N		N	
OK	N		N	
OR	N		N	
PA	N		N	
RI	N		N	
SC	N		N	
TN	N		N	
TX	N		N	
UT	N		N	
VA	N		N	
WA	N		N	
WI	N		N	
WV	N		N	
Total	Y= 0 N= 40		Y= 1 N= 39	

[1] 3.1.3 Family Planning and reproductive healthcare. […] Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: […] 3.1.3.13 maternity care: Contractor shall demonstrate capability for provision of evidence-based, timely care for pregnant Enrollees. At a minimum, Contractor shall provide the following services: […] 3.1.3.13.2 Contractor shall have systems and protocols in place to handle regular appointments; early prenatal care appointments; after-hours care with emergency appointment slots; a seamless process for timely transmittal of prenatal records to the delivering facility; and a Provider Network for social services support, and specialty care referrals including those for complex maternal and fetal health, genetic, emotional and Behavioral Health consultations, if indicated. Contractor must refer all pregnant Enrollees to the Women, Infants, and Children's (WIC) Supplemental Nutrition Program and have or be linked to case management services for identified high-risk Enrollees. Contractor must demonstrate ability to provide equally high-quality obstetrical care to special populations such as adolescents, homeless women, and women with developmental or intellectual disabilities; (pp. 308-310, January 2018, Illinois Medicaid Managed Care Model Contract)

Table 6. Quality Improvement and Performance Measurement

This table allows readers to view the extent to which states use performance measures for family planning and related services, both generally and for specific sub-populations, including adolescents and women receiving postpartum care. The table sets forth findings for each state, as well as the actual language used by the state in addressing each family planning domain.[*]

State	Specifies performance measures for family planning or related services[†]		Specifies performance measures for family planning or related services as part of maternity care		Specifies one or more family planning health outcome measures		Specifies adolescent performance measures for family planning or related services	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
AZ	Y	X[1]	Y	X[2]	N		Y	X[3]
CA	N		N		N		N	
CO	N		N		N		N	
DC	N		N		N		N	
DE	Y	X[4]	N		N		N	
FL	Y	X[5]	N		N		N	
GA	Y	X[6]	N		N		N	
HI	N		N		N		N	
IA	Y	X[7]	N		N		N	
IL	Y	X[8]	Y	X[9]	N		Y	X[10]
IN	N		N		N		N	
KS	N		N		N		N	
KY	N		N		N		N	
LA	Y	X[11]	Y	X[12]	N		Y	X[13]
MA	Y	X[14]	N		N		N	
MD	Y	X[15]	N		N		N	
MI	Y	X[16]	N		N		N	

[*] All language included in footnotes is directly quoted from state MCO model or executed contracts as of August 2020 (depending on what the state made publicly available), unless otherwise noted.

[†] States that include reference to the HEDIS measure set but do not specifically reference family-planning-related HEDIS measures, are not included in this column.

State	Specifies performance measures for family planning or related services[†]		Specifies performance measures for family planning or related services as part of maternity care		Specifies one or more family planning health outcome measures		Specifies adolescent performance measures for family planning or related services	
	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)	Incl. in Contract Y/N	Relevant provision(s)
MN	Y	X[17]	N		N		N	
MO	Y	X[18]	N		N		N	
MS	N		N		N		N	
ND	N		N		N		N	
NE	Y	X[19]	N		N		Y	X[20]
NH	Y	X[21]	N		N		Y	X[22]
NJ	Y	X[23]	Y	X[24]	N		N	
NM	Y	X[25]	N		N		N	X[26]
NV	N		N		N		N	
NY	N		N		N		N	
OH	Y	X[27]	N		N		N	
OK	Y	X[28]	Y	X[29]	N		Y	X[30]
OR	N		N		N		N	
PA	Y	X[31]	Y	X[32]	N		N	
RI	N		N		N		N	
SC	N		N		N		N	
TN	Y	X[33]	N		N		N	
TX	N		N		N		N	
UT	Y	X[34]	N		N		N	
VA	Y	X[35]	Y	X[36]	N		N	
WA	Y	X[37]	N		N		N	
WI	N		N		N		N	
WV	N		N		N		N	
Total (40)	Y = 23 N = 17		Y = 7 N = 33		Y = 0 N = 40		Y=7 N=33	

[1] ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES: The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the Contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted […] Maternity and Family Planning Services Plan and Evaluation. (Amendment #14, pp. 183-192, October 2019, Arizona Medicaid Managed Care Contract)

[2] PERFORMANCE MEASURES […] Maternal and Perinatal Health: […] Contraceptive Care – Postpartum Women (CCP) (Amendment #14, p. 222, Oct. 2019, Arizona Medicaid Managed Care Contract)

[3] Performance Measures; CMS CHILD CORE MEASURES: Immunizations for Adolescent (IMA) […] Human Papillomavirus (HPV) (Amendment #14, p. 222, October 2019, Arizona Medicaid Managed Care Contract)

[4] SECTION 8 QUALITY PERFORMANCE MEASURES (QPM): a. QPM Performance/Measurement Year: For purposes of this Appendix, the Contractor's performance/measurement on each QPM will be evaluated on a calendar year basis unless a different performance/measurement period is otherwise required by the selected QPM. b. For the calendar year (CY) 2018 through CY 2020 performance/measurement year, the Department selected the following seven (7) QPM: […] iii. QPM #3: Cervical Cancer Screening (HEDIS CCS); iv. QPM #4: Breast Cancer Screening (HEDIS BCS); vi. QPM #6: Prenatal and Postpartum Care (Timeliness of Prenatal Care) (HEDIS PPC). Contractor's performance on the QPM and for purposes of assessing, if any, penalty, the Contractor's performance in the CY 2019 performance/measurement period will be measured as follows: […] iii. QPM #3: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure. Contractor must be at or above the 50th percentile to achieve a satisfactory performance level on this QPM. iv. QPM #4: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure. Contractor must be at or above the 50th percentile to achieve a satisfactory performance level on this QPM. (pp. 391-394, December 2017, Delaware Medicaid Managed Care Contract)

[5] Table 6: Required Performance Measures: Healthcare Effectiveness Data and Information Set (HEDIS): Adults' Access to Preventive/Ambulatory Health Services - (AAP) […] Breast Cancer Screening – (BCS) […] Cervical Cancer Screening – (CCS) […] Chlamydia Screening in Women – (CHL) […] Adult Core Set 37. HIV Viral Load Suppression- (VLS) […] 39. Contraceptive Care – Postpartum Women Ages 21-44 – (CCPAD) (Exhibit #2, pp. 67-68, July 2020, Florida Medicaid Managed Care Contract)

[6] Quality Measures for Health Insurance Marketplace […] Preventive screenings (breast cancer, […] cervical cancer, Chlamydia. (p. 7424, 2016, Georgia CareSource Medicaid Managed Care Contract)

Planning 4 Healthy Babies Program Objectives […] Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by: Total family planning visits pre and post the Demonstration; o Use of contraceptive services/supplies pre and post the Demonstration; Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by: Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery; Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by: Average inter-pregnancy intervals for women pre and post the Demonstration; Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration; Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of

this objective will be documented by: The number of repeat teen births assessed annually; Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by: The number of Medicaid paid deliveries assessed annually; Increase consistent use of contraceptive methods by incorporating Care Coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by: Utilization statistics for family planning methods o Number of Deliveries to P4HB participants. (p. 871, 2016, Georgia CareSource Medicaid Managed Care Contract)

Performance Reporting In order for the program objectives to be achieved there must be sufficient outreach, uptake, and implementation of the Demonstration benefits. The performance measures identified below and in the CMS Special Terms and Conditions must be reported by the Contractor quarterly and annually or as identified in the CMS Special Terms and Conditions. I. Assessment of the rate at which the Demonstration was implemented using Enrollment, Participation and Use of Services as Performance Measures: These reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter […]; All Family Planning Services by type; All Contraceptives by type (inclusive of hormonal and non-hormonal contraceptives); Counts of primary care visits for those in the IPC component of the Demonstration. Utilization statistics per CMO for all IPC services and IPC services by type. (p. 8640, 2016, Georgia CareSource Medicaid Managed Care Contract)

[7] QM/QI Program Requirements […] The QM/QI program shall be submitted to the Agency for approval within 60 days after Contract initiation and include, at minimum, all of the following elements: […] Incorporation of clinical studies and use of Healthcare Effectiveness Data and Information Set (HEDIS) rate data, health care quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, Consumer Assessment of Health Plans (CAHPS) survey results and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members. (pp. 139-140) 14.5.4 HEDIS Report The Contractor shall conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report along with the same audited data provided to NCQA. The Agency will establish baseline performance targets for all HEDIS measures. 14.5.5 Quarterly Health Outcomes and Clinical Reports The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes. Priority areas for monitoring which the Contractor shall report on include, but are not limited to: […] Prenatal and Birth Outcomes: […] (ii) percentage of deliveries that received recommended prenatal and postpartum visit […] and (iv) frequency of ongoing prenatal care […] Adult Preventive Care, (I) cervical cancer screening; (ii) breast cancer screening; (iii) colorectal cancer screening; and (iv) adult access to preventive/ambulatory health services. (pp. 186-187, Jan. 2016, Iowa Amerigroup Medicaid Managed Care Contract)

TABLE F2: YEAR 2 CLINICAL PAY FOR PERFORMANCE MEASURES […] Adult Preventive Care: Adults' Access to Preventive/Ambulatory Health Services Based on HEDIS measure: The percentage of members 20 years and older who had an ambulatory or preventive care visit […] Adults Preventive Care: Breast Cancer Screening Based on HEDIS measure. The percentage of women with a mammogram at recommended interval... (pp. 256-259 January 2016, Iowa Amerigroup Medicaid Managed Care Contract)

[8] 1.1.3.1 Clinical areas to be monitored. The monitoring and evaluation of clinical care shall reflect the population served by Contractor in terms of age groups, disease categories, and special risk status, and shall include quality improvement initiatives as determined appropriate by Contractor or as required by the Department. The QAP shall, at a minimum, monitor and evaluate care and services in certain priority clinical areas of interest specified by the Department, based on the needs of Enrollees. At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources. At a minimum, the following areas shall be monitored for all populations: […] 1.1.3.1.10 utilization of Family Planning services. (pp. 227-228, January 2018, Illinois Medicaid Managed Care Model Contract)

[9] At a minimum, the following areas shall be monitored for pregnant women: […] 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC (p. 229, January 2018, Illinois Medicaid Managed Care Model Contract)

[10] Performance measure: Immunizations for Adolescents: Percentage of adolescents 13 years of age who had […] all required doses of the Human Papillomavirus (HPV) vaccine by their 13th birthday. (p. 244, January 2018, Illinois Medicaid Managed Care Model Contract)
[11] 14.2.5 Performance Measures 14.2.5.1 The MCO shall report on performance measures listed in Attachment C and in accordance with the timeline and format specified in the MCO Quality Companion Guide. (p. 249) HEDIS Measures Measure: Cervical Cancer Screening Measure Description: Percentage of women 21–64 years of age who were screened for cervical cancer: Women 21-64 who had cervical cytology performed every 3 years; Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years. (pp. 435-437, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract)
[12] CMS Measures Measure: Contraceptive Care-Postpartum (ages 15-20) Measure Description: The percentage of women ages 15-20 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. Contraceptive Care-Postpartum (ages 21-44) Measure Description: The percentage of women ages 21-44 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. 28-39, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract).
[13] CMS Measures Measure: Contraceptive Care-Postpartum (ages 15-20) Measure Description: The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. (pp. 28-39, January 2020, Louisiana Aetna Better Health Medicaid Managed Care Contract).
[14] The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and nonclinical care processes, outcomes and Enrollee satisfaction. Measurement and improvement projects shall be conducted in accordance with 42 CFR 438.330, and at EOHHS's direction, and shall include, but are not limited to:
a. Healthcare Plan Effectiveness Data and Information Set (HEDIS) (Attachment A, Sept. 2017, p. 236, MA Medicaid Managed Care Contract)
EOHHS has defined the following quality measures pursuant to Section 2.13.C.6 of the Contract. For measures that are not HEDIS, EOHHS will further define measure specifications, including due dates, sample size, and submission requirements […] Breast Cancer Screening (BCS) […] Chlamydia screening in women (CHL)… Prenatal & Postpartum Care (PPC) (Appendix B, pp. 6-8, September 2017, Massachusetts Medicaid Managed Care RFR Model Contract)
[15] An MCO shall participate in all quality assessment activities required by the Department to determine if the MCO is providing medically necessary enrollee health care. These activities include, but are not limited to: […] (3) The annual collection and evaluation of a set of performance measures with targets as determined by the Department as follows: […] (d) Effective January 1, 2014, the core performance measures are: […] (v) Breast cancer screening. (pp. 75-76, January 2020, Maryland Medicaid Managed Care Contract).
[16] HEALTH EQUITY HEDIS MEASURES PERFORMANCE AREA: Chlamydia Screening in Women (total) GOAL: Women enrolled in a health plan, ages 16 to 24, who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period PERFORMANCE AREA: Cervical Cancer Screening GOAL: Women enrolled in a health plan, ages 21 to 64, who were screened for cervical cancer using either of the following criteria: 1. Women ages 21 to 64 who had cervical cytology performed every three (3) years 2. Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years […] PEROFRMANCE AREA: Breast Cancer Screening GOAL: Women enrolled in a health plan, ages 50 to 74, who received a mammogram to screen for breast cancer during the measurement period or the two (2) years prior to the measurement period. (pp. 167-169, January 2016, Michigan Medicaid Managed Care Contract)
[17] 7.12 HYBRID METHOD HEDIS ANNUAL PERFORMANCE MEASURES AND RATES. 7.12.1 Measures. The MCO shall calculate and provide to the STATE the following HEDIS 2020 (based on calendar year 2019) performance measures and rates using the HEDIS hybrid method. The HEDIS hybrid measures and rates shall be submitted to the STATE by September 1 of the Contract Year. […] Cervical Cancer Screening (p. 139, January 2020, Minnesota Medicaid Managed Care Model Contract).
[18] 2.22.11 Quality Assessment and Improvement Evaluation Reports: a. Periodic Reports of Quality and Utilization: The health plan shall provide periodic reports regarding care management, quality initiatives, and other quality analysis reports per request of the state agency. When requested by the state agency,

these reports must be submitted to the state agency reporting website at MHD.MCReporting@dss.mo.gov. In addition, the health plan shall provide the following reports: HEDIS Measures: The health plan shall submit the HEDIS measures to the Department of Health and Senior Services (DHSS) in accordance with 19 CSR 10-5.010 as amended. Any changes to the list of specific HEDIS measures to be submitted shall be provided to the health plan by the state agency no later than December 31 prior to the measurement year. Additionally, the health plan shall submit these measures to the state agency on the annual Healthcare Quality Data Template located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (http://dss.mo.gov/business-processes/managed-care2017/health-plan-reporting-schedules-templates/). (p. 133) HEDIS Measure […] Women's Health: Chlamydia Screening in Women. (Amendment #5, pp. 148-149, July 2018, Missouri Medicaid Managed Care RFP)

[19] Attachment 7 – Performance Measures Adult Core Measures Cervical Cancer Screening (CCS) Chlamydia Screening in Women (CHL) […] Breast Cancer Screening (BCS) […] HIV Viral Load Suppression (HVL) (pp. 1-2, January 2017, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[20] Attachment 7- Performance Measures […] Child Core Measures: Child and Adolescents' Access to Primary Care Practitioners (CAP) Chlamydia Screening in Women (CHL) […] Immunizations for Adolescents (IMA) […] Human Papillomavirus Vaccine for Female Adolescents (HPV); Frequency of Ongoing Prenatal Care (FPC) Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC) Behavioral Health Risk Assessment (for Pregnant Women (BHRA). (pp. 1-2, January 2017, Nebraska Total Care Inc. Medicaid Managed Care Contract)

[21] Exhibit O – Quality and Oversight Reporting Requirements Name: Chlamydia Screening in Women Description/Notes: CMS Adult Core Set - Age and subpopulation breakout of data collected for HEDIS measure. (Appendix C, p. 62)

Exhibit O – Quality and Oversight Reporting Requirements Name: Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception Description/Notes: CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated. Name: Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC) Description/Notes: CMS Adult and Child Core Sets (member age determines in which set the member is reported) – to include subpopulation breakout as indicated (Appendix C, p. 66).

Exhibit O – Quality and Oversight Reporting Requirements Name: Breast Cancer Screening Description/Notes: HEDIS Measure Name: Breast Cancer Screening - Age 50-74 by Subpopulation Description/Notes: HEDIS Measure broken out by subpopulation

Name: Cervical Cancer Screening Description/Notes: HEDIS Measure Name: Chlamydia Screening in Women Description/Notes: HEDIS Measure (Appendix C, p. 69, 2019, New Hampshire Medicaid Managed Care Model Contract RFP)

[22] Exhibit O- Quality and Oversight Reporting Requirements Domain: Quality monitoring Name: Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception Domain: Quality Monitoring Name: Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC). (p. 66, Appendix C, 2019 New Hampshire Medicaid Managed Care Model Contract RFP)

[23] HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook. New Jersey Performance Measures ... Adults' Access to Preventive Care - by Dual, Disability, Other and Total categories […] Core Set Measure(s)-member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions: […] CCW: Contraceptive Care – All Women (Measure Steward – U.S. Office of Population Affairs). (pp. 80-81)

The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, mammography and prostate cancer screening. The program shall include the following components: Measurement of provider compliance with performance standards; Education outreach for both enrollees And practitioners regarding preventive cancer screening services; Mammography services for women ages sixty-five (65) to seventy-five (75) offered at least annually; Screen for prostate cancer for men aged sixty-five (65) and older, in accordance with the current Centers for Disease Control (CDC) recommendations. Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care. (p. 83)

Provider Performance Measures. The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate: Resource utilization of services, specialty and ancillary services; Clinical performance measures on outcomes of care; Maintenance and preventive services; Enrollee experience and perceptions of service delivery; and Access. (p. 86, January 2020, New Jersey Medicaid Managed Care Contract)

[24] Core Set Measure(s)-member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions: … CCP: Contraceptive Care – Postpartum Women (Measure Steward – U.S. Office of Population Affairs) (pp. 80-81, January 2020, New Jersey Medicaid Managed Care Contract)

[25] 4.12.17.8 TM#6 Long Acting Reversible Contraceptive (LARC) The CONTRACTOR shall measure the use of Long-Acting Reversible Contraceptives (LARC) among Members age 15–19. The contractor shall report LARC insertion/utilization data for this measure to the HSD on a quarterly and annual basis. (p. 213, April 2020, New Mexico BCBS Medicaid Managed Care Contract)

[26] 4.12.17.8 TM#6 Long Acting Reversible Contraceptive (LARC) The CONTRACTOR shall measure the use of Long-Acting Reversible Contraceptives (LARC) among Members age 15–19. The contractor shall report LARC insertion/utilization data for this measure to the HSD on a quarterly and annual basis. (p. 213, April 2020, New Mexico BCBS Medicaid Managed Care Contract)

[27] QUALITY MEASURES AND STANDARDS The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MCP performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Most measures have one or more Minimum Performance Standards. Specific measures and standards are used to determine MCP performance incentives. Measures with a minimum performance standard are used to determine MCP noncompliance sanctions. A limited number of measures are informational/reporting only and have no associated standards, incentives, or sanctions. All of the measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ), widely used for evaluation of Medicaid and/or managed care industry data. Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant […] Measure: Breast Cancer Screening Measure: Cervical Cancer Screening Measure: Chlamydia Screening in Women, Total. (p. 168, July 2020, Ohio Medicaid Managed Care Draft Model Contract)

[28] Physical Health Performance Measures: Adult CMS Core Set measures related to physical health: Cervical Cancer Screening Chlamydia Screening in Women Ages 21 to 24 […] Breast Cancer Screening […] HIV Viral Load Suppression. (p. 179, October 2020, Oklahoma Medicaid Managed Care RFP)

[29] Physical Health Performance Measures Maternal and Perinatal Health Prenatal and Postpartum Care: Postpartum Care Contraceptive Care – Postpartum Women Ages 21 to 44 Prenatal and Postpartum Care: Timeliness of Prenatal Care Contraceptive Care – Postpartum Women Ages 15 to 20 (p. 180, October 2020, Oklahoma Medicaid Managed Care RFP)

[30] Physical Health Performance Measures The Contractor shall be responsible for reporting on the physical health performance measures that are provided in the table below. These measures are subject to change. Physical Health Performance Measures: Child CMS Core Set measures related to physical health: Chlamydia Screening in Women Ages 16 to 20 Immunizations for Adolescents Adolescent Well-Care Visits. Prenatal and Postpartum Care: Timeliness of Prenatal Care Contraceptive Care – Postpartum Women Ages 15 to 20. (pp. 178-180, October 2020, Oklahoma Medicaid Managed Care RFP)

[31] The PH-MCO will analyze the following metrics through claims analysis: 1. Percentage of Members who received a service rendered by a primary care provider. The numerator is the number of Members who received a service rendered by a primary care provider and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period. […] 16. Percentage of female Members receiving contraception. The numerator is the number of female Members receiving contraception and the denominator is the number of female Members who

received a treatment or face-to-face care management service during the reporting period. 17. Percentage of female Members who received long-acting reversible contraception. The numerator is the number of female Members who received long-acting reversible contraception and the denominator is the number of female Members who received a treatment or face-to-face care management service during the reporting period. (pp. G-6-G-8, January 2020, Pennsylvania Medicaid Managed Care Contract)

[32] D. The PH-MCO will perform a claims analysis on an annual basis. The PH-MCO will identify OUD-COE clients as those members for whom a G9012 procedure code claim was submitted during the previous year and will analyze the additional claims submitted for those members, focusing on the metrics defined below. The purpose of this analysis will be to monitor COEs for adherence with the terms of their provider contracts and to ensure quality services are being provided to the PHMCO's members. The PH-MCO will analyze the following metrics through claims analysis: […] 9. Percentage of pregnant Members receiving post-partum contraception. The number is the number of pregnant Members receiving post-partum contraception and the denominator is the number of pregnant Members who received a treatment or face-to-face care management service during the reporting period. (pp. G-6-G-7, January 2020, Pennsylvania Medicaid Managed Care Contract)

[33] PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS C.3.10.1 General 3.10.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section C.3.10. […] Wave 1 measures will begin with measurement year 2019 and will remain in the program through measurement year 2020. At that time, TENNCARE will review for replacement and/or continuation. Wave 1 measures are the following HEDIS measures: […] Breast Cancer Screening. (Amendment #12, pp. 509-510, July 2020, Tennessee Medicaid Managed Care Contract)

[34] 12.2.4 Reporting of Abortions, Sterilizations, and Hysterectomies (A) On November 1 of each year, the Contractor shall submit to the Department the following information: (1) An excel spreadsheet containing the following information for all abortions, hysterectomies, and sterilizations performed during the prior fiscal year: (i) client name (ii) Medicaid ID number (iii) procedure code (iv) date of service (2) Consent forms for all abortions performed during the prior fiscal year; (3) Consent forms for a sample of 10% of hysterectomies and sterilizations during the prior fiscal year; (4) The medical records for all abortions performed during the prior fiscal year. (B) The Department shall evaluate the documentation requested under Article 12.2.4 and may require medical record submission. The Contractor agrees to provide the additional documentation to the Department in the timeframes required by the Department (p. 126, January 2020, Utah Medicaid Managed Care Model Contract).

[35] 9.9 HEDIS MEASURES The Contractor is required to consent to publication via NCQA's Quality Compass of all Medicaid HEDIS measures for the Virginia Medicaid product. The Department will require all measures to be reported based on populations in accordance to the Virginia Medallion 4.0 Managed Care Organization Data Request document provided by the EQRO. In addition, the Contractor shall, at a minimum, consider the following Medicaid HEDIS performance measures as a priority. The Contractor will assure annual improvement in these Medicaid HEDIS measures until such time that the Contractor is performing at least at the 50th percentile for "HMOs" as reported by Quality Compass. Thereafter, the Contractor is to at least sustain performance at the Medicaid 50th percentile. The Contractor is encouraged to set goals to support the Department's goal of attaining the seventy-fifth (75th) percentile for each of these measures. All measures must be calculated without rotation per NCQA technical specifications: […] Timeliness of Prenatal Care; Breast Cancer Screening […] Cervical Cancer Screening […] (pp. 237-238, July 2020, Virginia Medicaid Managed Care Contract)

[36] 8.2 Maternity Care The Contractor shall develop a comprehensive Maternity Care program for the provision of services to pregnant women in the Medallion 4.0 program. The Contractor must ensure that in the provision of services the Maternity Care program aligns with and advances the following goals: […] Increase family planning access (p. 184, July 2020, Virginia Medicaid Managed Care Contract).

[37] HEDIS® Performance Measures […] Measure: Breast Cancer Screening Measure: Cervical Cancer Screening Measure: Chlamydia Screening in Women […] Measure: Adults' Access to Preventive/Ambulatory Health Services (pp. 1-2, July 2020, Washington Medicaid Managed Care Contract).