

Appendix 1

Detailed Tables of Maternity Provisions Within Medicaid Managed Care Contracts

The following four tables summarize the maternity provisions found in states' Medicaid managed care contracts, current as of 2022. To produce these tables, the George Washington University research team conducted an extensive review of the standard state managed care contracts in use in 2022. This review examined if states address 35 key *maternity topics* drawn from an extensive review of the literature. If a state contract addresses a topic, the detailed contractual language is provided.

[Table 1: Contractor coverage and performance obligations across the continuum of maternal health](#)

[Table 2: Coverage and performance obligations related to augmentations of medical care for perinatal persons](#)

[Table 3: Coverage and performance obligations for services related to social drivers for perinatal persons](#)

[Table 4: Obligations related to access, networks, performance, payment and member rights](#)

Table 1. Contractor coverage and performance obligations across the continuum of maternal health

This table allows readers to view the extent to which any single state addresses any one of the major domains of managed care and maternity care services within its state purchasing agreements, as well as the actual language used by the state in addressing any maternity care domain.*

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description†	Incl. in contract	Contract provides detailed description‡	Incl. in contract	Contract provides detailed description§	Incl. in contract	Contract provides detailed description**	Incl. in contract	Contract provides detailed description††	Incl. in contract	Contract provides detailed description‡‡
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
AZ	Y	Y ¹	Y	Y ²	Y	Y ³	Y	Y ⁴	Y	Y ⁵	Y	Y ⁶
CA	Y	Y ⁷	N	N	N	N	Y	Y ⁸	Y	N	Y	Y ⁹
CO	Y	Y ¹⁰	N	N	N	N	Y	Y ¹¹	Y	N	Y	N
DC	Y	Y ¹²	N	N	N	N	Y ¹³	N	Y ¹⁴	N	Y ¹⁵	N
DE	Y	Y ¹⁶	N	N	N	N	Y	Y ¹⁷	Y	N	Y	N
FL	Y	Y ¹⁸	N	N	Y	Y ¹⁹	Y	Y ²⁰	Y	N	Y	Y ²¹
GA	Y	Y ²²	Y	Y ²³	Y	Y ²⁴	Y	Y ²⁵	Y	Y ²⁶	Y	N
HI	Y	Y ²⁷	N	N	N	N	Y	Y ²⁸	Y	Y ²⁹	Y	Y ³⁰
IA	Y	Y ³¹	N	N	N	N	Y	N	Y	N	Y	N

* Note: All language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of July 2022, unless otherwise noted.

† This includes, but is not limited to, all FDA approved birth control methods, freedom of choice provider, family planning only coverage for select individuals (SPA or waiver), and related services coverage (e.g., STI or HIV counseling, screening, and treatment, preventive services such as mammograms).

‡ This includes, but is not limited to, preconception care coverage/initiatives (e.g., use of preconception risk screening), pre-pregnancy visits, counseling, support services for planning pregnancy, or fertility assistance.

§ This includes, but is not limited to, rapid pregnancy testing and notification, obligation to rapidly schedule an appointment to begin prenatal care, or nondirective pregnancy option counseling for confirmed pregnancy.

** This includes, but is not limited to, coverage/initiatives related to pregnancy such as group prenatal care, childbirth, and infant care classes, ultrasounds, prenatal vitamins, equipment to monitor gestation diabetes mellitus (GDM), equipment to monitor preeclampsia, pregnancy loss counseling and support, or others.

†† This includes, but is not limited to, hospital births, home births, birth centers, cesarean births, early elective deliveries, or LARC coverage immediately postpartum.

‡‡ This includes, but is not limited to, postpartum visits, enhanced postpartum or interconception care initiatives (e.g., care coordination, chronic care management model), or parent and child “dyadic” interventions covered under child’s Medicaid number (e.g., maternal depression screening in well-child visits and developmental services provided jointly to parent and child).

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description [†]	Incl. in contract	Contract provides detailed description [‡]	Incl. in contract	Contract provides detailed description [§]	Incl. in contract	Contract provides detailed description ^{**}	Incl. in contract	Contract provides detailed description ^{††}	Incl. in contract	Contract provides detailed description ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
IL	Y	Y ³²	Y	Y ³³	Y ³⁴	N	Y	Y ³⁵	Y	Y ³⁶	Y	Y ³⁷
IN	Y	Y ³⁸	N	N	Y	Y ³⁹	Y	Y ⁴⁰	Y	N	Y	Y ⁴¹
KS	Y	Y ⁴²	N	N	N	N	Y	Y ⁴³	Y ⁴⁴	N	Y ⁴⁵	N
KY	Y	Y ⁴⁶	N	N	N	N	Y	Y ⁴⁷	Y	N	Y	N
LA	Y	Y ⁴⁸	Y	Y ⁴⁹	N	N	Y	Y ⁵⁰	Y	Y ⁵¹	Y	Y ⁵²
MA	Y	Y ⁵³	Y	Y ⁵⁴	N	N	Y	Y ⁵⁵	Y	N	Y ⁵⁶	N
MD	Y	Y ⁵⁷	N	N	N	N	Y	Y ⁵⁸	Y	Y ⁵⁹	Y	Y ⁶⁰
MI	Y	Y ⁶¹	Y ⁶²	N	N	N	Y	Y ⁶³	Y	N	Y ⁶⁴	N
MN	Y	Y ⁶⁵	N	N	N	N	Y	Y ⁶⁶	Y ⁶⁷	N	Y ⁶⁸	N
MO	Y	Y ⁶⁹	N	N	N	N	Y	Y ⁷⁰	Y	Y ⁷¹	Y ⁷²	N
MS	Y	Y ⁷³	N	N	N	N	Y	Y ⁷⁴	Y ⁷⁵	N	Y ⁷⁶	N
ND	Y	Y ⁷⁷	N	N	N	N	Y ⁷⁸	N	Y	N	Y	N
NE	Y	Y ⁷⁹	N	N	N	N	Y	Y ⁸⁰	Y	Y ⁸¹	Y	Y ⁸²
NH	Y	Y ⁸³	N	N	N	N	Y	Y ⁸⁴	Y	N	Y	N
NJ	Y	Y ⁸⁵	N	N	N	N	Y	Y ⁸⁶	Y	Y ⁸⁷	Y	N
NM	Y	Y ⁸⁸	N	N	N	N	Y	Y ⁸⁹	Y ⁹⁰	N	Y ⁹¹	N
NV	Y	Y ⁹²	N	N	N	N	Y	Y ⁹³	Y	N	Y	N
NY	Y	Y ⁹⁴	N	N	Y ⁹⁵	N	Y	Y ⁹⁶	Y ⁹⁷	N	Y ⁹⁸	N
OH	Y ⁹⁹	N	N	N	N	N	Y	Y ¹⁰⁰	Y	Y	Y	N
OR	Y	Y ¹⁰¹	N	N	N	N	Y	N	Y	N	Y	N
PA	Y	Y ¹⁰²	N	N	N	N	Y	Y ¹⁰³	Y	Y	Y	Y ¹⁰⁴
RI	Y	Y ¹⁰⁵	N	N	N	N	Y	Y ¹⁰⁶	N	N	Y	Y ¹⁰⁷
SC	Y	Y ¹⁰⁸	N	N	N	N	Y	Y ¹⁰⁹	Y ¹¹⁰	N	Y ¹¹¹	N
TN	Y	Y ¹¹²	N	N	N	N	Y	Y ¹¹³	N	N	Y	Y ¹¹⁴
TX	Y	Y ¹¹⁵	Y	Y ¹¹⁶	N	N	Y	Y ¹¹⁷	Y	Y ¹¹⁸	Y	Y ¹¹⁹
UT	Y	Y ¹²⁰	Y	Y ¹²¹	N	N	Y	Y ¹²²	Y	Y ¹²³	Y	N

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description [†]	Incl. in contract	Contract provides detailed description [‡]	Incl. in contract	Contract provides detailed description [§]	Incl. in contract	Contract provides detailed description ^{**}	Incl. in contract	Contract provides detailed description ^{††}	Incl. in contract	Contract provides detailed description ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
VA	Y	Y ¹²⁴	N	N	N	N	Y	Y ¹²⁵	Y	Y ¹²⁶	Y	Y ¹²⁷
WA	Y	Y ¹²⁸	N	N	N	N	Y	Y ¹²⁹	Y	Y ¹³⁰	Y	N
WI	Y	Y ¹³¹	Y ¹³²	N	N	N	Y	Y ¹³³	Y	Y ¹³⁴	Y	Y ¹³⁵
WV	Y	Y ¹³⁶ⁱ	N	N	N	N	Y	Y ¹³⁷	Y	Y ¹³⁸	Y	Y ¹³⁹
Total	Y = 39 N = 0	Y = 38 N = 1	Y = 9 N = 30	Y = 7 N = 32	Y = 6 N = 33	Y = 4 N = 35	Y = 39 N = 0	Y = 35 N = 4	Y = 37 N = 2	Y = 17 N = 22	Y = 39 N = 0	Y = 16 N = 23

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 Demonstration Waiver, 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. [42 CFR 457.1230(d), 42 CFR 438.210(a)(4)(ii)(C)]. 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, or AHCCCS will disenroll members who are seeking these services from the Contractor and assign them to another Contractor. The Contractor shall submit a Sterilization Report as specified in AMPM Policy 420 and Section F, Attachment F3, Contractor Chart of Deliverables (p.78, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates... utilization of Long Acting Reversible Contraceptives (LARC)... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

III. POLICY Family planning services and supplies, when provided by the appropriate family planning providers, are covered for members, regardless of gender, who voluntarily choose to delay or prevent pregnancy. Maternity care providers also provide family planning services and supplies. Services provided should be within each provider's training and scope of practice. Family planning services and supplies include covered medical, surgical, pharmacological, and laboratory benefits specified in this Policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available, as specified in this Policy. Members may choose to obtain family planning services and supplies from any appropriate provider regardless of whether or not the family planning service providers are network providers. The Contractor shall not require prior authorization in order to allow members to obtain family planning services and supplies from an out-of-network provider. A. AMOUNT, DURATION, AND SCOPE Members whose eligibility continues may remain with their assigned maternity provider or exercise their option to select another provider for family planning services and supplies. 1. Covered family planning services and supplies for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives): a.

Contraceptive counseling, medication, and/or supplies, including, but not limited to oral and injectable contraceptives, LARC (Long-Acting Reversible Contraceptive)(including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), diaphragms, condoms, foams, and suppositories, b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning, c. Treatment of complications resulting from contraceptive use, including emergency treatment, d. Natural family planning education or referral to qualified health professionals, e. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception),and f. Sterilization: i. Clarification related to hysteroscopic tubal sterilization: 1) Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy, and 2) At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test, the member is considered sterile. 2. Coverage for the following family planning services are as follows: a. Pregnancy screening is a covered service, b. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions, c. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for members, regardless of gender, d. Sterilization services are covered regardless of member's gender when the requirements specified in this Policy for sterilization services are met (including hysteroscopic tubal sterilizations, if available), and e. Pregnancy termination is covered only as specified in AMPM Policy 410. 3. Limitations The following are not covered for the purpose of family planning services and supplies: a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility, b. Pregnancy termination counseling, c. Pregnancy terminations except as specified in AMPM Policy 410, and d. Hysterectomies for the purpose of sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements. Refer to AMPM Policy 820 for prior authorization requirements for FFS providers. B. CONTRACTOR REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICESAND SUPPLIES The Contractor shall ensure that service delivery, monitoring, and reporting requirements are met. The Contractor shall: 1. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification shall be as specified in A.R.S. § 36.2904(L). The information provided to members shall include, but is not limited to: a. A complete description of covered family planning services and supplies available, including counseling regarding availability and benefits/risks of LARC and IPLARC, b. Information advising how to request/obtain these services, c. Information that assistance with scheduling is available, d. A statement that there is no copayment or other charge for family planning services and supplies as specified in ACOM Policy 431, and e. A statement that medically necessary transportation services as specified in AMPM Policy 310-BB is available. 2. Have policies and procedures in place to ensure that family planning providers, including maternity care providers, are educated regarding covered and non-covered services, family planning services and supplies, including LARC and IPLARC options. 3. Have family planning services and supplies that are: a. Provided in a manner free from coercion or behavioral/mental pressure, b. Available and easily accessible to members, c. Provided in a manner which assures continuity and confidentiality, d. Provided by, or under the direction of, a qualified physician or practitioner, and e. Documented in the medical record. In addition, documentation shall be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning services and supplies. 4. Incorporate medical audits for family planning services within quality management activities to determine conformity with acceptable medical standards. 5. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services. 6. Have written practice guidelines that detail specific procedures for the provision of LARC/IPLARC. (For more information on LARC, see "Arizona DRG Payment Policies" on the AHCCCS website at www.azahcccs.gov). These guidelines shall be written in accordance with acceptable medical standards. 7. Implement a process to ensure that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to the eligible member to increase the member's success with the device according to the member's reproductive goals. C. PROTOCOL FOR MEMBER NOTIFICATION OF PROVIDING FAMILY PLANNING SERVICES AND CONTRACTOR REPORTING REQUIREMENTS The Contractor is responsible for providing family planning services and supplies and notifying members regarding the availability of covered services. The Contractor shall establish processes to ensure the sterilization reports specified in this Policy comply with the procedural guidelines for encounter submissions. AHCCCS will notify all members eligible under the pregnancy category who become ineligible for full health care coverage. In addition, AHCCCS will provide information about AHCCCS covered family planning services and supplies to include: 1. Member notification of these covered services shall meet the requirements in AMPM Exhibit 400-3 and the following minimum requirements: a. As specified in A.R.S. § 36-2904(L), the Contractor shall notify members of reproductive age either directly or through the appropriate Health Care Decision Maker (HCDM), whichever is most appropriate, of the specific covered family planning services and supplies available to them, and a plan to deliver those services to members who request them. Notification shall include provisions for written notification, other than the member handbook, and verbal

notification during a member's visit with the member's primary care physician or primary care practitioner, b. For pregnant members, family planning notification shall be sent by the end of the second trimester and include information on LARC/IPLARC, c. Notification of family planning services and supplies shall include provision for written notification in addition to the member handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. Refer to AMPM Exhibit 400-3 and ACOM Policy 404 and 406 for further details, d. The Contractor shall conform to confidentiality requirements as specified in 45 C.F.R. 164.522(b) (i and ii), e. Notification is to be given at least once a year and shall be completed by November 1st. For members who enroll with a Contractor after November 1st, notification shall be sent at the time of enrollment, f. Notification shall include all of the family planning services and supplies covered through AHCCCS as well as instructions to members regarding how to access these services and supplies, g. As with other member notifications, notification shall be written at an easily understood reading level, h. The communications and correspondence shall be approved by AHCCCS, i. Notification shall be presented in accordance with cultural competency requirements as specified in ACOM Policy 405, j. The Contractor shall monitor compliance to ensure that maternity care providers verbally notify members of the availability of family planning services during office visits, and k. The Contractor shall report all members less than 21 years of age, undergoing a procedure that renders the member sterilized, using Attachment B, as specified in Contract. Documentation supporting the medical necessity for the procedure shall be submitted with the reporting form. D. FEE FOR SERVICE FAMILY PLANNING PROVIDER REQUIREMENTS FFS providers of family planning services and supplies shall make referrals to appropriate medical professionals for services that are beyond the scope of family planning services. Such referrals are to be made at the family planning provider's discretion. If the member is eligible for full health care coverage, the referral must be made to an AHCCCS registered provider. E. STERILIZATION The following AHCCCS requirements regarding member consent for covered sterilization services apply to Contractors and FFS providers as specified in 42 CFR 441.250 et seq. 1. The following criteria shall be met for the sterilization of a member to occur: a. The member is at least 21 years of age at the time the consent is signed (Attachment A), b. Member has not been declared mentally incompetent, c. Voluntary consent was obtained without coercion, and d. 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent shall have been given at least 30 days before the expected date of delivery. 2. Any member requesting sterilization shall sign an appropriate consent form (Attachment A) with a witness present when the consent is obtained. Consent for sterilization is not required for the placement of LARC or IPLARC. Suitable arrangements shall be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member shall first have been given a copy of the consent form and offered factual information that includes all of the following: a. Consent form requirements as specified in 42 CFR 441.250 et seq., b. Answers to questions asked regarding the specific procedure to be performed, c. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits, d. Advice that the sterilization procedure is considered to be irreversible, e. A thorough explanation of the specific sterilization procedure to be performed, f. A description of available alternative methods, g. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used, h. A full description of the advantages or disadvantages that may be expected as a result of the sterilization, and i. Notification that sterilization cannot be performed for at least 30 days post consent. 3. Sterilization consents may NOT be obtained when a member: a. Is in labor or childbirth, b. Is seeking to obtain, or is obtaining, a pregnancy termination, or c. Is under the influence of alcohol or other substances that affect that member's state of awareness. (pp. 1-6, Effective October 1, 2022, AMPM Policy 420, AHCCCS Medical Policy Manual, Chapter 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

² Well Preventative Care: Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older; refer to AMPM Policy 411. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program; Refer to AMPM Policy 430. (p. 91, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

B. WELL-WOMAN PREVENTIVE CARE SERVICES PROVIDER REQUIREMENTS Provider requirements for well-woman preventive care services include the following: 1. Covered services included as part of a well-woman preventive care visit: An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventive

care visit is inclusive of a minimum of the following:... x. Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes: (a) Reproductive history and sexual practices, (b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake, (c) Physical activity or exercise, (d) Oral health care, (e) Chronic disease management, (f) Emotional wellness, (g) Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and (h) Recommended intervals between pregnancies... (p. 3, Effective February 2021, AMPM Policy 411, AHCCS Medical Policy Manual, Chapter 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 1. Medically necessary preconception counseling. (p. 2, Effective September 2021, AMPM Policy 410, AHCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

³ Maternity Services: The Contractor shall provide pregnancy identification,... for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives... (p. 81, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 2. Identification of pregnancy. (p. 2, Effective September 2021, AMPM Policy 410, AHCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁴ Maternity Services: The Contractor shall provide... prenatal care, treatment of pregnancy related conditions... for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant... Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. Refer to AMPM Policy 410... The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal HIV/AIDS testing and the availability of medical counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter, to encourage pregnant women to be tested and instructions about where to be tested. The Contractor shall report to AHCCCS the number of pregnant women who have been newly diagnosed as HIV/AIDS-positive for each quarter during the Contract Year as specified in Section F, Attachment F3, Contractor Chart of Deliverables and AMPM Policy 410. (pp. 81-82, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for... prenatal... visits... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services, 2. Physician Assistants, 3. Nurse Practitioners, 4. Certified Nurse Midwives, and 5. Licensed Midwives. Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a

certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (p. 172, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 3. Medically necessary education and prenatal services for the care of pregnancy. 4. The treatment of pregnancy-related conditions. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁵ Maternity Services: The Contractor shall provide... labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives.... Members anticipated to have a low-risk delivery, may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice..... The Contractor shall allow women and their newborns to receive no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with an agreement by the mother, may discharge the mother or newborn prior to the minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the minimum 48 or 96 hour stay, whichever is applicable. (p. 81, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries... The Contractor shall implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence. The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 5. Labor and delivery services. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁶ Maternity Services: The Contractor shall... postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant... Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice... Refer to AMPM Policy 410. p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for... postpartum visits... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services, 2. Physician Assistants, 3. Nurse Practitioners, 4. Certified Nurse Midwives, and 5. Licensed Midwives. Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (p. 172, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 6. Postpartum Care. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁷ 2. Prior Authorizations and Review Procedures Contractor shall ensure that its Prior Authorization, concurrent review and retrospective review procedures meet the following minimum requirements:... Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. (no pg #, Effective FY 17-18, Utilization Management, Exhibit A, Attachment 5, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

9. Non-Contracting Family Planning Providers' Reimbursement Contractor shall reimburse non-contracting family planning Provider at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse noncontracting family planning Provider for services listed in Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy. 10. Sexually Transmitted Disease (STD) Contractor shall reimburse local health departments and non-contracting family planning Provider at no less than the appropriate Medi-Cal FFS rate, for the diagnosis and treatment of a STD episode, as defined in PL 96-09. Contractor shall provide reimbursement only if STD treatment Provider provide treatment records or documentation of the Member's refusal to release medical records to Contractor along with billing information. 11. HIV Testing and Counseling Contractor shall reimburse local health departments and non-contracting family planning Provider at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if local health departments and non-contracting family planning Provider make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to the Contractor. (no page #, Effective FY 17-18, Provider Compensation Arrangements, Exhibit A, Attachment 8, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

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 per Exhibit A, Attachment 13, Member Services. 1) Informed Consent Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with

requirements of Title 22 CCR Sections 51305.1 and 51305.3. 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) work 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 disease 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 and (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 Contractor's Provider Network and through the out-of-Network local health department and family planning Providers. D. Minor Consent Services Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the Provider Network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to: 4) Family planning. (no page #, Effective FY 17-18, Access and Availability, Exhibit A, Attachment 9, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

A. Member Rights and Responsibilities Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, and, upon request, Potential Enrollees. 1) Contractor's written policies regarding Member rights shall include the following: h) To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services and emergency services outside the Contractor's Network pursuant to the federal law.

F. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall complete Member Services Guide to DHCS for review and approval prior to implementing. Contract shall ensure that the Member Services Guide includes the following: 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 which 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. (no page #, Effective FY 17-18, Member Services, Exhibit A, Attachment 13, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

⁸ 7. Perinatal Services A. Prenatal Care Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services. B. Risk Assessment Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health

education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risk identified shall be followed up on by appropriate interventions, which must be documented in the medical record. C. Referral to Specialists Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

See Cal. Code Regs. Tit. 22, § 51348 - Comprehensive Perinatal Services for additional information on perinatal services.

⁹ 7. Pregnant Woman A. Prenatal Care Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services. B. Risk Assessment Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risk identified shall be followed up on by appropriate interventions, which must be documented in the medical record. C. Referral to Specialists Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services.

(d) Except where a capitated health system contract entered into by the Department provides otherwise, health education services shall include, but are not limited to:... (2) Written assessments of each patient's health education status. (A) A complete initial education assessment shall be performed at the initial visit or within four weeks thereafter and shall include an evaluation of:... postpartum self-care,... (4) Postpartum assessment, development of care plan, and interventions. (e) Except where a capitated health system contract entered into by the Department provides otherwise, psychosocial services shall include, but are not limited to:... (4) Postpartum reassessment, development of a care plan, and interventions. (f) Review and revisions of the care plan shall occur during... postpartum periods on a regular basis and will be based on repeated and ongoing assessments and evaluation of the client's status. Cal. Code Regs. Tit. 22, § 51348 - Comprehensive Perinatal Services (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate, California)

¹⁰ 1.1.16. Family Planning Services... 1.1.16.1. Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. The Contractor shall reimburse out-of-network family planning services at a rate equal to Medicaid fee-for-service reimbursement rates, or the Contractor's contractual reimbursement rates, whichever is higher. No referral is required. (p. 5, Effective January 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

1.1.32. Physician Services... 1.1.32.2.7. Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/member. See Family Planning under Covered Services. (p. 10, Effective January 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹¹ 14.2. Coverage of Specific Services and Responsibilities... 14.2.2.4. Wrap Around (Fee For Service) Benefits... 14.2.2.4.2... The Contractor shall also advise post-partum or breastfeeding or pregnant women of... enhanced prenatal care services... 14.3.41. Prenatal Plus - Enhanced program for high risk pregnant women that provides a care coordinator, dietitian and mental health professional. The program is offered through four packages with approved services as listed in 10 C.C.R. 2505 – 10 §8.748. (p. 91, 95, Effective January 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹² C.5.28.4.5 The Contractor shall place appropriate limits on services for the purpose of utilization control, provided that the furnished services can reasonably achieve their purpose as required in 42 C.F.R. § 438.210 (a)(3)(i)... Family planning services shall be provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning without coercion or mental pressure to be used consistent with 42 C.F.R. § 441.20. (p. 83, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

Table A: Medicaid Covered Services... Family planning services and supplies. Benefit Limit: Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

Table D: Alliance Covered Services... Adult Wellness Services. Furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force (USPSTF): Family planning services and supplies (p. 102, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.29.2.2 Primary Care... C.5.29.2.3 Obstretic-Gynecological Care... C.5.29.2.3.2 The Contractor shall demonstrate that its Provider Network includes family planning providers to deliver timely access to Covered Services by enrollees seeking the respective services. (p. 112, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.29.10 Women's Health... C.5.29.10.2 In accordance with 42 C.F.R. § 431.51, all Enrollees have the right to receive family planning services from a provider of their choice, whether the provider is in or out of the Contractor's network. In addition, Enrollees do not need a referral to access family planning services. 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. 120, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹³ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁴ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁵ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁶ 3.4.1.4 Per 42 CFR 438.210, the Contractor may place appropriate limits on a service:... 3.4.1.4.2.3. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. (p. 53, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.4.6.5 Family Planning 3.4.6.5.1 All members, except DHCP members (see Section 3.4.4 of this Contract, above), shall be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including non-participating providers who are DMAP-enrolled providers. (p. 73, Effective 2020, Addendum 1, MCO MSA, Delaware)

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. While family planning is a benefit for DHCP members, this "freedom of choice" option does not apply to DHCP members. (p. 198, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.14.2.8 Family Planning Education 3.14.2.8.1 The Contractor must provide its members with sufficient information to allow them to make an informed choice regarding the types of family planning services available, their right to access these services in a timely and confidential manner, and the freedom of members (other than DHCP members) to choose a qualified family planning provider both within and outside the Contractor's provider network. (p. 270, Effective 2020, Addendum 1, MCO MSA, Delaware)

¹⁷ 3.4.6.6 Prenatal Care 3.4.6.6.1 The Contractor shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The Contractor's program shall include participation and coordination with Smart Start. (p. 73, Effective 2020, Addendum 1, MCO MSA, Delaware)

¹⁸ I. Services to be Provided... C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 2A: Required MMA Services... (13) Family Planning Services and Supplies (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies (a) The Managed Care Plan shall furnish family planning services on a voluntary and confidential basis. (b) The Managed Care Plan shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications. (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. (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.) (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

F. Quality Enhancements The Managed Care Plan shall offer QEs to enrollees as specified below:... 4. Pregnancy-Related Programs... b. The Managed Care Plan shall ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

¹⁹ Section VI. Coverage and Authorization of Services... 3. Enrollee Screening and Education a. Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care. (p. 29, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies... (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²⁰ D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by "X" in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 3: Approved Expanded Benefits... Prenatal/Perinatal Visits (p. 5, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... 9. Additional Care Coordination/Case Management Requirements... e. Prenatal Care The Managed Care Plan shall: (1) Require care coordination through the gestational period according to the needs of the enrollee. (2) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care. (3) Assist enrollees in making delivery arrangements, if necessary. (p. 35, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

4. Pregnancy-Related Programs a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

5. Healthy Start Services a. The Managed Care Plan shall develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants. b. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes. (p. 40, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²¹ Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies... (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.) (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

4. Pregnancy-Related Programs a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²² xxvi Family Planning Services: Family planning services and supplies include at a minimum: i. Education and counseling necessary to make informed choices and understand contraceptive methods; ii. Initial and annual complete physical examinations; iii. Follow-up, brief and comprehensive visits; iv. Pregnancy testing; v. Contraceptive supplies and follow-up care; vi. Diagnosis and treatment of sexually transmitted diseases; vii. and Infertility assessment. (p. 21, no date, RFP #DCH0000100, Georgia Families Contract)

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. In meeting this obligation, the Contractor 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. The Contractor shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not limit Members' or P4HB Participants' freedom of choice for family planning services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. 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. 4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. 4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum: 4.6.4.3.1 Education and counseling necessary to make informed choices and understand contraceptive methods; 4.6.4.3.2 Initial and annual complete physical examinations including a pelvic examination and Pap test; 4.6.4.3.3 Follow-up, brief and comprehensive visits; 4.6.4.3.3 Pregnancy testing; 4.6.4.3.5 Contraceptive supplies and follow-up care; 4.6.4.3.6 Diagnosis and treatment of sexually transmitted infections with the following exceptions: P4HB participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration; 4.6.4.3.7 For P4HB participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements); and 4.6.4.3.8 Infertility assessments with the following exception – P4HB participants are excluded from receiving this benefit. 4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age. (pp. 86-87, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

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

²⁴ 4.11.10 Case Management... 4.11.10.2 Case Management functions include, but are not limited to: 4.11.10.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO; (p. 155, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁵ 4.6.9 Perinatal Services 4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members... The Contractor shall have in place a system that provides, at a minimum, the following services: 4.6.9.1.1 Pregnancy planning and perinatal health promotion and education for reproductive-age women; 4.6.9.1.2 Perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and newborns and children up to five (5) months of age. The Contractor must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination; 4.6.9.1.3 Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation and translation services if necessary pursuant to Sections 4.3.10 and 4.3.11 of this Contract; 4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care; 4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and 4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems. 4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor

and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery. (p. 93, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁶ 4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery. (p. 93, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁷ 7. Family Planning Services a. 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. The Health Plan may not restrict a Member's free choice of family planning services and supplies providers. Family planning services include family planning drugs, supplies, and devices to include, but not be limited to, any FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity. Same day access to family planning services shall be provided, as needed, with no prior authorization. b. The Health Plan shall furnish all services on a voluntary and confidential basis to all Members. (p. 150, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²⁸ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services: 1) Prenatal care; 2) Radiology, laboratory, and other diagnostic tests; 3) Treatment of missed, threatened, and incomplete abortions; 4) Delivery of the infant and post-partum care; 5) Prenatal vitamins; 6) Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports; 7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on childbirth, breastfeeding, and infant care; 10) Counseling on healthy behaviors; and 11) Inpatient hospital services, physician services, other practitioner services, and any other services that impact pregnancy outcomes. c. The Health Plan is prohibited from limiting benefits for post-partum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. The Health Plan is not permitted to require that a provider obtain authorization from the Health Plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours. d. The Health Plan is prohibited from: 1) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA); 2) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or 3) Providing incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA. e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services: 1) Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care; 2) Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary; 3) Availability and accessibility of: a) Appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating women with complex perinatal diagnoses; and b) Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses. Perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program. (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²⁹ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents...b. The following services are covered under pregnancy-related services:... 4) Delivery of the infant and post-partum care;... c. The Health Plan is prohibited from limiting benefits for post-partum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. The Health Plan is not permitted to require that a provider obtain authorization from the Health Plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours. d. The Health Plan is prohibited from: 1) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA); 2) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or 3) Providing incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁰ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services:... 4)... post-partum care... 6) Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports; 7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on childbirth, breastfeeding, and infant care; 10) Counseling on healthy behaviors;... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services: 1) Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care; 2) Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary;... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³¹ Table D3: Iowa Family Planning Network Covered Services Family Planning Benefits: Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. • Approved methods of contraception; • Sexually transmitted infection (STI) or sexually transmitted disease (STD) testing, Pap smears and pelvic exams; • Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider; and • Contraceptive management, patient education, and counseling. The laboratory tests done during an initial family planning visit for contraception may include a Pap smear, screening tests for STIs or STDs, or pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

Family Planning Related Benefits: "Family planning-related services and supplies" are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular federal medical assistance percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was defined or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include: • Colposcopy and procedures done with or during a colposcopy or repeat Pap smear performed as a follow-up to an abnormal Pap smear that was done as part of a routine periodic family planning visit. • Drugs for the treatment of STIs or STDs, except for HIV/AIDS and hepatitis, when the STI or STD is identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs and subsequent follow-up visits to rescreen for STIs or STDs based on the Centers for Disease Control and Prevention guidelines may be covered. • Drugs or treatment for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections, where these conditions are identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs may also be covered. • Other medical diagnosis, treatment, and preventative services that are routinely provided pursuant to family planning services in a family planning setting. • Treatment of major complications arising from a family planning procedure, such as: • Treatment of a perforated uterus due to an intrauterine device insertion; • Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or • Treatment of surgical or anesthesia-related complications during a sterilization procedure. (pp. 236-237, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

³² 1.1.79 Family Planning means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services appropriately provided within the Provider's scope of practice and competence. 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. (p.19, Effective 2018, State of IL Model Contract)

5.3 Pharmacy Requirements... 5.3.1.4 Contractor may determine its own utilization controls, including, but not limited to, step therapy and prior approval, unless otherwise prohibited under this Contract, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family planning drugs and devices pursuant to Attachment XXI. (pp. 67-68, Effective 2018, State of IL Model Contract)

5.3.2.8 Contractor may determine its own utilization controls, including therapy and prior authorization, unless otherwise prohibited under this Contract, the Department's PDL, or State law, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and Attachment XXI. (p. 71, Effective 2018, State of IL Model Contract)

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, Effective 2018, State of IL Model Contract)

5.21.5.7 At a minimum, the Enrollee handbook must contain: ...how and the extent to which the Enrollee may obtain direct-access services, including Family-Planning services. (Page 110, 2022 State of IL Model Contract) 5.26.3.18 All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable: ...Family Planning and counseling. (p.120, Effective 2018, State of IL Model Contract)

5.29.3 Contractor shall pay for Family-Planning services, subject to sections 5.5 and 5.29.35.6 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, Effective 2018, State of IL Model Contract)

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, Effective 2018, State of IL Model Contract)

1.1.1 These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: 1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care; 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. At a minimum, the following areas shall be monitored for all populations: ...1.1.3.1.10 utilization of Family Planning services... 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC (pp. 227-229, Attachment XI QUALITY ASSURANCE, Effective 2018, State of IL Model Contract)

1.1.9 All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (pp. 227-239, Attachment XI QUALITY ASSURANCE, Effective 2018, State of IL Model Contract)

3.1.3 Family Planning and reproductive healthcare. Contractor shall ensure provision 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. Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. 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. 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: 3.1.3.1 a reproductive

life plan, which may include a preconception care risk assessment (see HFS Form 27, *Preconception Screening Checklist*, which can be found on Illinois.gov/hfs under the *Medical Programs Forums* section) and preconception and interconception care discussions; 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; 3.1.3.2 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; 3.1.3.5 basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, if indicated. (Infertility medications and procedures are not Covered Services.); 3.1.3.6 reproductive health exam if medically necessary to determine safety and provision of contraception; 3.1.3.7 sexually transmitted infection (STI) screenings in accordance with USPSTF A and B recommendations; 3.1.3.9 lab and screening tests that are clinically necessary for safe and prudent delivery of Family Planning and reproductive health services; 3.1.3.10 Cervical, breast and other cancer screening in accordance with USPSTFs A and B recommendations; 3.1.3.11 vaccines for preventable reproductive health in accordance with current CDC recommended immunization schedule, updated annually; 3.1.3.12 genetic counseling and testing, if clinically indicated. (pp. 308-309, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS OF CARE, Effective 2018, State of IL Model Contract)

3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items...3.1.3.13.3.5 visits close to the third (3rd) trimester should include... options for postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated. 3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: ... 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as... effective Family Planning. 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning... 3.1.3.14.1 At a minimum, Contractor shall provide and document an annual exam that includes... guidance related to reproductive health issues, Family Planning and management of identified chronic diseases must be addressed. 3.1.3.14.4 Cervical and breast screening per USPSTF A and B recommendations. (pp. 311-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS OF CARE, Effective 2018, State of IL Model Contract)

³³ 3.1.3. 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: 3.1.3.1 a reproductive life plan, which may include a preconception care risk assessment (see HFS Form 27, *Preconception Screening Checklist*, which can be found on Illinois.gov/hfs under the *Medical Programs Forums* section) and preconception and interconception care discussions. 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. (p. 308 & 313, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

³⁴ 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁵ 5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management. (p. 88, Effective 2018, State of IL Model Contract)

5.20.1.1.5 Unexpected hospitalization due to complications of pregnancy shall be covered. (p. 102, Effective 2018, State of IL Model Contract)

1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.17 describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., ... prenatal care...). (p. 224, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

1.1.2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management, Disease Management). This written description must meet federal and State requirements, as outlined below. (p. 226, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.14 timeliness and frequency of prenatal visits; 1.1.3.1.15 postpartum care rate; 1.1.3.1.16 provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests; 1.1.3.1.17 birth outcomes; 1.1.3.1.18 birth intervals; 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.21 utilization of 17P; 1.1.3.1.22 referral to the Perinatal Centers, as appropriate; 1.1.3.1.23 length of hospitalization for the mother; 1.1.3.1.24 length of hospital stay for the infant; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant. (pp.228-229, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

1.1.9. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (p. 239, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

3.1.1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services to Enrollees under the age of twenty-one (21)... 3.1.1.5 Contractor shall inform pregnant women about the availability of EPSDT services for children under age twenty-one (21), including children eligible as newborns. 3.1.1.6 Contractor shall assist pregnant women and new mothers, or their legal guardians, to enroll their newborns in Medicaid and to identify a PCP for the newborn. It is suggested that plans use HFS Form 4691 as an educational tool, but plans may use other means, including direct assistance, to help in enrollment. (p. 306, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

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: 3.1.3.13.1 a comprehensive prenatal evaluation, examination, testing, and care in accordance with the latest standards recommended by ACOG, USPSTF and other leading academic and national clinical or specialty based organizations, which shall include: ongoing risk assessment and development of an Individualized Plan of Care (IPoC) most likely to result in a successful outcome of pregnancy and a healthy baby, and takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family; 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; 3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items: 3.1.3.13.3.1 risk detection by appropriate inquiry, testing and consultation if necessary, counseling and treatment if indicated for: various chronic medical conditions including hypertension and diabetes mellitus; STI/HIV; intimate partner violence; teratogen exposure; alcohol, tobacco,

and substance use including prescription opioids and marijuana; and, to prevent when possible, potential of preeclampsia and eclampsia, a stillbirth, prematurity, low birth weight, fetal alcohol syndrome, and neonatal abstinence syndrome among other issues. Contractor must put in place and be able to demonstrate that various evidence based strategies and interventions (including 17 P and referral to substance use, alcohol and tobacco abstinence programs, when indicated) to reduce adverse maternal and birth outcomes are operational; 3.1.3.13.3.2 screening for diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools); 3.1.3.13.3.3 health maintenance promotion, with attention to nutrition, exercise, dental care, CDC recommended immunizations, management of current Chronic Health Conditions, over-the-counter and prescription medication, breastfeeding counseling, appropriate weight gain in pregnancy, obesity counseling, signs and symptoms of common pregnancy ailments and management of the same, and provision of appropriate maternal education and support, including training classes to help with childbirth, breastfeeding, and various other helpful maternity education tools, platforms and materials; 3.1.3.13.3.4 routine laboratory screening per ACOG and USPSTF recommendations, physical exam, and dating by ultrasound for accurate gestational age. Every prenatal exam at a minimum should include weight and blood pressure check, fetal growth assessment, and fetal heart rate check. Genetic screening and counseling, if indicated, should be offered depending on risk factors (Enrollee's age, previous birth history, medical/family history, and ethnic background); and 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, circumcision, newborn care, car seat, sudden infant death syndrome (SIDS), the importance of waiting at least thirty-nine (39) weeks to deliver unless medical necessity or safety of mother and fetus dictates otherwise, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy; 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (pp. 309-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. 3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes. (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁶ 5.20.1.1.5 ...Routine delivery at term outside the Contracting Area, however, shall not be covered if the Enrollee is outside the Contracting Area against medical advice, unless the Enrollee is outside of the Contracting Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy. (p. 102, Effective 2018, State of IL Model Contract)

1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care. (p. 225, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.17 birth outcomes... 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery. (p. 229, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

3.1.3.13.5 Contractor shall require that all contracted hospitals and birthing centers have policies in place that safely reduce c-sections and early elective deliveries (EED). (p. 312, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁷ 1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care. (p. 225, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.15 postpartum care rate... 1.1.3.1.17 birth outcomes; 1.1.3.1.18 birth intervals; 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.22 referral to the Perinatal Centers, as appropriate; 1.1.3.1.23 length of hospitalization for the mother; 1.1.3.1.24 length of hospital stay for the infant; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant. (pp. 228-229, Attachment XI: Quality Assurance, Effective 2028, State of IL Model Contract)

1.1.9 All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (Page 227-239, Attachment XI QUALITY ASSURANCE, 2022 State of IL Model Contract)

3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items...3.1.3.13.3.5 visits close to the third (3rd) trimester should include... options for postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated.... transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective Family Planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials and WIC; 3.1.3.13.5.2 postpartum depression screening during the one (1)-year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). After delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)-week postpartum visit; 3.1.3.13.5.3 Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if Medically Necessary, to avoid interruption of care; 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease; and 3.1.3.13.5.5 Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery. (pp. 312-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.14 Well-woman exam: 3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes. (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁸ 6.2 Self-Referral Services. ... With the exception of family planning services and emergency services, when HIP members choose to receive self-referral services from IHCP-enrolled self-referral providers, they shall go to an in-network provider or receive prior authorization to go to an out-of-network provider. The Contractor is responsible for payment for self-referral services up to the applicable benefit limits and at a rate of 100% of the Medicare rate or 130% of Medicaid if there is no Medicare rate for in-network providers. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 9-7 (HIP) provides further detail regarding these benefits. Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services. Under the Contractor's HIP line of business, the Contractor shall provide all covered family planning services and supplies. (pp.64-65, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.1 Member Handbook. The HIP member handbooks shall include the following: ...Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers. (p.100, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

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

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

management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p.144, Amendment #14, Effective, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential... b. Additional Maternity Payments and Incentives. FSSA will reimburse Contractor \$60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire \$60 payment to the physician that completed the NOP form on behalf of the pregnant member. For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit \$40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c. NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA. (p. 193, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁰ 3.4 Pregnancy Coverage under HIP. Effective February 1, 2018, HIP members who become pregnant will receive maternity benefits through the HIP Maternity (MAMA) benefit plan. ... The Contractor will provide pregnancy, post-partum, and HIP benefits aligned with the dates and benefits specified on the 834... . Additional guidelines regarding the Contractor's responsibility to assist pregnant members obtain and maintain coverage are located in the HIP MCE Policies and Procedures Manual. (pp. 35-36, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.1 Covered Benefits and Services. In addition, HIP will cover additional pregnancy-only benefits which will only be available for pregnant HIP members enrolled in either the HIP Plus or HIP Basic plans. The additional pregnancy-only benefits are specified in the applicable ABP and include such services as nonemergency transportation, chiropractic manipulations, vision and dental. (p. 64, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. The Contractor shall educate pregnant women and work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. (p. 66, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.8 Disease Management...6.8.1 Population-Based Interventions. ...All pregnant members shall receive standard pregnancy care educational materials, OMPP-approved tobacco cessation materials and access information for 24-Hour Nurse Call Lines. Materials should be delivered through postal and electronic direct-to-consumer contacts, including Interactive Voice Recordings (IVR), as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest shall receive materials no less than bi-annually. The Contractor shall document the number of persons with conditions of interest, mailings and website hits. (pp. 80-82, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.10 Other Covered Benefits and Services. In addition to the benefits and services listed above, the Contractor shall also cover the following: ...The Contractor shall provide prenatal care programs targeted to avert untoward outcomes in high-risk pregnancies. (p. 83, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.15 Enhanced Services. The State encourages the Contractor to cover programs that enhance the general health and well-being of its HIP members, including programs that address preventive health, risk factors or personal responsibility. Enhanced services may include, but are not limited to, such items as: Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.). (p. 86, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.17 Opioid Treatment Program (OTP). The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups. OTP coverage will include those members as defined by OMPP and approved by CMS. The MCE will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix. Eligible members include... pregnant members. (p. 89, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.1 Member Handbook. The HIP member handbooks shall include the following: ... HIP pregnancy policies, including, a description of the HIP Maternity program (MAMA). (p. 100, Amendment #14, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

8.7.3 Education for HIP Providers. The Contractor shall also educate its HIP providers about its pregnancy-related services and policies. Such education shall emphasize that members will transition to the HIP Maternity (MAMA) benefit plan. (p. 132, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.1 Quality Management and Improvement Program. The Contractor's Quality Management and Improvement Program shall: ... *Participate in any state-sponsored prenatal care coordination programs. *Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. OMPP reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include: ... prenatal care. *Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes, as described in Section 9.2.2. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments and scheduling appointments for routine and preventive services such as prenatal care, disease screenings, compliance with behavioral health drug therapy, compliance with diabetes treatment and well-child visits. (pp.139-140, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.2 Member Incentive Programs. Contractors shall establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The Contractor will determine its own methodology for providing incentives to members, subject to OMPP review and approval. For example, the Contractor may offer member incentives for: *Attending all prenatal visits. (p. 143, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

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

management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p.144, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential. ... b. Additional Maternity Payments and Incentives. FSSA will reimburse Contractor \$60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire \$60 payment to the physician that completed the NOP form on behalf of the pregnant member. For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit \$40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c. NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA. (p. 193, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴¹ 3.4 Pregnancy Coverage under HIP... As of April 1, 2022, HIP Maternity benefits will continue for a twelve (12) month temporary postpartum period which begins on the last day of pregnancy. The Contractor will provide pregnancy, postpartum, and HIP benefits aligned with the dates and benefits specified on the 834. The Contractor shall communicate regularly with the member during the postpartum period... (pp. 35-36, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.10 Other Covered Benefits and Services. In addition to the benefits and services listed above, the Contractor shall also cover the following: * The Contractor shall provide newborn health, postpartum care and parenting education. (p. 84, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.1 Quality Management and Improvement Program. The Contractor's Quality Management and Improvement Program shall: ... *Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. OMPP reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include: ... postpartum care. (pp. 139-140, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴² 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. 2.32.1 All medically approved services prescribed by physician/ARNP/nurse midwife and physician's assistant including diagnosis, treatment, counseling, drug, supply, or device to individuals of childbearing age shall be covered. 2.32.2 For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR § 441.250-§ 441.259. 2.32.3 Sterilizations shall be provided in accordance with the Federally mandated guidelines and consent form. 2.32.3.1 The approved Sterilization consent form can be found on the KMAP website. 2.32.3.2 The form shall be available in English and Spanish, and the CONTRACTOR(S) shall provide assistance in completing the form when an alternative form of communication is necessary. 2.32.3.3 The CONTRACTOR(S) must assure that the Federal Sterilization Consent form required by CMS in 42.CFR § 441.250 - 441.259 is properly completed as described in the instructions and a copy of the Sterilization Consent form is obtained from the performing Provider before paying the service claim. The CONTRACTOR(S) must maintain a copy of the form in the event of audit. In the event of an audit the CONTRACTOR(S) will provide additional supporting documentation to ascertain compliance with Federal and State regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders. 2.32.3.4 Hysterectomies are covered when the requirements, stated in the State Provider Manuals, State Policy and 42 CFR § 441.250-§ 441.259, are met. (p. 10, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.5.9. NON-PARTICIPATING PROVIDERS... J. Ensure that the CONTRACTOR(S)' Provider network adheres to the following: ... 3. Demonstrates that its network includes sufficient family planning Providers to ensure timely access to Covered Services. (p. 83, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

10.7. MEMBER HANDBOOK REQUIREMENTS ... E. The content of the Member Handbook must include the following: ...19. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from Non-Participating Providers. This includes an explanation that the CONTRACTOR(S) cannot require a Member to obtain a referral before choosing a family planning Provider. (p. 141, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁴³ 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: ...2.1.2 Maternity services. ...2.24 Prenatal Health Promotion/Risk Reduction Enhanced Social Work Services. (p. 2 & 9, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

2.7 Prescription Drugs....2.7.2.1 The drugs that may be excluded from coverage or otherwise restricted include: ...2.7.2.1.6 Non-prescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A) of the SSA, agents approved by the Food and Drug Administration under the over-the-counter (OTC) monograph process for purposes of promoting, and when used to promote, tobacco cessation. 2.7.2.1.5 Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations (Vitamins and minerals should be provided where medically necessary for children). (p. 3, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

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

Reports and Data Elements. For each data type and report, the CONTRACTOR(S) must provide details as to how the data is captured and submitted (file formats, etc.), as well as which system(s) house the data and the existence of any data dictionaries associated with the data elements. The CONTRACTOR(S) shall provide an example of each report type. ...Health Risk Assessments Report. Number of completed health risk assessments, as well as a summary and analysis of the information collected as it pertains to chronic conditions, preventive care, prenatal care referrals including the month a pregnant Member was identified and screened, and relevant demographic and regional information. Report to include: • Number of Members screened • Number of Members refusing screen • Number of Members unable to contact for screen • Number of Members referred for an HRA • Number of Members with an HRA completed • Number of Members refusing an HRA • Number of Members with an HRA completed telephonically or in-person. (p. 1 & 9, no date, Attachment H: Reports and Data Elements)

5.5.7. BEHAVIORAL HEALTH PROVIDER NETWORK STANDARDS. ...D. For Members presenting for SUD services: ... 5. Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within twenty-four (24) hours of assessment. When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care. (p. 79, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁴⁴ 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: ...2.1.2 Maternity services. (p. 2, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

⁴⁵ 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: ...2.25 Postpartum/Newborn Home Visit. (p. 9, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

⁴⁶ 1.1 General Definitions. ... Family Planning Services means counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. (p. 18, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.1 Required Functions. ...Q. Facilitating direct access to ...voluntary family planning; ... and testing for HIV, HIV-related conditions and other communicable diseases. (p. 88, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.2 Enrollee Handbook. The Enrollee Handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information: ... L. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services. (p. 90, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.7 Information Materials Requirements. ...I. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services, from Out-of-Network Providers; (p. 92, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

28.2.5 Family Planning Services. The Contractor shall contract with Network Providers who are qualified by experience and training to provide Family Planning Services. (p. 119, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

28.4 Provider Network Access and Adequacy. ... B. Specific to voluntary family planning, counseling and medical services as soon as possible within a maximum of thirty (30) Days. If not possible to provide complete medical services to Enrollees less than eighteen (18) years of age on short notice, counseling and a medical appointment as immediately as possible and within ten (10) Days. (p. 121, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

29.3 Payment to Out-of-Network Providers. The Contractor shall reimburse Out-of-Network Providers in accordance with Section 29.1 "Claims Payments" for the following Covered Services: ... C. Services provided for family planning; (p. 130, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

32.6 Voluntary Family Planning. The Contractor shall ensure direct access for any Enrollee to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I "Covered Services" to this Contract. The Contractor may not restrict an Enrollee's choice of his or her provider for Family Planning Services. The Contractor must ensure access to any qualified provider of Family Planning Services without requiring a referral from the PCP. See Section 28.4 "Provider Network Access and Adequacy" for allowable wait times for appointments. The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and court orders for Enrollees less than eighteen (18) years of age pursuant to Title X. 42 C.F.R. 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et

seq., KRS 202A et seq., and KRS 214.185. All information shall be provided to the Enrollee in a confidential manner. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will ensure the Enrollee's privacy. (p. 146, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

38.2 Confidentiality of Records The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.15 "Health Insurance Portability and Accountability Act." The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. (p.168, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

⁴⁷ 22.1 Required Functions. ...Q. Facilitating direct access to ...maternity care for Enrollees under age eighteen (18)... (p. 88, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.2 Enrollee Handbook. The Enrollee Handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information: ... L. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services. (p. 90, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

32.5 Maternity Care. When a woman has entered prenatal care before enrolling with the Contractor, the Contractor shall make every effort to allow her to continue with the same prenatal care provider throughout the entire pregnancy. Contractor shall also establish procedures to ensure either prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant when they enroll. The Contractor shall provide maternity care that includes prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. All newborn Enrollees newborn screening shall be covered as specified in the Commonwealth of Kentucky metabolic screen. (p. 146, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

34.3 Population Health Management Program Tools... B. Health Risk Assessments (HRA). The Contractor shall conduct HRAs as follows... 2. Within thirty (30) Days of Enrollment if the Contractor has a reasonable belief an Enrollee is pregnant. If determined pregnant, the Contractor shall refer the Enrollee for appropriate prenatal care. (p. 155, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

38.2 Confidentiality of Records The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.15 "Health Insurance Portability and Accountability Act." The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. (p. 168, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

APPENDIX D. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES ...85. Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions. Describe activities of the EPSDT staff, including outreach, education, and care management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations. (p. 243, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

⁴⁸ 6.0 CORE BENEFITS AND SERVICES. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.10. Sexually Transmitted Infection (STI) Prevention. The MCO shall address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations. (p. 79, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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: 6.14.1.1. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits, this visit includes anticipatory guidance and education related to members' reproductive health/needs; 6.14.1.2. Contraceptive counseling to assist members in reaching an informed decision (including natural family planning, education follow-up visits, and referrals); 6.14.1.3. Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health; 6.14.1.4. Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered; 6.14.1.5. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; 6.14.1.6. Male and female sterilization procedures provided in accordance with 42 CFR Part 441, Subpart F; 6.14.1.7. Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and 6.14.1.8. Transportation services to and from family planning appointments provided all other criteria for NEMT are met. 6.14.2. Services shall include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection or treatment of STIs, and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs. 6.14.3. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). 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. 6.14.5. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network. 6.14.6. The MCO shall encourage family planning providers to communicate with PCP's once any form of medical treatment is undertaken. 6.14.7. The MCO shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one (1) week. 6.14.8. The MCO shall make certain that payments from LDH are not utilized for the services for the treatment of infertility. (pp. 81-82, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.33. Preconception/Inter-conception Care For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient 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 prior authorization shall not be required for approval. (p. 98, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.6. Direct Access to Women's Health Care ... 7.8.6.1. The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services. 7.8.6.2. 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. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this Contract. 7.8.6.3. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network. 7.8.6.4. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services. 7.8.6.5. The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients. (pp. 129-130, Effective 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

12.12. MCO Member Handbook. 12.12.1.1. At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook (see Section 3.3.3): ...12.12.1.11. The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. (p. 217, Effective 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁴⁹ 6.33. Preconception/Inter-conception Care For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient 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 prior authorization shall not be required for approval. (p. 98, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.6. Direct Access to Women's Health Care ... 7.8.6.2. ...The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this Contract. (pp. 129-130, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵⁰ 6.0 CORE BENEFITS AND SERVICES. 6.1. General Provisions... 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: ... Pregnancy-Related Services. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.11. Prenatal Care Services. 6.11.1. The MCO shall ensure Medicaid members under its care who are pregnant, begin receiving care within the first trimester or within seven (7) days after enrolling in the MCO. (See Attachment C.) The MCO shall provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services, including specialized behavioral health services that are incidental to a pregnancy (in accordance with 42 CFR Part 440, Subpart B,) to all members. As noted in the Women's Health Services subsection, the pregnant member shall be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP. 6.11.2. The MCO shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members. 6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients

including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth. 6.11.4. The MCO shall ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to the MCO as well as appropriate referrals to the WIC program for nutritional assistance. (A sample WIC Referral Form may be found at this link). 6.11.5. The MCO shall develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to LDH for approval. Some goals of this program would be to: 6.11.5.1. Improve overall engagement in the maternity population and help women keep appointments and educate them about needed health screenings throughout pregnancy; 6.11.5.2. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources; and 6.11.5.3. Improve health decisions across the pregnant population based on available Statebased and MCO-based programs and services. (pp. 79-80, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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

6.19. Services for Special Populations 6.19.1. Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. Individuals with special health care needs include: ... 6.19.1.3. Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome. (p. 85, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.39. Case Management. 6.39.2. Case Management program functions shall include but not be limited to the following, all of which shall be addressed in the MCO's case management policies and procedures: ... 6.39.2.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, reproductive aged women with a history of prior poor birth outcomes and high-risk pregnant women; 6.40. Case Management Policies and Procedures... The MCO shall submit Case Management Program policies and procedures to LDH for approval annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements: 6.40.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: ... 6.40.3.2. High risk pregnant women. (p. 108, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8. Primary Care. ... 7.8.7. Prenatal Care Services 7.8.7.1. The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted (p. 130, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

14.0 QUALITY MANAGEMENT... 14.1.7 The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6. (p. 245, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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

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: ...6.13.1.3. Incentives for vaginal birth after cesarean (VBAC); ...6.13.1.5. Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and 6.13.1.6. Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age. (p. 81, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵² 6.0 CORE BENEFITS AND SERVICES. 6.1. General Provisions... 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: ... Pregnancy-Related Services. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.13. Perinatal Services. ...6.13.2. The MCO shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated). (p. 81, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵³ Section 2.4 Enrollment and Education Activities... f... The Enrollee Information, shall include, but not be limited to, a description of the following:... 7) The MCO Covered Services... that do not require authorization or a referral from the Enrollee's PCP, for example, family planning services... 8) The extent to which, and how, Enrollees may obtain benefits, including... family planning services, from out-of-network providers (p. 52, Effective 2022, 4th Amended and Restated Tufts MCO Contract)

F. Services for Specific Populations... In addition, the Contractor shall: ... 10. Provide or arrange family planning services as follows: 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; b. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the Contractor's Provider Network; c. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to: 1) All methods of contraception, including sterilization, vasectomy, and emergency contraception; 2) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and 3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination; d. Maintain sufficient family planning providers to ensure timely access to family planning services. (p. 132, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

J. Provider Education The Contractor shall establish ongoing Provider education, including but not limited to, the following issues:... 6. For PCPs, education and information on:... c. Issues, including but not limited to, the following: 1) Pre-conception health concerns, including... family planning guidance... (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

APPENDIX C: Exhibit 1: MCO Covered Services... Family Planning – family planning medical services, family planning counseling services, follow-up health care, outreach, and community education. Under Federal law, an Enrollee may obtain family planning services from any MassHealth provider of family planning services without the Contractor’s authorization. (p. 4, Effective 2022, Appendix C – Covered Services, 4th Amended and Restated Tufts MCO contract)

⁵⁴ J. Provider Education. The Contractor shall establish ongoing Provider education, including but not limited to, the following issues: ...6. For PCPs, education and information on:... c. Issues concerning women, including but not limited to, the following: 1) Pre-conception health concerns, including folic acid administration; family planning guidance; nutrition; osteoporosis prevention; HIV and STD prevention; and HIV testing prior to becoming pregnant. (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁵⁵ Section 2.5 Care Delivery, Care Coordination, and Care Management. A. General Care Delivery Requirements In accordance with all other applicable Contractor requirements, the Contractor shall ensure that all Enrollees receive care that is timely, accessible, and Linguistically and Culturally Competent. The Contractor shall: ...9. Develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS: ...2) Tobacco cessation programs, with targeted outreach for adolescents and pregnant women; 3) Childbirth education classes; 4) Nutrition counseling, with targeted outreach for pregnant women, older Enrollees, and Enrollees with Special Health Care Needs (p. 68, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Enrollee Outreach, Orientation, and Education The Contractor shall: ...2. The Contractor must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall: ... Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in Section 2.5. Condition and disease specific information must be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to: ... 9) Pregnant women with substance use disorders (pp. 70-71, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Services for Specific Populations. ...In addition, the Contractor shall: ... 8. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice... 10. Provide or arrange family planning services as follows: ...3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination; (p. 135, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Breast Pumps – to expectant and new mothers as specifically prescribed by their attending physician, consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014, including but not limited to double electric breast pumps one per birth or as medically necessary. (p. 1, Effective 2022, Appendix C, Exhibit 1: MCO Covered Services, 4th Amended and Restated Tufts MCO Contract)

c. Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) – 24- hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs. ... d. Clinical Support Services for Substance Use Disorders (Level III.5) – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care. ... d. Structured Outpatient Addiction

Program (SOAP) - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring. (pp. 17-19, Effective 2022, Appendix C – Covered Services, 4th Amended and Restated Tufts MCO Contract)

⁵⁶ F. Services for Specific Populations. ... In addition, the Contractor shall: ... 8. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice. (p. 132, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁵⁷ F. Service Authorization and Utilization Management. 1. To place appropriate limits on services for utilization control, provided that: ... c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used. (p. 11, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.01 Definitions. ... (58) "Family planning" means providing individuals with the information and means to prevent unwanted pregnancy and maintain reproductive health. (p. 62, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.20 MCO Payment for Self-Referral, Emergency, Physician, and Hospital Services. ... (2) An MCO shall reimburse out-of-plan providers to whom enrollees have self-referred for school-based services as described in COMAR 10.67.07.03 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. 169, January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.02 Access Standards: Enrollee Handbook and Provider Directory. 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: (10) Information about the availability of EPSDT, prenatal care, family planning, and other wellness services, including education programs; (11) A statement that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider (p. 180, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.07 Access Standards: Clinical and Pharmacy Access. ... (ii) Initial assessments of pregnant and postpartum women and individuals requesting family planning services shall be scheduled to be completed within 10 business days of the request for an appointment; (iii) If the new enrollee is a person requesting family planning services, the MCO shall ensure that an initial appointment is scheduled to occur within 10 days of the date of the enrollee's request for an appointment (p. 199, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.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. B. An MCO may place appropriate limits on family planning services for the purpose of utilization control, provided that the services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. C. An MCO may not apply a copayment or coinsurance requirement for contraceptive drugs or devices. D. An MCO shall provide coverage for a single dispensing of a supply of prescription contraceptives for a 12-month period. (p. 216, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.28 Benefits — Self-Referral Services. A. An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.67.04.20, an out-of-plan provider chosen by the participant for the following services: (1) Family planning services specified in COMAR 10.67.04.20A(2), (6), and (7) (p. 225, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁵⁸ .02 Access Standards: Enrollee Handbook and Provider Directory. 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: (10) Information about the availability of EPSDT, prenatal care, family planning, and other wellness services, including education programs; (11) A statement that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider (p. 180, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

07 Access Standards: Clinical and Pharmacy Access. ... (ii) Initial assessments of pregnant and postpartum women and individuals requesting family planning services shall be scheduled to be completed within 10 business days of the request for an appointment (p. 200, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

D. Covered Services 1. To cover, for Enrollees: b. Doula services for pregnant and postpartum individuals as part of MCO-covered pregnancy-related benefits. c. Home visiting services for pregnant and postpartum individuals as well as other Enrollees identified as participating in home visiting services, as part of MCO-covered pregnancy-related benefits. (p. 9, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.20 MCO Payment for Self-Referral, Emergency, Physician, and Hospital Services. ... (4) An MCO shall reimburse out-of-plan providers rendering pregnancy-related services, as described in COMAR 10.67.06.28C and K, at the Medicaid rate. (p. 170, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate; (2) Prenatal risk assessment and development of an individualized plan of care that specifies the actions required to address each identified need and is appropriately modified during the course of care; (3) Enriched maternity services, including: (a) Prenatal and postpartum counseling and education; (b) Basic nutritional education; (c) Substance abuse treatment, as provided in Regulation .10 of this chapter; (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and (ii) Healthy Start services; (e) High-risk nutrition counseling services for nutritionally high-risk pregnant women; (f) Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers; and (g) Smoking cessation education and treatment. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.28 Benefits — Self-Referral Services. A. An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.67.04.20, an out-of-plan provider chosen by the participant for the following services: ... (3) Pregnancy-related services for women who are pregnant and, at the time of initial enrollment, have received prenatal care during their current pregnancy from an out-of-plan provider, and this pre-enrollment care consists of at least the following: (a) A full prenatal examination; (b) A risk assessment; and (c) Appropriate laboratory services (pp. 225-226, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁵⁹ .21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate;... B. When an enrollee recovering from childbirth elects to be discharged before 48 hours following a normal vaginal delivery or 96 hours following an uncomplicated cesarean section, the MCO is responsible for providing: (1) One home visit scheduled to occur within 24 hours after discharge; and (2) An additional home visit as may be prescribed by the attending provider. C. When an enrollee recovering from childbirth and her newborn enrollee remain in the hospital for at least as long as the period of time provided under §B of this regulation, the MCO shall provide a home visit as prescribed by the attending provider. D. An MCO shall provide for home visits required by §§B and C of this regulation to be performed by a registered nurse and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child, including: (1) An

evaluation of the presence of immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse physical symptoms of the infant; (2) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother; (3) Collection of a blood specimen for newborn screening if not previously completed; (4) Referrals for any medically necessary continuing health care services; and (5) Any other nursing services ordered by the referring provider. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.07 Benefits — Inpatient Hospital Services. ... D. Childbirth — Length of Stay and Home Visits. (1) Except as provided in §D(2) and (3) of this regulation, the criteria and standards used by an MCO in performing utilization review of hospital services related to maternity and newborn care, including length of stay, shall be in accordance with the medical criteria outlined in the Guidelines for Perinatal Care, which is incorporated by reference in COMAR 10.67.04.01. (2) Unless the enrollee decides, in consultation with her attending provider, that less time is needed for recovery, an MCO shall provide or reimburse the cost of hospitalization including at least the following length of stay for an enrollee recovering from childbirth: (a) 48 hours of inpatient hospitalization care following an uncomplicated vaginal delivery; or (b) 96 hours of inpatient hospitalization care following an uncomplicated cesarean section. (3) If the enrollee elects to be discharged earlier than the length of stay specified in §D(2) of this regulation, the MCO is required to provide a home visit or visits pursuant to Regulation .21B—D of this chapter. E. In addition to the mother's length of stay required to be afforded by §D(2) of this regulation, whenever a mother is required to remain hospitalized after childbirth for medical reasons and she requests that her newborn remain in the hospital while she is hospitalized, the MCO shall afford the newborn additional hospitalization while the mother remains hospitalized, for up to 4 days. F. If an enrollee is in the hospital at the time of disenrollment from the MCO, and remains eligible for Medical Assistance, the MCO is responsible for covering the remainder of that hospital admission following disenrollment. G. An MCO shall provide for a private hospital room when: (1) The enrollee's condition requires a need for isolation; or (2) The enrollee requires admission and only private rooms are available. H. Payment For Ancillary Services. (1) Effective January 1, 2009, an MCO shall pay for all medically necessary ancillary services provided on inpatient hospital days including those days for which the inpatient hospitalization is otherwise appropriately denied. (2) A denial of an inpatient ancillary service shall be based on the medical necessity of the specific ancillary service. (3) An MCO is not required to pay for ancillary services if the entire hospitalization in §H(1) of this regulation is appropriately denied. I. Transports between hospitals are covered by the MCO when: (1) A medically necessary covered service is not available at the hospital where an enrollee is being treated; and (2) The enrollee is not being discharged from the sending hospital. (pp. 212-213, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁶⁰ .08 Special Needs Populations — Pregnant and Postpartum Women. A. An MCO shall meet the standards set forth in this regulation for treating pregnant and postpartum women. B. An MCO shall ensure access to prenatal care for pregnant women and postpartum care for postpartum women by: (3) Arranging for an adequate network of providers including obstetricians, gynecologists, perinatologists, neonatologists, anesthesiologists, and advanced practice nurses who are capable of addressing complex maternal and infant health issues; and (4) Linking a pregnant woman with a pediatric provider before delivery. ... E. An MCO shall refer pregnant and postpartum women with a substance use disorder to the behavioral health ASO for substance use treatment within 24 hours of request. F. An MCO shall refer pregnant and postpartum women, infants, and children younger than 5 years old to the WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Program, and shall provide to WIC necessary medical information to determine WIC nutritional eligibility. G. An MCO shall follow, at a minimum, the American College of Obstetricians and Gynecologists (ACOG) guidelines for pregnant and postpartum women. H. An MCO shall provide risk-related medical and nonmedical preventive treatment services, including nutrition counseling by licensed nutritionists or dietitians and smoking cessation education and treatment for pregnant and postpartum women. I. An MCO shall provide HIV counseling, including a risk assessment and information about possible transmission of HIV to the fetus. J. An MCO shall offer its pregnant and postpartum enrollees voluntary HIV counseling and testing following the requirements of COMAR 10.67.06. K. An MCO shall arrange for the appropriate emergency transfer of pregnant women, newborns, and infants to tertiary care centers. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate; (2) Prenatal risk assessment and development of an individualized plan of care that specifies the actions required to address each identified need and is appropriately modified during the course of care; (3) Enriched maternity services, including: (a) Prenatal and postpartum counseling and education; (b) Basic nutritional education; (c) Substance abuse treatment, as provided in Regulation .10 of this chapter; (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and (ii) Healthy Start services; (e) High-risk nutrition counseling services for nutritionally

high-risk pregnant women; (f) Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers; and (g) Smoking cessation education and treatment. B. When an enrollee recovering from childbirth elects to be discharged before 48 hours following a normal vaginal delivery or 96 hours following an uncomplicated cesarean section, the MCO is responsible for providing: (1) One home visit scheduled to occur within 24 hours after discharge; and (2) An additional home visit as may be prescribed by the attending provider. C. When an enrollee recovering from childbirth and her newborn enrollee remain in the hospital for at least as long as the period of time provided under §B of this regulation, the MCO shall provide a home visit as prescribed by the attending provider. D. An MCO shall provide for home visits required by §§B and C of this regulation to be performed by a registered nurse and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child, including: (1) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse physical symptoms of the infant; (2) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother; (3) Collection of a blood specimen for newborn screening if not previously completed; (4) Referrals for any medically necessary continuing health care services; and (5) Any other nursing services ordered by the referring provider. (pp. 218-219, Effective January 2022 Maryland HealthChoice Managed Care Organization Agreement)

⁶¹ G. Family Planning Services 1. Contractor must demonstrate that its network includes sufficient family planning Providers to ensure timely access to Covered Services. Family planning providers are providers who provide reproductive health care services to beneficiaries including but not limited to; family planning centers and clinics, Obstetrician/Gynecologists, and PCPs. 2. Contractor must ensure that Enrollees have full freedom of choice of family planning Providers, both in-network and Out-of-Network. a. Contractor may encourage the use of public providers in their network. 3. Contractor may encourage family planning Providers to communicate with PCPs once any form of medical treatment is undertaken. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization. 4. Regarding type, duration or frequency of drugs, supplies and devices for the purpose of family planning, Contractors may not be more restrictive than Medicaid FFS. 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. 6. Contractor must maintain accessibility and confidentiality for family planning services through promptness in scheduling appointments, particularly for minors. 7. Contractor must make certain Medicaid funding is not used for services for the treatment of infertility. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

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... I. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis) (p. 48, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

E. Member Materials... 2. Member Handbook... I. 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:... xxxiii... family planning services, and how to access these services... 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. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

J. Confidentiality... 4. Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for... family planning services. (p. 118, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶² LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶³ V. Access and Availability of Providers and Services. H. Pregnant Women 1. Contractor must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice. 2. Contractor must allow pregnant women to receive all Medically Necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in Network Provider. 3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate. 4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

V. Access and Availability of Providers and Services. I. Maternity Care 1. Contractor must ensure an individual maternity care Provider is designated for each enrolled pregnant woman for the duration of her pregnancy and post-partum care. a. Maternity care Providers' scope of practice must include maternity care and meet the Contractor's credentialing requirements. b. A clinic or practice may be designated as the maternity care Provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care. 2. Contractor must allow an Enrollee's maternity care Provider to also be the Enrollee's PCP if primary care is within their scope of practice. (pp. 42-43, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

VI. Covered Services. B. Services Covered Under This Contract... u. Maternal and Infant Health Program (MIHP) services. (p. 49, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

HOME VISITING VI.... N. Maternal, Infant and Early Childhood Evidence Based Home Visiting Programs The Maternal and Infant Health Program (MIHP) is a home-visiting program for Medicaid eligible women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP Provider organizations must be certified by MDHHS and adhere to program policies, procedures, and expectations outlined in Medicaid Policy, the MIHP Program Operations Manual and Public Act 291 of 2012. 1. Contractor must refer all eligible Enrollees to an MIHP or when appropriate, other MDHHS approved evidence-based home-visiting program Other MDHHS approved programs are as follows: a. Nurse Family Partnership b. Healthy Families America c. Family Spirit (p. 62, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

2. Member Handbook... i. 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: ... xxix. Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant (p. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶⁴ I. Maternity Care 1. Contractor must ensure an individual maternity care Provider is designated for each enrolled pregnant woman for the duration of her pregnancy and post-partum care. a. Maternity care Providers' scope of practice must include maternity care and meet the Contractor's credentialing requirements. b. A clinic or practice may be designated as the maternity care Provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care. 2. Contractor must allow an Enrollee's maternity care Provider to also be the Enrollee's PCP if primary care is within their scope of practice. (pp. 42-43, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

V. Access and Availability of Providers and Services... H. Pregnant Women...4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶⁵ 2.56 Family Planning Service means a family planning supply (related drug or contraceptive device) or health service, including screening, testing, and counseling for sexually transmitted diseases, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to an Enrollee's condition of fertility. (pp. 20-21, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

3.10.3 Handbook... 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. 45, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

6.1 MEDICAL ASSISTANCE (PMAP) COVERED SERVICES..... The MCO shall provide services that shall include but are not limited to the following:... 6.1.16 Family Planning Services. 6.1.16.1 The MCO must comply with the sterilization consent procedures required by the federal government, and must ensure open access to Family Planning Services. [42 CFR §431.51 and Minnesota Statutes, §62Q.14] 6.1.16.2 The MCO may not restrict the choice of an Enrollee as to where the Enrollee receives the following services. [42 CFR §441.20 and Minnesota Statutes, §62Q.14]: • Voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services; • Diagnosis of infertility, including counseling and services related to the diagnosis (for example Provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results); • Testing and treatment of a sexually-transmitted disease; and • Testing for AIDS and other HIV-related conditions. 6.1.16.3 The MCO may require family planning agencies and other Providers to refer Enrollees back to the MCO under the following circumstances for other services, diagnosis, treatment and follow-up: • Abnormal pap smear/colposcopy; • Infertility treatment; • Medical care other than Family Planning Services; • Genetic testing; and • HIV treatment. (pp. 90, 98, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁶ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁷ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.5 Inpatient Hospitalization for Childbirth is covered. (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁸ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.2 Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered. [Minnesota Statutes, §256B.0625, subd. 28b] 6.1.35.3 Prenatal Care Services. ... (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁹ 2.4 Health Plan Provider Networks:... 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. A listing of Family Planning and STD treatment providers is provided in Exhibit C and Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/>). (p. 30, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

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/>):... k. 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. (p. 54, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management:... e. Care Plans:... 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;... (p. 76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.12.16 Member Handbook:... Information on... family planning... 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 (p. 91, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.16 Provider Services... 2.16.1 Provider Services Staff... The health plan's provider services staff shall be responsible for the following:... e. Educating providers about conditions under which members may directly access services including, but not limited to,... family planning... services (p. 117, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.18 Quality Assessment and Improvement:... 2.18.8 Internal Procedures: The health plan shall have an internal written quality assessment and improvement program procedures. The procedures shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, clinical areas relating to... family planning... as well as on key access or other priority issues for members such as reducing the incidence of STDs... The health plan shall implement mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. (p. 127, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

3.16 Confidentiality:... 3.16.6 The health plan shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services. (p. 194, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷⁰ 2.7.7 Additional Services: In addition to the services listed in the comprehensive benefits package herein, the health plan shall provide the following services to... pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98... a. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury); b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan; c. Diabetes self-management training for persons with gestational, Type I, or Type II diabetes; d. Hearing aids and related services; e. Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two (2) years, replacement lens(es) when there is a .50 or greater change and, for children under age twenty-one (21), replacement frames and/or lenses when lost, broken or medically necessary, and HCY/EPST optical screen and services; f. Podiatry services; g. Services that are included in the comprehensive benefits package, medically necessary, and not identified in the IFSP or IEP; and h. Therapy services (physical, occupational, and speech). (pp. 59-60, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management... d. General Eligibility and Assessment 1) The health plan shall screen all pregnant members for care management needs and offer care management to all pregnant members... e. Care Plans:... 3) In addition to the requirements listed below, the health plan shall include the following in the care plans of pregnant women: A risk appraisal form must be a part of the member's record. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd. Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in care management; Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment; Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21); Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in care management; Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation; Assistance in making transportation arrangements for prenatal care, delivery, and postpartum care; Referrals to prenatal or childbirth education where available; Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment; Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed; Assistance in identifying and selecting a medical care provider for both the mother and the child; Identification of feeding method for the child; Notifications to current health care providers when care management services are discontinued; Referrals for family planning services if requested; and Directions to start taking folic acid vitamin before the next pregnancy (pp. 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

23.2 Coordination of Benefits:... a. The health plan must provide... prenatal care for pregnant women... (p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷¹ 23.2 Coordination of Benefits:... a. The health plan must provide labor, delivery... (p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

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/>):... q. Maternity Benefits for Inpatient Hospital and Certified Nurse Midwife: 1) The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended. 2) The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with Federal and State law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and is documented in the member's medical record. 3) The health plan shall provide coverage for post-discharge care to the mother and her newborn. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use. (pp. 56-57, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷² 2.23.2 Coordination of Benefits... a. The health plan must provide... postpartum care... (<http://dss.mo.gov/business-processes/managedcare-2017/bidder-vendor-documents/>) p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷³ D. Member Handbook... The Member Handbook must include at a minimum the following information:... 7. Making appointments and accessing care:... e. 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; (p. 72, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

B. Provider Network Requirements... 7. Family Planning The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services. (p. 96, Effective July 2017, MSCAN Magnolia Health Plan inc. Managed Care Executed Contract)

⁷⁴ G. Additional Requirements for Communication with Contractor's Members... 1. Allowable Contractor Communication Activities... b. The Contractor is allowed to offer non-cash incentives to its Members for the purposes of rewarding for compliance in... prenatal visits... (p. 81, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁵ O. Reporting Maternity Admissions for Delivery Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, as required by the Division. Medicaid policy exempts certain maternity admissions for delivery from the reporting requirement and providers are not required to submit reports for these situations. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization time frame and the Medicare benefits are not exhausted. No review is required if the beneficiary's Medicaid eligibility is only for the Family Planning Waiver. The Contractor shall develop, implement, and maintain a maternity admission for delivery reporting process. The Contractor shall issue a written notification for issuance of a Prior Authorization Number to the requesting provider within two (2) business days from receipt of completed report. (p. 135, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁶ O. Reporting Maternity Admissions for Delivery Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn.... (p. 135, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁷ 3.4 Enrollee Orientation 3.4.1 Initial Contact – General Orientation... (E) During the initial contact, MCO's representative shall provide, at minimum, the following information to the Enrollee or Potential Enrollee: (2) Availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Out-of-Network Providers (p. 26, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

3.5.4 Enrollee Handbook... (B) At a minimum, in accordance to 42 CFR § 438.10(g)(2) and any other content as required by STATE, the Enrollee handbook shall explain in clear terms the following:... (4) The extent to which, and how, Enrollees may obtain benefits, including family planning services, from Out-of-Network Providers (p. 29, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

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). 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. MCO is required to reimburse Out-of-Network Providers for family planning services. (p. 36, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

5.1.4 Out-of-Network Services... B) Enrollees must have the option of obtaining Medically Necessary Covered Services from any Out-of-Network Provider, if the following conditions exist:... (10) The Enrollee seeks Family Planning Services; (p. 48, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁷⁸ Coverage (438.210) MCO must provide for all medically necessary and appropriate Medicaid covered services in sufficient amount, duration, and scope to achieve the purpose of the service (consistent with 438.210(a)(1)). MCO must provide a comprehensive health care services benefit package. The covered services will include all services that North Dakota requires be made available to enrollees in North Dakota Medicaid expansion, including but not limited to:... Maternity... care (pp. 19-20, Amendment D, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁷⁹ B. Covered Services and Benefits... 16. Family Planning Services a. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the choice of provider from whom/which the member may receive family planning services and supplies. At a minimum, the MCO must provide coverage for the following family planning services: i. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits. This visit includes anticipatory guidance and education related to members' reproductive health/needs. (p. 62, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸⁰ Prenatal and Maternity Care Services a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis. B. The MCO must cover nurse-midwife services that are medically necessary...C. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸¹ Prenatal and Maternity Care Services a. The MCO must cover ...deliveryC. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸² Prenatal and Maternity Care Services a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis. B. The MCO must cover nurse-midwife services that are medically necessary...C. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸³ 2.1.47 Family Planning Services 2.1.47.1 "Family Planning Services" means services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include: 2.1.47.1.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases; (p. 20, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.1.4 Member Handbook... 4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not limited to, the following information:... 4.4.1.4.3.2. Benefits. 4.4.1.4.3.2.1 How and where to access any benefits provided, including... Family Planning Services... 4.4.1.4.3.3. Service Limitations:... 4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider... (pp. 121-122, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.3 Member Rights 4.4.3.1 The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:... 4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers; (p. 130, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.7.6 Women's Health... 4.7.6.2 The MCO shall provide access to Family Planning Services as defined in Section 2.1.47 (Definitions) 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. 4.7.6.3 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)] (p. 170, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.11.6.17 Neonatal Abstinence Syndrome... 4.11.6.17.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:... 4.11.6.17.6.6. Information on family planning options; (p. 252, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

⁸⁴ 4.9.4.6 Healthy Behavior Incentive Programs 4.9.4.6.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:... 4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members with risk of having a child with NAS (p. 189, Exhibit A, Amendment #8, Effective FY 2023, Granite State Health Plan Inc. Medicaid Care Management Services Contract Contract)

⁸⁵ 4.1.2 BENEFIT PACKAGE A. 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 (p. 10, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Family Planning--The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Abortions (and related services) and infertility treatment services are excluded. (p. 14, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

LARC--Long-acting reversible contraceptives (LARC) are a safe and highly effective method of family planning that provide contraception for an extended period without requiring member action (or compliance). They include intrauterine devices (IUDs) and subdermal contraceptive implants. Both methods are reversible and can be removed at any time if member chooses. (p. 17, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Referral Services--those health care services provided by a health professional other than the primary care practitioner and which are ordered and approved by the primary care practitioner or the Contractor. 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. (p. 28, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

4.2.2 FAMILY PLANNING SERVICES AND SUPPLIES A. General. Except where specified in Section 4.1, the Contractor's MCO enrollees are permitted to obtain family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The Contractor shall reimburse family planning services provided by non-participating Network providers based on the Medicaid fee schedule. All Providers must be registered with New Jersey Medicaid as 21st Century Cures Act Providers in order to provide services to NJ FamilyCare members. B. Non-Participating Providers. The Contractor shall cooperate with non-participating family planning providers accessed at the enrollee's option by establishing cooperative working relationships with such providers for accepting referrals from them for continued medical care and management of complex health care needs and exchange of enrollee information, where appropriate, to assure provision of needed care within the scope of this contract. The Contractor shall not deny coverage of family planning services for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider. (p. 29, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

5.8.2 ENROLLEE NOTIFICATION/HANDBOOK... 5. A notification of the enrollee's right to obtain family planning services from the Contractor's network of providers of family planning services, 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. (p. 12, Article 5, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

⁸⁶ D. Perinatal Risk Assessment Form. 1. An obstetrical Provider or other approved licensed health care Provider, including nurse midwives, shall complete the DMAHS uniform Perinatal Risk Assessment form (the form) during the first prenatal visit with a pregnant Member and shall update the form in the third trimester. 2. The Contractor shall require its Providers to submit the form (see sample in Appendix A.4.2.3) and the update to DMAHS, its contracted designee or the health information network. Beginning January 1, 2021, consistent with N.J.S.A. 30:4D-7z, no Provider may receive reimbursement for prenatal services provided to the Member until the form is completed and submitted for that Member. If there is a pattern of late submission of the forms and updates, the Provider shall be counseled in writing and verbally to submit them timely. (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

F. Centering. The Contractor shall provide pregnant female Members the option of attending "Centering" group prenatal care at a site accredited by the Centering Healthcare Institute. The center shall utilize the Centering Pregnancy model and incorporate the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each visit. The program consists of ten (10) prenatal visits, each 90 minutes - two hours long, where Providers engage in health assessments and group education/discussion that covers topics including but not limited to, nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care. Sessions are held in a group setting consisting of 2-20 women. (p. 31, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). (p. 50, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

⁸⁷ 4.2.3 Women's Health Services... B. The Contractor shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time and the provisions of N.J.S.A. 26:2J-4.9 are met. 1. The Contractor shall not provide monetary payments or rebates to mothers to encourage them to accept less than the minimum protections provided for in this Article. 2. The Contractor shall not penalize, reduce, or limit the reimbursement of an attending provider because the provider provided care in a manner consistent with this Article. (pp. 29-30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).

E. Non-medically indicated early elective deliveries. 1. Beginning January 1, 2021, consistent with N.J.S.A. 30:4D-9.2, no Provider shall be reimbursed by the Contractor for a non-medically indicated early elective delivery performed at a hospital on a pregnant woman earlier than the 39th week of gestation. A "non-medically indicated early elective delivery" means the artificial start of the birth process through medical interventions or other methods, also known as labor induction, or the surgical delivery of a baby via a cesarean section for purposes or reasons that are not fully consistent with established standards of clinical care as provided by the American College of Obstetricians and Gynecologists 2. The Contractor shall support education efforts for health care Providers and women and their support networks, and prohibit coverage of such medical interventions which are not medically necessary by clinical standards. During 2019, the Contractor must advise all of its Providers of pregnancy-related services of the risks of early elective deliveries and the prohibition on payment for such (below) 3. The Contractor shall provide accessible educational materials to inform pregnant women, their support networks, and Providers about the risks of a non-medically indicated early elective delivery. (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).

⁸⁸ 4.5.8 Family Planning Services 4.5.8.1 Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall implement written policies and procedures, previously approved by HSD, that define how Members are educated about their right to family planning services, freedom of choice (including access to Non-Contract Providers) and methods for accessing family planning services. 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: 4.5.8.1.1 HIV and other sexually transmitted diseases and risk reduction practices; 4.5.8.1.2 Birth control pills and devices (including Plan B); and 4.5.8.1.3 That Members can self-refer to Non-Contracted family planning providers (p. 89, no date, New Mexico Amended Version Sample RFP, 2022).

4.8.9.2 Local Department of Health Offices 4.8.9.2.1 The CONTRACTOR shall make best efforts to contract with public health providers for family planning services and other clinical preventive services not otherwise available in the community such as prenatal care or perinatal case management and those defined as public health services under State law, NMSA 1978, §§ 24-1-1 et. seq. 4.8.9.2.2 The CONTRACTOR shall make best efforts to contract with local and district public health offices for family planning services. (p. 115, no date, New Mexico Amended Version Sample RFP)

4.10.2.3 Family Planning Non-Contract Providers The CONTRACTOR shall reimburse family planning Non-Contract Providers for the provision of service to Members at a rate set by HSD. (p. 127, no date, New Mexico Amended Version Sample RFP)

4.10.2.9 Pharmacy Services... 4.10.2.9.7 The CONTRACTOR shall reimburse family planning clinics, SBHCs and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to Members and billed using HCPC codes and CMS 1500 forms (p. 130, no date, New Mexico Amended Version Sample RFP)

Attachment 5: Adult Benefit Plan Covered Services... Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives (Sterilization reversal is not covered. Infertility treatment is not covered.) (p. 314, no date, New Mexico Amended Version Sample RFP)

⁸⁹ 4.5.9 Prenatal Care Program 4.5.9.1 The CONTRACTOR shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. (p. 89, no date, New Mexico Amended Version Sample RFP)

4.8.9.2 Local Department of Health Offices 4.8.9.2.1 The CONTRACTOR shall make best efforts to contract with public health providers for... other clinical preventive services not otherwise available in the community such as prenatal care or perinatal case management... 4.8.9.2.3 The CONTRACTOR may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or prenatal case management. (p. 115, no date, New Mexico Amended Version Sample RFP)

4.8.15.3 The CONTRACTOR shall contract with the DOH Families First and Children's Medical Services (CMS) programs for case management related activities. 4.8.15.3.1 Families First Program:... 4.8.15.3.1.1 Prenatal members are typically seen four times during the pregnancy/postpartum and the postpartum visit is conducted in the Member's home with the member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit. (p. 120, no date, New Mexico Amended Version Sample RFP)

4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize participation. (p. 160, no date, New Mexico Amended Version Sample RFP)

4.22.1.2 Specific Requirements... 4.22.1.2.1 The following reward activities are under consideration for the Member Incentive program:... Perinatal (1st trimester, ongoing prenatal, and postpartum visits (p. 219, no date, New Mexico Amended Version Sample RFP)

Attachment 5: Adult Benefit Plan Covered Services... Over-the-counter medicines – prenatal drug items... (p. 315, no date, New Mexico Amended Version Sample RFP)

Attachment A: Adult Benefit Plan Covered Services... Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, New Mexico Amended Version Sample RFP, 2022).

⁹⁰ Attachment A: Adult Benefit Plan Covered Services... Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, no date, New Mexico Amended Version Sample RFP)

⁹¹ 4.8.15.3.1 Families First Program: The DOH Families First program provides case management functions to Prenatal and Pediatric members. 4.8.15.3.1.1 Prenatal members are typically seen four times during the pregnancy/postpartum and the postpartum visit is conducted in the Member's home with the member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit. (p. 120, no date, New Mexico Amended Version Sample RFP)

4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize participation. (p. 160, no date, New Mexico Amended Version Sample RFP)

4.22.1.2 Specific Requirements... 4.22.1.2.1 The following reward activities are under consideration for the Member Incentive program:... Perinatal (1st trimester, ongoing prenatal, and postpartum visits) (p. 219, no date, New Mexico Amended Version Sample RFP)

Adult Benefit Plan Services Included Under Centennial Care...Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, no date, New Mexico Amended Version Sample RFP)

⁹² 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:... 7.4.2.1.15. Family Planning Services;... 7.4.2.1.43. Special Clinics (e.g., Comprehensive Rehabilitation Facility, Genetics, Family Planning, Methadone Public Health Clinic, Community Health Clinic (State Health Division), School Based Health Centers, Special Children's Clinic, TB Clinic, HIV, Substance Abuse Agency Model); (pp. 99-102, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.4.2.7. Family Planning Services 7.4.2.7.1. The Contractor is prohibited from restricting the Member's free choice of Family Planning Services, supplies, and Providers. Federal regulations grant the right to any Member of childbearing age to receive Family Planning Services from any qualified Provider, even if the Provider is not part of the Contractor's Network. The Contractor may not require family planning services to be prior authorized. Family Planning Services are provided to Members who want to control family size or prevent unwanted pregnancies. Family Planning Services may include education, counseling, physical examinations, birth control pills, intrauterine devices, implants, injections, patches, rings, diaphragms, condoms, and other birth control supplies. 7.4.2.7.2. Pursuant to MSM Chapter 600, tubal ligations and vasectomies are included for Members twenty-one (21) years of age or older. Tubal ligations and vasectomies to permanently prevent conception are not covered for any Member under the age of twenty-one (21) or any Member who is adjudged mentally incompetent or is institutionalized. Hysterectomy is not a covered Family Planning Service. 7.4.2.7.3. At a minimum, the Contractor must reimburse qualified Out-of-Network Providers for Family Planning Services rendered to its Members at the FFS rate paid by the State. The Contractor will be responsible for coordinating and documenting Out-of-Network family planning services provided to its Members and the amounts paid for such services. (pp. 106-107, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

Members must be allowed to self-refer for family planning (in or Out-of-Network)...services within the Contractor's Network; (p. 175, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁹³ 7.5.5. Health Needs Assessment The Contractor must conduct a Health Needs Assessment Screening for all new Members with the following timeframes from the date of enrollment with the Contractor: 7.5.5.1. The Contractor must arrange for or conduct an initial screening assessment of new Members, to confirm the results of a positive identification and to determine the need for Care Coordination and/or Case Management services within sixty (60) Calendar Days of enrollment. Screening assessment for pregnant women, children with special health care needs, adults with special health care needs must be conducted within thirty (30) Calendar Days;... 7.5.5.4. The Contractor will submit its Health Needs Assessment Screening form and screening-related data for the State upon request. The State reserves the right to standardize the Health Needs Assessment Screening form across Contractors. The Health Needs Assessment tool must, at a minimum, address the following:... 7.5.5.4.4. Pregnancy screen, as applicable. (p. 143, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.10. High Risk Maternal Case Management 7.5.6.7.10.1 The Contractor will make a good faith effort to screen Medicaid and CHIP pregnant Members for maternal high risk factors. 7.5.6.7.10.2 Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, Personal Care Services or Home Health care, substance abuse services, and Care Coordination services, in addition to maternity care. 7.5.6.7.10.3 All Case Management requirements and standards outlined within Section 7.5.6.7 apply to the Contractor's High Risk Maternal Care Management Program. 7.5.6.7.10.4 Any identification of high-risk factors will require the PCP, OB/GYN Provider, Case Manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Contractor's High Risk Maternal Case Management Program. 7.5.6.7.10.5. The Contractor must demonstrate ongoing and active efforts to educate Providers on how to make referrals to the Contractor's High Risk Maternal Case Management Program for Members identified as pregnant for screening. 7.5.6.7.10.6. As appropriate, the Contractor must assist the Member in contacting appropriate agencies for Care Coordination of noncovered/carved-out plan services or community health information. The Contractor's Case Manager will begin medical Case Management services for those risk factors identified. 7.5.6.7.10.7. The State and/or the External Quality Review Organization (EQRO) will conduct on-site reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies. (pp. 152-153, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.15. Case Management Priority Conditions The Contractor must, at a minimum, provide Case Management to Members with the following conditions or status. The priority list is not exhaustive and Case Management should be offered to Members who health condition warrant Case Management Services... 7.5.6.7.15.11. High Risk Pregnancy including Members who are pregnant and have a SUD or history of a SUD;... (p. 159, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁹⁴ 10.10 Family Planning and Reproductive Health Services. 10.10.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. 10.10.a.i. MMC Enrollees may receive such services from any qualified Medicaid provider, regardless of whether the provider is a Participating or a Non-Participating Provider, without referral from the MMC Enrollee's PCP and without approval from the Contractor. 10.10.a.ii. FHPlus Enrollees may receive such services from any Participating Provider if the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, or from any qualified Medicaid provider if such services are not included in the Contractor's Benefit Package, as specified in Appendix M of this Agreement, without referral from the FHP Enrollee's PCP and without approval from the Contractor. 10.10.b. The Contractor shall permit Enrollees to exercise their right to obtain Family Planning and Reproductive Health services. 10.10.b.i. If the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, the Contractor shall comply with the requirements in Part C.2 of Appendix C of this Agreement, including assuring that Enrollees are fully informed of their rights. 10.10.b.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. (pp. 10-7-to-10-8, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10.17 Contractor Responsibilities Related to Public Health... b) The Contractor will inform Enrollees about HIV testing services available through the Contractor's Participating Provider network and HIV testing services available when performed as part of a Family Planning and Reproductive Health encounter. HIV testing rendered outside of a Family Planning and Reproductive Health encounter, as well as services provided as the result of an HIV+ diagnosis, will be furnished by the Contractor in accordance with standards of care. The HIV testing provided shall be done in accordance with all Public Health Laws, including Article 27-F. (p. 10-26, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10.31 Coordination of Services a) The Contractor shall coordinate care for Enrollees, as applicable, with:... iii) family planning clinics... (p. 10-32, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

15.2 Appointment Availability Standards a) The Contractor shall comply with the following minimum appointment standards, as applicable... xii) Initial family planning visits: within two (2) weeks of request. (p. 15-2, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

1. Family Planning and Reproductive Health Services a) Family Planning and Reproductive Health services mean the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. I) Family Planning and Reproductive Health services include the following medically-necessary services, related drugs and supplies which are furnished or administered under the supervision of a physician, licensed midwife or certified nurse practitioner during the course of a Family 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); B) emergency contraception and follow up; C) sterilization; D) screening, related diagnosis, and referral to a Participating Provider for pregnancy; 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. II) Family Planning and Reproductive Health services include those education and counseling services necessary to effectively render the services. Iii) Family Planning and Reproductive Health services include medically-necessary ordered contraceptives and pharmaceuticals: The contractor is responsible for pharmaceuticals and medical supplies such as IUDS and Depo-Provera that must be furnished or administered under the supervision of a physician, licensed midwife, or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit. B) When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit: I) Screening, related diagnosis, ambulatory treatment and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology. Ii) Screening, related diagnosis and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease. Iii) Screening and treatment for sexually transmissible disease. Iv) HIV testing and pre- and post-test counseling.

2. Free Access to Services for MMC Enrollees 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. B) The Family Planning and Reproductive Health services listed above are the only services which are covered under the Free Access policy. Routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are not covered under the Free Access policy, and are the responsibility of the Contractor.

3. Access to Services for FHPlus Enrollees a) FHPlus 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 Services encounter, from either the Contractor pursuant to C.2 below or any appropriate Medicaid health care provider pursuant to C.3 below, as applicable. No referral from the PCP or approval by the Contractor is required to access such services. B) The Contractor is responsible for routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care, regardless of whether Family Planning and Reproductive Health services are included in the Contractor's Benefit Package.

C.2 Requirements for MCOs that Include Family Planning and Reproductive Health Services in Their Benefit Package 1. Notification to Enrollees a) 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. The notification must contain the following: i) Information about the Enrollee's right to obtain the full range of Family Planning and Reproductive Health services, including HIV counseling and testing when performed as part of a Family Planning and Reproductive Health encounter, from the Contractor's Participating Provider without referral, approval or notification. ii) MMC Enrollees must receive notification that they also have the right to obtain Family Planning and Reproductive Health services in accordance with MMC's Free Access policy as defined in C.1 of this Appendix. There is no Free Access policy for FHPlus Enrollees. iii) A current list of qualified Participating Family Planning Providers who provide the full range of Family Planning and Reproductive Health services within the Enrollee's geographic area, including addresses and telephone numbers. The Contractor may also provide MMC Enrollees with a list of qualified Non- Participating providers who accept Medicaid and provide the full range of these services. iv) Information that the cost of the Enrollee's Family Planning and Reproductive Health care will be fully covered, including when a MMC Enrollee obtains such services in accordance with MMC's Free Access policy... 3. Consent and Confidentiality a) The Contractor will comply with federal, state, and local laws, regulations and policies regarding informed consent and confidentiality and ensure Participating Providers comply with all of the requirements set forth in Sections 17 and 18 of the PHL and 10 NYCRR Section 751.9 and Part 753 relating to informed consent and confidentiality. B) Participating Providers may share patient information with appropriate Contractor personnel for the purposes of claims payment, utilization review and quality assurance, unless the provider agreement with the Contractor provides otherwise. The Contractor must ensure that any Enrollee's, including a minor's, use of Family Planning and Reproductive Health services remains confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure. 4. Informing and Standards... b) The Contractor will inform its Participating Providers that they must comply with professional medical standards of practice, the Contractor's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Task Force on Preventive Services and the New York State Child/Teen Health Program. These standards and laws recognize that Family Planning counseling is an integral part of primary and preventive care. (pp, C-1 – C-5, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁵ Family Planning and Reproductive Health Care... If the Contractor excludes Family Planning and Reproductive Health services from its Benefit Package . . . the Contractor is required to comply with the requirements of Appendix C.3 of this Agreement and still provide the following services:...screening, related diagnosis, and referral to Participating Provider for . . . pregnancy. (p.C-2, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁶ 10.11 Prenatal Care and Elective Deliveries Less Than 39 Weeks Gestation a) The Contractor agrees to provide or arrange for comprehensive prenatal care services to be provided in accordance with standards and guidelines established by the Commissioner of Health pursuant to Section 365-k of the Social Services Law. (p. 10-8, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

13.6 Notification of Enrollee Rights... b) The Contractor agrees to make all reasonable efforts to conduct a brief health screening, within sixty (60) days of the Enrollee's Effective Date of Enrollment, to assess the Enrollee's need for any special health care (e.g., prenatal.. services)... Reasonable efforts are defined to mean at least (3) attempts, with more than one method of contact being employed. If a special need is identified, the Contractor shall assist the Enrollee in arranging an appointment with his/her PCP or other appropriate provider. (p. 13-6, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

16.3 Incentivizing Enrollees to Complete a Health Goal a) Upon approval by SDOH, the Contractor may offer its Enrollees incentives for completing a health goal, such as finishing all prenatal visits,... Additionally, the Contractor may offer its Enrollees incentives to promote the delivery of preventive care services, as defined in 42 CFR 1003.101. SDOH will determine if the incentive

meets the requirements at 42 CFR 1003.101 and outlined in DHHS OIG Special Advisory Bulletin "Offering Gifts and Other Inducements to Beneficiaries. (p. 16-4, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas... c) For Medicaid Managed Care and Family Health Plans... vi) The following drugs are not covered: 1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy. (p. K-23, Effective March 2019, Appendix K, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

14. Home Health Services... d) The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. Criteria for medical necessity are as follows: i) High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or ii) Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or iii) Women otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or iv) Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance use, unsafe housing and nutritional risk. Home health service visits may be provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician. All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above. The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records: i) A comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit; ii) Timely notification to treating providers and case manager concerning significant changes in the woman or infant's condition; iii) Referral and coordination with appropriate health, mental health and social services and other providers; iv) Review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and v) An appropriate discharge plan. (pp. K-26-K-27, Effective March 2019, Appendix K, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁷ App'x C.1. C.1.3. Access to Services for FHPlus Enrollees. C.1.3.b. The Contractor is responsible for... delivery... care.... regardless of whether Family Planning and Reproductive Health services are included in the Contractor's Benefit Package. (pp. C-3, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁸ App'x C.1. C.1.3. Access to Services for FHPlus Enrollees. C.1.3.b. The Contractor is responsible for . . . post-partum care, regardless of whether Family Planning and Reproductive Health services are included in the Contractor's Benefit Package. (p. C-3, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁹ Basic Benefit Package... Services covered by the MCP benefit package shall include:... g. Family planning services and supplies (p. 88, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

22. Healthcheck and Pregnancy Related Services. Healthchek, Ohio's early and periodic screening, diagnostic and treatment (EPSDT) and Pregnancy Related Services programs are outlined in OAC rules 5160:1-2-15, 5160:1-2-16, and 5160-1-14... b. Informing Members about Pregnancy Related Services (PRS): i. Upon the identification of a member as pregnant, the MCP shall deliver

to the member within 5 calendar days a PRS form as designated by ODM. ii. The MCP may be required to communicate with the member's local CDJFS agency any requests made by the member for county-coordinated services and supports (e.g. social services). (p. 29, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

42. Information Required for MCP Websites... b. The MCP provider website shall include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions:... xi. Prominent, easily understood information on its website for members and providers regarding the optimization of pregnancy outcomes. This shall include information for providers, trusted messengers (e.g., community health workers), and patients about the prevention of preterm birth through the use of progesterone treatment by linking to the Ohio Perinatal Quality Collaborative's information about progesterone best practices at (<https://www.opqc.net/prematurity-prevention?adlt=strict>) and the Ohio Department of Health's progesterone-messaging toolkit located at (GoWhenYouKnow.org). The MCP shall include a link to the official ODM notification of pregnancy and risk assessment form (PRAF 2.0) located at <https://medicaid.ohio.gov/Provider/PRAF> with a statement encouraging MCP contracted providers to complete and submit the form to assist pregnant women in maintaining Medicaid eligibility and connecting to needed services and supports (e.g., home visiting). (p. 56, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

10. Specialized Services for High Risk Populations. The MCP may provide or arrange for specialized (or nontraditional) services to be delivered via different models in the community, including home visiting, centering, community hub, community workers, etc., as appropriate, for high risk populations identified by the MCP or ODM. The MCP is responsible for ensuring that the community services are culturally competent, meet the member's needs, honor member preference, and do not duplicate other services paid for by the MCP and/or ODM. At a minimum, if a member is pregnant or capable of becoming pregnant, resides in a community serviced by a qualified community hub, has been recommended to receive HUB pathway services by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCP or ODM, the MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub: a. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and b. Care coordination performed for the purpose of ensuring that the member is linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services. (p. 163, Appendix K Quality of Care, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

Rule 5160:1-2-16, Medicaid: pregnancy related services (PRS). A) The purpose of this rule is to outline the responsibilities of the administrative agency to inform medicaid-eligible pregnant women about the benefits and importance of pregnancy related services (PRS), to make requested or needed referrals to support services, and to provide non-medical services promoting healthy birth outcomes in accordance with 42 C.F.R. 440.210 (as in effect January 1, 2014). (B) Definitions. (1) "Individual" for the purpose of this rule, means a medicaid-eligible individual who is pregnant, as verified by either self-declaration or medical verification, including the sixty days post-partum period. (2) ODM 03515 "Pregnancy Related Services Implementation Plan" (PRSIP) (rev. 1/2015) means the document submitted by an administrative agency describing how it delivers PRS to pregnant women in its county and which entity is responsible for ensuring the delivery of PRS. (3) "PRS coordinator" means the administrative agency employee who is responsible for the implementation of PRS. (4) "Support services" are non-medical services offered or provided by the administrative agency to assist the individual and may include arranging or providing transportation, making medical appointments, accompanying the individual to medical appointments, and making referrals to community and other social services. Support services will be coordinated with the individual's medicaid-contracting managed care plan (MCP), where applicable. (C) The individual (or the individual's parent(s), guardian or legal custodian, as applicable) may: (1) Complete and sign the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014) to verify understanding of PRS and Healthchek services; (2) Complete, sign, and return the ODM 03528 to identify her own and her children's need for services. (D) Administrative agency responsibilities. The administrative agency shall: (1) Inform individuals in its county about PRS within sixty days of the eligibility determination. Informing methods shall be written, oral or a combination of written and oral methods, as described below: (a) Provide the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014). (b) Provide information about: (i) The benefits and importance of early and continual prenatal and postpartum care. (ii) The services covered by PRS as described in Chapter 5160-4 of the Administrative Code. (iii) The benefits of healthchek services as described in 5160:1-2-05 of the Administrative Code. (iv) Transportation services and scheduling assistance available to individuals, if needed and upon request, in accordance with Chapter 5160-15 of the Administrative Code. (v) Availability of transportation services through the individual's MCP. The transportation services shall be provided by the administrative agency if not available from the MCP. (vi) Transportation services and scheduling assistance available to infants during the first year of life. (vii) Medical and non-medical support

services to include but not limited to: (a) "The Help Me Grow" (HMG) program; (b) The special supplemental food program for women, infants and children (WIC); (c) Maternal and child health clinics; (d) Local health departments; (e) Social services and other community services. (viii) Availability of assistance for scheduling medical appointments, as requested by the individual. (ix) A list of medicaid prenatal care providers, if requested, available to the community and/or information about medicaid-contracting MCPs. (2) Inform individuals enrolled in a MCP that they should contact the MCP for medical care options and referrals. (3) Re-inform the individual of the benefits of healthchek services as soon as possible after the infant's birth. (4) Refer the individual to support services as requested verbally, in writing, or via the ODM 03528 and ensure: (a) Referrals are made, as needed, for medical and non-medical support services. (b) Coordination between the individual, medical provider, MCP or other entity where the referral is made. (c) Transportation assistance is provided to individuals, as requested. (d) Individuals in need of non-medicaid covered medical services are referred to community, medical or other social services. This includes providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual. (5) Establish contact with the individual upon notification from the medical provider or MCP that the individual has missed appointments or there are other problems in the delivery of care and inform the individual's medical provider or MCP about the outcome of the contact. (6) Provide a copy of the ODM 03528 (if applicable) and the ODM 03535 "Prenatal Risk Assessment Form" (if applicable) (rev. 7/2014) to the individual's MCP. (7) Make a second attempt to contact the individual by alternate means if written information about PRS sent to the individual is returned as undeliverable. (8) Submit a new or amended ODM 03515 "Pregnancy Related Services Implementation Plan" (rev. 1/2015) to Ohio department of medicaid (ODM), including but not limited to, when there has been a change of agency address, director, PRS coordinator or where the responsibility for PRS is organizationally located within the agency. The ODM 03515 shall be submitted to ODM within ten business days of the change. (9) Obtain a HIPAA compliant signed authorization for release of information, ODM 03397 "Authorization for the Release or Use of Protected Health Information (PHI) or Other Confidential Information" (rev. 8/2014), when additional medical information is needed from the individual. (10) Maintain a listing of fee-for-service providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual. It is recognized that the ability of the administrative agency to recruit and maintain an adequate provider network depends on the existence of appropriate providers within a reasonable geographic area. (11) Maintain documentation in a case file for each eligible individual. The file shall consist of permanent records, either hard copy or electronically stored, containing the following information, when appropriate: (a) Copy of the ODM 03528, ODM 03535, or other referral forms received by the county; (b) Copy of correspondence received and sent; (c) Documentation of agency contacts with the individual, both attempted and established; (d) Documentation of the MCP in which the individual is enrolled; (e) Information received from another county when the individual is an intercounty transfer; (f) Documentation of all service requests, steps taken by the administrative agency, and whether the individual received services; and (g) Records of transportation services provided. (E) Each administrative agency PRS coordinator, or such coordinator's designee(s), shall attend annual and other pertinent trainings offered by ODM. Verification of attendance shall consist of documentation of roll call and sending an evaluation form to the state email box within three days of the video conference or training. Verification of attendance at onsite training shall be documented by the PRS coordinator or such coordinator's designee(s) by signing the attendance log.

¹⁰¹ 3. Authorization or Denial of Covered Services... (3) Contractor can require Members and Subcontractors to obtain Prior Authorization for Covered Services from Contractor provided that such Prior Authorization:... (ii) is in accordance with 42 CFR 438.210(4) and 42 CFR 441.20 as follows:... (b) without limiting a Member's right under Para. b, Sec. 6 of this Ex, B, Part 2 of the Contract, family planning services are provided in a manner that protects and enables a Member's freedom to choose a method of family planning (p. 53, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

6. Covered Service Components: Preventive Care, Family Planning, Sterilization & Hysterectomies and Post Hospital Extended Care... b. Family Planning Services Members may receive Covered Services for Family Planning Services from any OHA Provider as specified in the Social Security Act, Section 1905 (42 U.S.C. 1396d), 42 CFR 431.51 and as defined in OAR 410-120-0000 and 410-130-0585. In the event Members choose 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. (pp. 66-67, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁰² V. Program Requirements... 6. Self-Referral/Direct Access... 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, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Home Visiting Program The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Proposals submitted for the Home Visiting Program must encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers. I. Home Visiting Program Requirements and Goals... C. Home Visiting activities must be primarily focused on:... 10. Family planning, which includes access to counseling for available contraceptive options, childbirth-spacing education, and support to attain contraceptives if requested by mother... Q. The PH-MCO or contracted Home Visiting agency must follow-up with all provided referrals to ensure risks and needs are addressed. All families must receive information on... family planning... if needed... T. The Maternal Needs and Risk Assessment must include at a minimum the following:... family planning... (p. B(5a)-1, 5(5a)-4, Effective January 2022, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

Family Planning Services Procedure. Procedures which may be included with a Family Planning comprehensive visit, a Family Planning clinic problem visit, or a Family Planning Clinic routine visit: Insertion, implantable contraceptive capsules • Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only) • Removal, Implantable contraceptive capsules • Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only) • Destruction of vaginal lesion(s); simple, any method (females only) • Biopsy of vaginal mucosa; simple (separate procedure) (females only) • Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only) • Colposcopy (vaginocopy); separate procedure (females only)A • Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettageA • Colposcopy (vaginocopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)B • Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)B • Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only) • Cauterization of cervix; electro or thermal (females only) • Cauterization of cervix; cryocautery, initial or repeat (females only) • Cauterization of cervix; laser ablation (females only) • Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only) • Alpha-fetoprotein; serum (females only) • Nuclear molecular diagnostics; nucleic acid probe, each • Nuclear molecular diagnosis; nucleic acid probe, each • Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each • Fluorescent antibody; screen, each antibody • Immunoassay for infectious agent antibody; quantitative, not elsewhere specified • Antibody; HIV-1 • Antibody; HIV-2 • Treponema Pallidum, confirmatory test (e.g., FTA-abs) • Culture, chlamydia • Cytopathology, any other source; preparation, screening and interpretation • Progestasert I.U.D. (females only) • Depo-Provera injection (once per 60 days) (females only) • ParaGuard I.U.D. (females only) • Hemoglobin electrophoresis (e.g., A2, S, C) • Microbial Identification, Nucleic Acid Probes, each probe used • Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

Procedures Which May Be Included with a Family Planning Clinic Problem Visit: • Gonadotropin, chorionic, (hCG); quantitative • Gonadotropin, chorionic, (hCG); qualitative • Syphilis test; qualitative (e.g., VDRL, RPR, ART) • Culture, bacterial, definitive; any other source • Culture, bacterial, any source; anaerobic (isolation) • Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography • Culture, bacterial, urine; quantitative, colony count • Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection • Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types • Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes) • Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites • Smear, primary source, with interpretation; wet and dry mount, for ova and parasites • Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision • Level IV - Surgical pathology, gross and microscopic examination • 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) • Breast cancer screen (females only) • Mammography, bilateral (females only) • Genetic Risk Assessment (p. F-1 – F-3, Effective January 2022, Exhibit F, Pennsylvania HealthChoices Physical Health Agreement)

Opioid Use Disorder Centers of Excellence... C. The following services, when provided as clinically appropriate and included or reflected in the individual member's care plan, constitute community-based care management services covered by procedure code G9012... 3. Referrals Facilitating referrals to necessary and appropriate clinical services according to the member's care plan, including:... 2... Family Planning Services (p. G-2, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

PH-MCO Member Handbook... B. In compliance with 42 C.F.R. §438.10(g), the content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. At a minimum, the Member handbook shall include:... 7. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PH-MCO cannot require a Member to obtain a referral before choosing a family planning provider. (p. DD-2, Effective January 2022, Exhibit DD, Pennsylvania HealthChoices Physical Health Agreement)

¹⁰³ 15. New Member Orientation The PH-MCO must have written policies and procedures for new Members or a written orientation plan or program that includes: Orienting new Members to their benefits (e.g., prenatal care...) (p. 76, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Home Visiting Program... I. Home Visiting Program Requirements and Goals... C. Home Visiting activities must be primarily focused on: 1. Maternal... promotion and prevention 2. Parent/caregiver education and support... 8. Reducing disparities in perinatal health... 12. Increasing screenings for Maternal/Caregiver depression and anxiety... D. The objective of the Home Visiting Program is to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality, especially in individuals identified to be at risk... R. The home visitor must complete maternal... risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. The plan of care addresses the family's needs, applies the family's strengths and is outcome focused. The plan of care includes family-specific objectives, interventions and goals based on identified needs and risks. If any safety concerns are identified for the parent/caregiver or child, a safety plan must be included... T. The Maternal Needs and Risk Assessment must include at a minimum the following: demographic information, pregnancy health history, chronic disease health history, other health history (sexually transmitted infections, prescription drugs, oral health), family planning, prenatal care, nutrition, breastfeeding, tobacco, alcohol and drug use, stressors, social support, mental health (depression, anxiety), intimate partner violence and social determinants of health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), and parenting... V. The following domains must be addressed in assessments for all families:... Perinatal and Child Health Outcomes: Examples of factors that indicate risks under this domain include mother's utilization of adequate and timely prenatal care, was the mother counseled about family planning options, is the mother breastfeeding, current or past maternal postpartum depression, infant preterm birth, low birth weight, NICU admission and status of well child visit utilization... W. The Home Visiting Program must minimally address the following: 1. Maternal Physical Assessment 2. Infant Physical Assessment 3. Maternal Depression and Anxiety Screening 4. Childbirth Preparation including obtaining prenatal care if needed 5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol) 6. Tobacco Use Assessment 7. Lactation Care 8. Parent/Caregiver-Infant Care and interaction 9. Well Child Screening and Visits Assessment 10. Family Planning 11. Home Assessment 12. Intimate Partner/Interpersonal Violence Risk Assessment 13. Parent/Caregiver Skills Education 14. Positive Parenting Practices 15. Nutrition Counseling 16. Physical recovery from birth 17. Chronic disease management 18. Health promotion 19. Postpartum health 20. Safe Sleep practices 21. Assessment and Development of Home Visiting Plan 22. Social Determinants of Health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain) 23. Referral to support programs (Home Visiting Programs, Health coverage, SNAP, housing, employment, transportation, WIC) 24. Child Safety Education 25. Child Development Screening 26. Age Appropriate Immunizations 27. EPSDT scheduling and education 28. Early language and literacy activities 29. Maternal and Infant Lead Screening and education (p. B(5a)-2, B(5a)-4-6, Effective January 2022, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

¹⁰⁴ Ex.B(5a). The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Ex.B(5a).I. Home Visiting Program Requirements and Goals. Ex.B(5a).I.C. Home Visiting activities must be primarily be focused on: Ex.B(5a).I.C.1. Maternal and Infant Health promotion and prevention . . . Ex.B.(5a).I.C.11. Increasing postpartum healthcare visits. Ex.B.(5a).I.C.12. Increasing screenings for Maternal/Caregiver depression and anxiety; Ex.B(5a).I.W. The Home Visiting Program must minimally address the following: 16. Physical recovery from birth. (pp. B(5a)-1, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

¹⁰⁵ 2.05.02.02 Enrollment in Extended Family Planning The Contractor agrees to offer an Extended Family Planning program (with premiums to be paid by EOHHS for women up to two hundred fifty percent (250%) FPL to persons who obtain Title XIX eligibility due to a pregnancy ("SOBRA-Extension" eligible) and who would lose eligibility sixty (60) days post-partum or sixty (60) days

following birth or loss of the pregnancy. EOHHS will notify the Contractor of a member's change of eligibility to Extended Family Planning. The Contractor must have written policies and procedures for informing eligible members of this benefit. (p. 58, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.05.10.01 Required information The New Member packet will be written at no higher than a sixth-grade level and contain at least the following:... Information that enrollment Medicaid Managed Care does not restrict the choice of provider from whom the member may receive family planning services and supplies... Members may obtain benefits, including family planning services, from out-of-network providers. (pp. 63-64, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.06.01 Description of Comprehensive Benefit Package 2.06.01.01 General... The comprehensive benefit package includes Medically Necessary... family planning services... (p. 73, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

Prenatal Tracking, Follow-up and Outreach The Contractor agrees to have written policies and procedures for educating enrollees about the importance of early prenatal care and is encouraged to offer incentives to women who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits. In addition, the Contractor agrees to do the following:... Ensure that family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six week post-partum visit. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

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. These policies and procedures must also include that members may see out of network providers for these services. (p. 109, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.09.06 Access for Women The Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services and supplies. (pp. 118-119, Effective January 202, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.12.03.02 Utilization Review... The Contractor is permitted to conduct utilization review and place appropriate limits on services supporting member with ongoing or chronic conditions so long as services are authorized in a manner that reflects the member's ongoing needs for such services and supports. The Contractor may also conduct utilization review for family planning services but only in a manner that protects the member's freedom to choose their method of family planning. (p. 129, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.12.03.04 Confidentiality... The Contractor will have available in its network providers willing to provide confidential family planning and STI services to adolescents. (p. 134, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS Services below are covered for all members based on medical necessity criteria. Contractor is responsible for ensuring access and quality of care to services listed in ATTACHMENT A. The Contractor will provide services which increase the member's opportunities to remain at home and out of an institutional setting. The Contractor

is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health. The Contractor will recognize that services in entitled "scope of benefits" are provided as examples and do not represent an all-inclusive list of benefits.... SERVICE: Family Planning Services... SCOPE OF BENEFIT (ANNUAL) Including but not limited to:... 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 F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription. (p. 272, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

ATTACHMENT F Extended Family Planning Program 1. Eligibility Requirements. Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, meeting the eligibility criteria below into the demonstration who have a family income at or below 253 percent of the FPL and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP). Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 253 percent of the FPL at the time of annual redetermination are auto enrolled in the Extended Family Planning group. 2. Primary Care Referral. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services. 3. Eligibility Redeterminations. The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the State's option, redeterminations may be administrative in nature. 4. Disenrollment from the Extended Family Planning Program. If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program. 5. Extended Family Planning Program Benefits. Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including: a. Approved methods of contraception; b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams; Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception. c. Members covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription d. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and e. Contraceptive management, patient education, and counseling. 6. Family Planning-Related Benefits. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning related services and supplies include: a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered. c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered. d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer. e. Treatment of major complications (including anesthesia) arising from a family planning procedure such as: i. i. Treatment of a perforated uterus due to an intrauterine device insertion; Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or i. Treatment of surgical or anesthesia-related complications during a sterilization procedure. 7. Services. Services provided through the Extended Family Planning program are paid either through a capitated managed care delivery system or fee for service (FFS). (pp. 300-302, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁶ 2.06. IN-PLAN SERVICES. 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. Prenatal Tracking, Follow-up and Outreach. The Contractor agrees to have written policies and procedures for educating enrollees about the importance of early prenatal care and is encouraged to offer incentives to women who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits.

Tobacco Cessation The Contractor agrees to have written policies and procedures to assess members for smoking behavior, particularly... pregnant women... The Contractor will arrange for tobacco cessation programs and services to be offered to all members at convenient times and in accessible locations and will cover tobacco cessation supplies specified in ATTACHMENT A. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.07.06.02 Adolescent Self-Sufficiency Collaborative Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. The ASSC provides: (1) case management services, including home visiting, and intensive case management to minor parents focusing on parenting education and life-skills development;... (pp. 90-91, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.09.08 Health Risk Assessments For all members, the Contractor will conduct a Health Risk Assessment with the member, caregiver or guardian. The Health Risk Assessment will be used to identify members who require short term care coordination or intensive care management for medical, behavioral or social needs. The Contractor will:... (2) ensure the administration of the Health Risk Assessment to pregnant women and members with complex and serious medical or behavioral conditions within thirty (30) days of the date of identification. (p. 119, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

B. Crisis Stabilization Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner. These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service... I. Education, Support, and Consultation to Client's Families and Other Major Supports Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:... 5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to: a) Services to help clients throughout pregnancy and the birth of a child (p. 358, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁷ 2.06. IN-PLAN SERVICES. 2.06.01.09. Enhanced Services.... In addition, the Contractor agrees to do the following: . . . Schedule or assure that its PCPs or prenatal care providers schedule a post-partum visit nor more than six (6) weeks after delivery. Ensure that family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six week post-partum visit. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.15.01.08 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. The Contractor will provide quarterly reporting regarding payments as stipulated by R.I. General Law Chapter 40-8, Section 40-8-13.4. (p. 157, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁸ 3.12.2 Member Handbook The CONTRACTOR shall:... 3.12.2.5. At a minimum, include the following information within the Member handbook:... 3.12.3.5.13. The extent to which, and how, members may obtain benefits, including Family Planning Services and supplies from out-of-network Providers: 3.12.2.5.13.1 The CONTRACTOR may not require an Enrollee to obtain a referral before choosing a Family Planning Provider. (p. 37, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

4. CORE BENEFITS AND SERVICES. 4.1.5.4. Family Planning Services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of Family Planning to be used consistent with §441.20. (p. 55, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

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, (4) health education, prevention and counseling services related to alternative birth control and prevention as prescribed and rendered by various Providers. and 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. 4.2.12.3. May encourage but not require Members to receive Family Planning Services through an in-network Provider or by appropriate referral as to promote the integration/coordination of these services. (pp. 63-64, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹⁰⁹ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include prenatal . . . services . . . for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹⁰ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include delivery. . . services . . . for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹¹ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include . . . postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹² Amend. 7. 22. Section A.2.14.1.6 shall be amended by deleting the word "and" after Section A.2.14.1.6.4 and adding a new A.2.14.1.6.5 as follows and renumbering the remaining Section accordingly, including any references thereto. 2.14.1.6.5. Assure family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. (p. 29, no date, Amendment 7, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

2.17.4 Member Handbook... 2.17.4.6 Each member handbook shall, at a minimum, be in accordance with the following guidelines:... 2.17.4.6.1 0 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract 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. 29, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

51. Section A.2.13.7 shall be amended as follows: A.2.13.7 Local Health Departments... 2.13.7.2 The CONTRACTOR shall recognize that public health nurses employed by the local health departments are appropriately trained and practice within a scope of protocols developed by the state. The protocols allow public health nurses from across the licensure spectrum to provide services specific to diagnosis, treatment and delivery of preventive services under the general, but not necessarily onsite, supervision of a physician. These services include, but may not be limited to... family planning and sexually transmitted disease treatment. TennCare is a state operated program and is not bound by Medicare policy regarding the interpretation of billing codes, therefore,

in accordance with the training and protocols the state's public health nurses practice within, the CONTRACTOR shall allow public health nurses to bill using the same CPT codes, related to the aforementioned services, as would be used if the service was delivered by an advance practice nurse. (no page, no date, Amendment 5, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

A.2.7.5 Preventive Services 2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to, ... family planning services... in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section A.2.6.7 of this Contract (see TennCare rules and regulations service codes). (p. 62, January 2014, United Healthcare Plan of the River Valley dba UnitedHealthCare Community Plan, Executed Agreement, Tennessee)

¹¹³A.2.8.4 Risk Level and Program Content and Minimum Interventions... 2.8.4.4 Low Risk 2.8.4.4.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with rising risk and chronic care needs. The goal of the cohorts is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support. The Low-Risk cohorts shall include a maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Low Risk Minimum Interventions 1. Four documented non-interactive communications each year. The communications shall address self-management education emphasizing the following: A. Increasing the members knowledge of chronic health conditions B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of health conditions E. Self-efficacy & support 2. Offering of individual support for self-management if member desires to become engaged. 3. Availability of 24/7 NurseLine. 4. Availability of health coaching.

2.8.4.4.2 Low Risk Maternity 2.8.4.4.3 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into High Risk Maternity. 2.8.4.4.4 The CONTRACTOR shall provide to members eligible for Low Risk Maternity the following minimum standard interventions:... 1. Screening for risk factors to include screening for mental health and substance use. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract. 2. One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health. 3. Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management. 4. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. 5. Referrals to appropriate community-based resources and follow-up for these referrals.

2.8.4.5 High Risk 2.8.4.5.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with high risk needs. The goal of the cohorts is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. The High Risk cohorts shall include a high risk maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition. C. Development and implementation of individualized care plan. D. Problem solving techniques E. The emotional impact of member's condition F. Self-efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs

2.8.4.6 High Risk Maternity Program 2.8.4.6.1 The CONTRACTOR shall provide to members enrolled in High Risk Maternity the following minimum standard interventions:... One interactive contact to the member per month of pregnancy to provide intense case management including the following: Development of member support relationship by face to face visit or other means as appropriate. Monthly interactive contacts to support and follow-up on patient self-management. If prenatal visits have not been kept more frequent calls are required. Comprehensive HRA to include screening for mental health and substance abuse. Development and implementation of individualized care plan to include information on pregnancy, newborn, and inter-conception health. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. Referrals to appropriate community-based resources and follow-up for these referrals. If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including Tennessee Tobacco QuitLine. (p. 44-46, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

A.2.7.5 Preventive Services 2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to,... prenatal care... These services shall be exempt from TennCare cost sharing responsibilities described in Section A.2.6.7 of this Contract (see TennCare rules and regulations for service codes). 2.7.5.2 Prenatal Care 2.7.5.2.1 The CONTRACTOR shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section A.2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections A.2.9.2.2 and A.2.9.2.3 regarding prior authorization of prenatal care. 2.7.5.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from a PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Contract. 2.7.5.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section A.2.11.4 of this Contract. (p. 62, January 2014, United Healthcare Plan of the River Valley dba UnitedHealthCare Community Plan, Executed Agreement, Tennessee)

¹¹⁴ 2.8.4 Risk Level and Program Content and Minimum Interventions... 2.8.4.4.2 Low Risk Maternity 2.8.4.4.3 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into High Risk Maternity. 2.8.4.4.4 The CONTRACTOR shall provide to members eligible for Low Risk Maternity the following minimum standard interventions:...t 4. Follow-up to assure member is established with a provider, receives...postpartum visits, and postpartum depression screening.

2.8.4.5 High Risk 2.8.4.5.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with high risk needs. The goal of the cohorts is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. The High Risk cohorts shall include a high risk maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition. C. Development and implementation of individualized care plan. D. Problem solving techniques E. The emotional impact of member's condition F. Self-efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs.

2.8.4.6 High Risk Maternity Program 2.8.4.6.1 The CONTRACTOR shall provide to members enrolled in High Risk Maternity the following minimum standard interventions:... Follow-up to assure member is established with a provider, receives...postpartum visits, and postpartum depression screening... (pp. 44-46, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹¹⁵ 8.1.22.2. Family Planning - Specific Requirements. The MCO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family services. The MCO must ensure that Members have the right to choose any Medicaid participating family planning Provider, whether the Provider chosen by the Member is in or outside the Provider Network. The MCO must provide Members access to information about available Providers of family planning services and the Member's right to choose any Medicaid family planning Provider. The MCO must provide access to confidential family planning services. The MCO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid fee-for-service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program and will reimburse Out-of-Network family planning Providers in accordance with HHSC's administrative rules. The MCO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider. The MCO

must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor. The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding state and federal laws governing Member confidentiality, including minors. Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member confidentiality for family planning services. (pp. 159–160, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; p. 8-153, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; p. 8-189, Effective March 1, 2022, Document Version 2.16, Attachment B-1 – HHSC STAR Health MCO RFP, Section 8, Texas).

8.1.24.2 Family Planning – Specific Requirements... As described in Section 8.1.33, the MCO must also have procedures in place to educate the following Members about family planning programs, including the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs: 1. Pregnant Women in Medicaid who will lose eligibility after delivery 2. Young pregnant adults in Children's Medicaid who will have aged out of Children's Medicaid by the time of delivery (p. 8-153, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

8.1.33 Coordination with Other State Health and Human Services Programs The MCO must coordinate with other state Health and Human Services (HHS) Programs in each Service Area, or each Texas Health and Human Service Region, regarding the provision of essential public healthcare services. The MCO must meet the following requirements:... 13. Educate Providers and Members about primary and family planning services available through the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs (p. 8-189, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

¹¹⁶ 8.1.22.4. Perinatal Services. The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services: 1. Pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents; 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; Access to appropriate levels of care based on risk assessment, including emergency care. (p. 163., Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; p. 8-157, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; p. 8-167, Effective March 1, 2022, Document Version 2.16, Attachment B-1 – HHSC STAR Health MCO RFP, Section 8, Texas)

¹¹⁷ Services included under the MCO capitation payment... Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center... 21. Prenatal Care (pp. 7-8, Effective March 1, 2022, Document Revision V1.39, Attachment B-2 – STAR+PLUS, Dallas and Tarrant Service Areas RFP, STAR+PLUS, Covered Services; pp. 3-4, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; pp. 4-5, Effective March 1, 2022, Document V2.16, Attachment B-2 – HHSC STAR Health MCO RFP, STAR Health Covered Services, Texas)

8.1.22.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; 3. Access to appropriate levels of care based on risk assessment, including emergency care; 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of

dealing with complicated perinatal problems; and 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services... The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include service management under Section 8.1.13 and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate... The MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born... The MCO must notify Providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network Providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises. (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; pp. 8-157-8-158, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

8.1.22.11 Case Management for Children and Pregnant Women The MCO must coordinate services with Case Management for Children and Pregnant Women. This coordination includes, but is not limited to, client education, outreach, case collaboration and referrals to Case Management for Children and Pregnant Women. The MCO is required to follow referral procedures as outlined by the State. Referrals to Case Management for Children and Pregnant Women are to be based upon guidelines provided by the State, assessment, plan of care, change in client's physical, mental or psychosocial condition or at client's request. Annually, all MCO Care Coordination/Case Management Staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion. (p. 167, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions, pp. 8-167-8-168, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

¹¹⁸ 8.1.22.4. Perinatal Services... The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the Newborn Member, and may not place limits on the duration of such care. (p. 164, Effective March 1, 2022, Document Revision V1.39, Attachment B-2 – STAR+PLUS, Dallas and Tarrant Service Areas RFP, STAR+PLUS, Covered Service; p. 8-158, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; Texas)

¹¹⁹ 8.1.22.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; 3. Access to appropriate levels of care based on risk assessment, including emergency care; 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services... The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include service management under Section 8.1.13 and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate... The MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born... The MCO must notify Providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network Providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises. (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; pp. 8-157-8-158, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

¹²⁰ 3.5 Member Orientation 3.5.1 Initial Contact - General Orientation (A) Within 30 days of Enrollment, the Contractor shall conduct an in-person welcome intake visit with the Enrollee. During the welcome intake visit the Contractor shall:... (6) explain the availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Non-Network Providers; (pp. 21-22, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 21, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE); (p. 23, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

3.6.5 Enrollee Handbook... (C) The Enrollee handbook shall contain information:... (17) on the extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from Non-Network Providers; (18) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider; (p. 26, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 24, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE); (p. 29, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

4.1 General Provisions 4.1.1 Basic Standards... (E) The Contractor may place appropriate limits on a service on the basis of criteria applied under the State Plan such as Medical Necessity, or for the purpose of utilization control, provided:... (3) family planning services are provided in a manner that protects and enables an Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. (p. 33, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 311, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE))

1.3.25 Family Planning Services (A) Family planning services are Covered Services. Family planning services include disseminating information, counseling, and treatments relating to family planning services. (B) Family planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law. (C) Birth control services include information and instructions related to the following: (1) birth control pills; (2) Norplant (removal only); (3) Depo Provera; (4) IUDs; (5) barrier methods including diaphragms, male and female condoms, and cervical caps; (6) vasectomy or tubal ligations; (7) NuvaRing®; and (8) office calls, examinations, or counseling related to contraceptive devices. (D) Family planning Covered Services for Non-Traditional Enrollees are the same as Traditional Enrollees family planning Covered Services except the following are not Covered Services: (1) Norplant; (2) infertility drugs; (3) in-vitro fertilization; and (4) genetic counseling. (p. 10, Effective July 2021, Attachment C – Covered Services, Utah Medicaid HOME Program Contract; p. 9, Effective January 2018, Attachment C – Traditional, pp. 9-10, Attachment D – Non-Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

1.18 Family Planning Services This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law. The following family planning services are not covered: (A) Norplant (B) Infertility drugs (C) In-vitro fertilization (D) Genetic counseling (no page #, Effective July 2021, Molina CHIP Attachment C – Covered Services, Utah CHIP Model Contract Managed Care Entity (MCE))

¹²¹ 1.3.25 High-Risk Prenatal Services... (B)... Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others. (p. 10, Effective January 2018, Attachment C – Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹²² 1.3.25 High-Risk Prenatal Services (A) The Contractor shall ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility. (B) In the determination of the Provider and facility to which a high risk prenatal Enrollee shall be referred, care shall be taken to ensure that the Provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as

impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others. (C) Enrollees who are pregnant shall be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not be moderate or high risk shall be evaluated for change in risk status throughout their pregnancy. (D) The Contractor shall have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers shall be consistent with standards of practice and linked to the Contractor's care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care providers shall be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy. (E) The Contractor's healthy pregnancy programs shall also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The Contractor shall refer to and coordinate care with the prenatal care providers concerning the treatment plan and risk factors. The Contractor's risk assessments shall be overseen by the Contractor's Medical Director. (F) Assessment tools used by prenatal care providers and the Contractor shall include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the Contractor and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care. (G) The Department recommends Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The Department recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk shall receive care coordination/case management services. (H) The Department recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on: (1) evidence of clinical hepatitis during pregnancy; (2) injection drug use; (3) occurrence during pregnancy or a history of STDs; or (4) judgment of the health care provider. (I) When a woman is found to be HBsAg-positive, the Contractor shall provide HBIG and HB vaccine at birth. Initial treatments shall be given during the first 12 hours of life. The Contractor shall comply with all other requirements as specified in Utah Administrative Code R386-702-9. (J) The Department recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Health Code 26-6-20. Testing for STDs shall be repeated in the 3rd trimester for Enrollees at high risk for exposure. (K) The Department also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The Contractor shall encourage providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to: (1) universal testing with an opt-out approach (testing of all pregnant women and not just those who appear to be at high risk for HIV; (2) flexibility in the consent process; and (3) prevention and referral through education during prenatal care. (L) Prenatal care providers shall have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy shall be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive shall receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns. (M) Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women: (1) perinatal care coordination (T1017) (2) prenatal and postnatal home visits (3) group prenatal and postnatal education (4) nutritional assessment and counseling (5) prenatal and postnatal psychosocial counseling (N) Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness shall be referred to an appropriate mental health care provider. (pp. 10-12, Effective January 2018, Attachment C – Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹²³⁴ 4.5 Covered Services, Maternity 4.5.1 Maternity Stays (A) The Contractor is responsible for paying for and providing post-delivery care services to an Enrollee and their newborn as follows: (1) inpatient care for a minimum of 48 hours of inpatient care following a normal vaginal delivery; (2) inpatient care for a minimum of 96 hours of inpatient care following a caesarean section; and (3) the Contractor shall not require the Provider attending the Enrollee and their newborn to obtain authorization from the Contractor in order to keep the Enrollee and their newborn in the inpatient setting for the periods of time described in Article 4.5.1 (A)(1) or (2). (B) The Contractor shall not be required to provide coverage for post-delivery inpatient care for an Enrollee and their newborn during the periods described in Article 4.5.1(A)(1) or (2) if: (1) the attending Provider, in consultation with the Enrollee, discharges the Enrollee and the newborn prior to the expiration of the time periods described in Article 4.5.1(A)(1) or (2); and (2) the Contractor provides Timely Post-Delivery Follow-Up Care. (C) Post-delivery care shall be provided to a Enrollee and their newborn by a

registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in a hospital. (p. 35, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE))

¹²⁴ 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)]... 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. 120, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.1. L Out-of-Network Services... b. The Contractor shall cover and pay for... family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract. (p. 138, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.1.N Out-of-State Services The Contractor is not responsible for services obtained outside the Commonwealth except under the following circumstances:... b. Family planning where it is a general practice for members in a particular locality to use medical resources in another State (p. 140, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2 Covered Services... The Contractor shall ensure that coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210:... 5. The Contractor shall ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20; (p. 147, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

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. In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 CFR § 431.51(b)(2), as amended, the Contractor may not restrict a member's choice of provider for family planning services, drugs, supplies, or devices. Federal law (42 CFR § 441.20) requires that the Contractor also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. Code of Virginia § 54.1-2969 (E), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization. As required by section 1902(a)(23)(B) of the Act, the Contractor cannot require the member to obtain a referral prior to choosing a provider for family planning services. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral. 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. Outpatient Coverage The Contractor must provide coverage for all LARC devices, The Contractor shall not impose service authorization requirements or quantity limits on LARCs. The Contractor shall reimburse practitioners for evaluation/management (E/M) visits, where the practitioner and member discuss contraceptive options, in addition to same day LARC insertion or removal procedures. The Contractor must reimburse practitioners for LARC devices and procedures at a rate no less than the Medicaid fee schedule. (pp. 172-173, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2. X Prenatal Care Requirements... The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g.... family planning) (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services – Part 1 – Medical Benefits.... Family Planning Services... services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its members by network and out-of-network providers. Individuals enrolled in Plan First are excluded from Medallion 4.0 program participation (unless implemented as an Enhanced Benefit as listed in the RFP). (p. 349, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Attachment III – Network Provider Agreement Requirements... At a minimum, MCO Contracts with Providers must include the following:... The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

Attachment XIV – FAMIS Addendum.. K. Family Planning FAMIS covered services include drugs and devices provided under the supervision of an in-network physician. Code of Virginia, § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization. (p. 427, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁵ 8.2.W 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: Ensure access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant women; Ensure an increase in post-partum care including maternal mental health screenings; Reduce early elective deliveries; Support lower C-Section rates; Increase family planning access; Increase HEDIS scores related to maternity; Implement Addiction and Recovery Treatment Services (ARTS), specifically for pregnant women with substance use disorder; Increase screenings for SUD for both high risk and non high risk mothers (Monthly Maternal Reports); Increase outreach and education, including the use of social media, to pregnant women; and, Collaborate with the Department on initiatives targeted to pregnant women. When the Department determines a pregnant woman's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum woman, the Contractor shall: Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290; Cover services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; and Cover prenatal and infant programs as outlined in this contract.

8.2. X Prenatal Care Requirements The Contractor shall have written policies and procedures that outline how the Contractor will provide access to prenatal services for all pregnant women, including identifying and tracking high risk members. At a minimum, the policies and procedures must outline how the following requirements will be met: Within ten (10) days of identification, the Contractor shall send information to pregnant women to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services; The Contractor shall cover all obstetric and gynecological services as stated in Section 8.2.DD; The Contractor shall ensure that the travel time and distance standards stated in Section 4.6 are met; The Contractor shall ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant members as follows:... The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g., reducing preterm birth, breast feeding, applying for WIC, safe sleep practices, and family planning), etc.; The Contractor shall ensure that every pregnant member is advised of the value of HIV testing as set forth in 12 VAC 30-50-510 and shall request that each pregnant member consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Pregnant members shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record; The Contractor shall ensure preauthorization requirements do not apply to basic prenatal care as stated in Section 8.1.D; The Contractor shall cover the services of certified nurse-midwives as stated in Section 8; The Contractor shall disseminate information about the WIC Program to potentially eligible women, infants, and children. A. Promotion and Incentives The Contractor shall promote and incent access and adherence to timely and adequate prenatal services as may be appropriate based on aid category or eligibility. B. Promotion and Incentives The Contractor shall promote and incent access and adherence to timely and adequate prenatal services as may be appropriate based on aid category or eligibility. C. Ancillary Services a. Certified

Nurse-Midwife The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260. **b. Smoking Cessation Services** The Contractor shall ensure tobacco cessation services, education, outreach and pharmacotherapy are covered for all pregnant individuals (12VAC30-50-60). **c. Day and Residential Treatment for Substance Abuse** Day and residential treatment for substance use for pregnant and postpartum women shall be covered as outlined in the ARTS requirements. **d. Expanded Prenatal Care Services** The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510: Nutritional assessment, counseling, and follow-up, as well as blood glucose meters. Addiction and recovery treatment services. Patient education in areas such as labor and delivery, Lamaze, planned parenthood, smoking cessation, substance abuse, and child rearing. Household maintenance services for pregnant women, primarily in third trimester, who need bed rest. **D. High Risk Pregnancy Requirements** The Contractor shall have written policies and procedures that outline how the Contractor differentiates pregnant women according to risk status. The methods applied to assess the risk of a pregnant member shall be evidence-based and developed in accordance with guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). At a minimum, the process must consider: The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.; Previous pregnancy complications and adverse birth outcomes; History of or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use); History of, or a current positive screen for, depression, anxiety and/or other behavioral health concerns; The member's personal safety (e.g., housing situation, violence). The Contractor shall have methods in place to monitor high-risk maternity programs and track members who are deemed by the Contractor as being "high-risk." The Contractor shall also continue to monitor, as deemed appropriate, the risk status of pregnant members not originally considered "high-risk" for potential enrollment in the Contractor's high-risk maternity programs. The Contractor shall report monthly to the Department information outlined on the Managed Care Technical Manual on the status of both their high-risk maternity programs and services rendered for all other pregnant and postpartum women. (pp. 190-192, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

g. Maternity Reporting Maternity Policies and Procedures The Contractor shall submit its maternity program policies and procedures and a plan to support positive birth outcomes to the Department in accordance with the requirements outlined in the MCTM. This report shall also include accomplishments, challenges, and partnerships during the previous contract year as well as copies of educational, training, and informational materials that the Contractor provided to OBGYNs. **Maternity Program Summary Report** The Contractor shall submit reporting related to maternity services, including measures demonstrating services for both its high-risk and non high-risk prenatal and postpartum members to the Department in accordance with the requirements outlined in the MCTM. (p. 196, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services - Part 1 - Medical Benefits... Service: Pregnancy-Related Services... The Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor shall cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements. (pp. 353-364, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁶ **8.2.S Hospital Services... e. General Obstetrical Hospital** The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and follow-up visits as set forth in 12 VAC 30-50-220. (p. 187, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

12 VAC 30-50-100:...**E. Mandatory lengths of stay. 1. Coverage for a normal, uncomplicated vaginal delivery** shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2 VAC 30-50-220... C. Maternity length of stay and early discharge. 1. If the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care," 4th Edition, August 1997, as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The mother and newborn, or the newborn alone if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of his choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments' clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

¹²⁷ 8.2.W Maternity Care... When the Department determines a pregnant woman's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum woman, the Contractor shall: Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290; (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services - Part 1 - Medical Benefits... Service: Pregnancy-Related Services... The Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor shall cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements. (pp. 353-364, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁸ 16 BENEFITS... 16.1.7 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the Enrollee's right to choose the method of family planning to be used is protected. (p. 295, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17 General Description of Contract Services... 17.1.31.4 The Contractor may enter into contractual agreements with... family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. (p. 312, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.2 Enrollee Self-Referral 17.2.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington... 17.2.4. The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to Enrollees up to the limits described herein. 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. 17.2.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or IHCP Providers as Participating Providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract. 17.2.7 The services to which an Enrollee may self-refer are: 17.2.7.1 Family planning services and supplies, and sexually transmitted disease screening and treatment services provided at participating or non-Participating Providers, including but not limited to family planning agencies, such as Planned Parenthood. 17.2.7.2... family planning services through and if provided by a local health department. 17.2.7.3...family planning... services through and if provided by a school-based health center. (p. 316, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.3.3 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL... 17.3.3.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL... 17.3.3.2.5 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. Coverage of contraceptive drugs, devices and supplies must include: 17.3.3.2.5.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA approved to be dispensed over-the-counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits. 17.3.3.2.5.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit. 17.3.3.2.5.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months. 17.3.3.2.5.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the Enrollee requests a smaller supply. 17.3.3.2.5.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs. (pp. 319-320, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹²⁹ 17.3.3 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL... 17.3.3.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL:... 17.3.3.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care; (p. 319, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.4 Excluded and Non-Contracted Services... 17.4.3 The following Covered Services are provided by the state and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication, or Contractor publications... 17.4.3.15 Prenatal Genetic Counseling (p. 329, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

Scope of Benefits... Service: Health Care Professional Services... Services include, but are not limited to: Maternity care, delivery, and newborn care services; Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers (p. 5, Exhibit M-1, Revised September 2021, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹³⁰ Scope of Benefits... Service: Health Care Professional Services... Services include, but are not limited to: Maternity care, delivery, and newborn care services; Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers (p. 5, Exhibit M-1, Revised September 2021, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹³¹ Article IV: Services A. BadgerCare Plus and/or Medicaid SSI Services... 2. Medical Necessity:... Per 42 CFR §438.210(a)(4), the HMO can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and DHS 101.03(96m) or place appropriate limits on a service for the purpose of utilization control provided that:... c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. (p. 67, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

10. Family Planning Services and Confidentiality of Family Planning Information BadgerCare Plus and Medicaid SSI Plan members: a. The HMO must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or assigned to the member. 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. c. All information and medical records relating to family planning shall be kept confidential including those of a minor. (p. 78, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... Health education and disease prevention programs, including... family planning, teen pregnancy, sexually transmitted disease prevention,... (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus and/or Medicaid SSI.) (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HMOs must meet the following requirements with regard to women at high risk of a poor birth outcome. For this purpose, these women include: Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age... 5. 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. 173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

11. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers. a. Community-Based Health Organizations The Department encourages the HMO to contract with community-based health organizations for the provision of care to BadgerCare Plus and/or Medicaid SSI members in order to ensure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services. (p. 187, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³² D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women... e. HMO Responsibilities... 3) OB Medical Home Sites... d) Provide appropriate best practice medical care for high-risk pregnant women, which may include... 4. Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens. (p. 100, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HOMs must meet the following requirements with regard to women at high risk of poor birth outcomes. For this purpose, these women include Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age... 6. The HMO must have a plan in place for interconception care to ensure that the member is healthy prior to a subsequent pregnancy. At a minimum, the plan must address the needs of high-risk women with chronic conditions such as diabetes and hypertension. (p. 174, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³³ D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services. The HMO, in partnership with the medical home sites, shall be guided by four core principles: • Having a

designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries; • Providing ongoing care over the duration of the pregnancy and postpartum period; • Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and • Coordination of care across a person's conditions, providers and settings. Additional information regarding the OB Medical Home Initiative may be found on the ForwardHealth Portal (click the link to be directed to the website): OB Medical Home Initiative 1. Requirements a. Target Population The target population for the OB Medical Home Initiative is pregnant BadgerCare Plus and Medicaid SSI members who are at high-risk for a poor birth outcome. A poor birth outcome is defined as: 1) Preterm birth – gestational age less than 37 weeks 2) Low birth weight – birth weight less than 2,500 grams (5 lbs. 8 oz.) 3) Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life 4) Stillbirth – a fetal demise after 20 weeks gestation b. Members eligible to participate in the OBMH Initiative Documentation must confirm that the member is within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria: 1) Listed on the Department's Birth Outcome Registry Network (BORN) of high-risk women 2) Less than 18 years of age 3) African American 4) Homeless 5) Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy whether the symptoms be current or historical. The reason(s) for the member's medical home eligibility must be documented in the medical record. c. Payment Structure Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department currently issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site. Medical record reviews by the Department's External Quality Review Organization (EQRO) will be used to verify eligibility. If the EQRO is unable to verify any of the criteria as required by the OB Medical Home Initiative, the clinic is ineligible for the enhanced payment for those women. To receive the initial \$1,000, at minimum, the clinic must clearly document that all the following criteria are met. The member: 1) Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy. She must also be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation). Enrollment in the OB Medical Home means being entered into the OBMH registry. 2) Has attended a minimum of 10 medical prenatal care appointments with the OB care provider, 3) Has a member centric, comprehensive care plan that has been reviewed by the member and, at minimum, the OB provider, 4) Has been continuously enrolled in the OB medical home and receiving services during her pregnancy, and 5) Has continued enrollment through 60 days postpartum, including the date of the scheduled 60 day medical postpartum visit, and any documentation of no shows or appointment refusals. The Department will issue an additional \$1,000 (for a total of \$2,000) if the mother has a healthy birth outcome as defined by the Department. Pregnancy loss prior to 20 weeks will not be eligible for the OBMH incentive, as limited care coordination and delivery of other services has occurred. Providers will still receive payment for the medical prenatal care through the usual claim submission process. d. External Quality Review The Department has established a process for verifying that members enrolled in the OB Medical Home Initiative meet the requirements. The Department's EQRO will conduct chart reviews that: 1) Verify enrolled members meet the defined contract requirements; 2) Collect data to support potential future program refinements; and 3) Collect data to support program evaluation. The HMO is responsible for working with the medical home sites, external PNCC providers, hospitals and any other care provider that may or should have documentation of OB medical home services to ensure required documentation is submitted to the Department's EQRO in a timely manner. For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH members. If the patient is not on the record review list, the EQRO will not access those records. The Department does not provide additional reimbursement to HMOs or clinics for submission of medical records. HMOs are encouraged to define responsibilities of each party, which may include reimbursement policies and reporting requirements, in their subcontracts or agreements with medical home providers. e. HMO Responsibilities 1) HMO representative The HMO must designate a staff person to oversee the execution of the OB Medical Home Initiative. The HMO designee will be responsible for representing the HMO regarding inquiries pertaining to the initiative and will be available during normal business hours. The HMO representative will be responsible for ensuring the medical home is implemented in accordance with the contract. 2) HMO Outreach and Member Engagement HMOs must actively seek to identify and engage eligible members for participation in the OBMH. At a minimum, this should include a variety of strategies, e.g., working with existing organizations having similar goals, increasing public awareness about the OB Medical Home Initiative and its services, screening new members for eligibility, reviewing the BORN report periodically and working with colleagues to develop and implement creative strategies such as health fairs or street teams. 3) OB Medical Home Sites HMOs must distribute communications from DHS to its participating clinics and are accountable for ensuring contracted OB medical home sites meet the requirements below. The OB Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must: a) Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB care provider) will work together to identify the prenatal and psychosocial needs of the member to ensure that she will have a healthy birth outcome. b) Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and wait times according to Art. V of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week. c) Use an electronic health record system to

manage patient data to: 1. Document medical home enrollment date, 2. Organize clinical information, 3. Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy, 4. Track patient test results, 5. Identify abnormal patient test results, 6. Systematically track referrals and follow up, and 7. Document birth outcomes. d) Provide appropriate best practice medical care for high-risk pregnant women, which may include: 1. Consultation from a maternal fetal specialist and close monitoring and surveillance; 2. To the extent it is covered by ForwardHealth (such as through in person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. 3. Progesterone therapy, as appropriate; 4. Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens. e) Adopt and implement evidence-based guidelines that are based on, but not limited to, screening, treatment and management of the following chronic medical conditions: 1. Asthma 2. HIV/AIDS 3. Cardiac disease 4. Diabetes mellitus 5. Hypertension 6. Pulmonary disease 7. Behavioral health, including A. Depression B. Smoking C. Substance Abuse 8. Morbid Obesity The HMO and medical home sites must have clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists and community resources. f) Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following: 1. Integrating initial and periodic screening into information gathering, 2. Incorporating identified social needs (and strengths) into the comprehensive care plan, 3. Effective strategies for addressing social factors, including the following: • Identifying pertinent community resources, including personal supports; • Referral to community health worker services; • Developing effective working/referral relationships with these resources; • Communication and information sharing (e.g., obtaining written authorization from the member where necessary); • Obtaining periodic feedback from members and community resources to ensure identified resources continue to be relevant and appropriate. 4. Systematic electronic tracking and follow-up on community and social determinants of health referrals to ensure referral completion. g) Actively support and promote patient self-management. h) Demonstrate cultural competency among provider and office staff. 4) Documentation Requirements The medical home should retain electronic documentation to support the provision of the medical home services outlined in this section of the contract. f. Care Coordination – General Requirements A key component of the OB Medical Home Initiative is the coordination of care for the member. Each medical home site must have a designated care coordinator on-site (located where the member's OB care provider is located) to do the following: 1) Establish a relationship with the member and maintain regular face-to-face contact throughout the pregnancy; 2) Communicate with the member and other care providers to identify needs and assist in developing a member-centric care plan and keeping the plan up-to-date; 3) Make referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provide follow up. The care coordinator may be an employee of the medical home site or of the HMO, under contract, or under a Memorandum of Understanding/Agreement. All care coordinators must be easily accessible on a regularly established schedule for members participating in the OB medical home. To ensure continuity of care, the care coordinator shall work with the member to obtain the appropriate release forms, and contact the office(s) of any PCP, with whom the participating member had/has an ongoing relationship, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member. HMOs and medical home sites must use the OB Medical Home Registry, provided by the Department and hosted by the Department's External Quality Review Organization, to track enrollment in the OB Medical Home. a. Information Gathering and Comprehensive Assessment of Need Prior to the development of a comprehensive care management plan, the OB care provider must communicate with pertinent health care providers, the member and others as appropriate, to identify the member's strengths and care coordination needs. Information gathering activities include: 1) Obtaining pertinent information from the initial prenatal clinic visit, the OB care provider, the member's PCP, HMO or other source; 2) Taking the member's history to identify social factors that could have a negative impact on the health and well-being of the mother and baby; 3) Identifying the member's strengths and social support. b. Comprehensive Care Plan The care coordinator must ensure that each medical home member has a comprehensive care plan. The OB care provider must be central to the development of the care plan. To the maximum extent possible, the member and the member's PCP (if different from the OB care provider) must also be included in the development of the care plan. The care plan must address the medical and non-medical needs identified during the information gathering process and must include: 1) A listing of key health and community resources specific to the member's needs; 2) A prioritized plan of action that reflects the member's preferences and goals; 3) Timeframes for addressing (and following-up on) each identified need; 4) Strategies to encourage patient self-care and adherence to treatment recommendations (e.g., assisting the member in identifying selfmanagement goals and in communicating with her obstetric care provider, offering home visits, checking in with the member between visits, referring members to group classes, and sharing culturally sensitive and appropriate materials). The care coordinator should offer home visits. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members, who decline the initial offer, should be asked again throughout the pregnancy. The offer attempts and refusals must be documented in the medical record. The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, and any home visiting agency/provider the member may be working with, to track progress on the care plan and ensure coordinated care. The care plan must be developed by the OB care provider, the care coordinator, and the member. The provider must attest to the agreement and understanding

of the care plan by the respective parties and document, including the date, within the EHR. The plan must be reviewed and updated as the member's health and circumstances change. c. Ongoing Monitoring and Follow-up Ongoing monitoring and follow-up include activities and contacts that are necessary to implement and maintain the care plan. These activities include: 1) Ensuring services are being furnished in accordance with the member's care plan; 2) Making referrals, which includes related activities such as assisting with scheduling follow-up appointments; 3) Tracking and following up on all referrals, including referrals to community resources; 4) Flagging critical referrals to ensure immediate follow-up on overdue reports (e.g., following up on laboratory and imaging results to determine the need for additional services). a) Referrals are not complete without timely follow up with the member and/or with the service provider to track the results of the referral. 5) Communicating with the member, the OB care provider and other individuals instrumental to the member's care and support, to assess the usefulness of key community resources and to ensure the care plan is meeting the member's needs. 6) Reviewing and updating the care plan, as necessary, following each health care encounter or home visit. 7) Assisting in removing barriers to care, e.g., offering flexible scheduling and assessing and addressing communication gap between the health care provider and the member. d. Transition Plan (Transfer of Care) All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care: 1) Engage the member in the transfer of care, to the maximum extent possible. 2) Collaborate with the HMO to ensure continuity of care for the mother and newborn following medical home discharge. For example, the medical home could summarize and share issues related to the need for ongoing support, outstanding test results, community referrals, upcoming appointments, and any unmet needs or concerns from the member's care plan. 3) Ensure that each member has a transition plan, as described below. a) Healthy Birth Outcome If the member has a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period: 1. The member shall have at least one postpartum followup appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines. 2. Ensure that the member is connected to a PCP and has an appointment as appropriate with a PCP. 3. Ensure that the member has identified a PCP for the newborn and has made an initial appointment. 4. The care coordinator shall contact the member's PCP to inform her/him of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum. 5. The care coordinator shall educate the member on interconception care specific to her needs. b) Poor Birth Outcome In addition to items listed under healthy birth outcome above, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following: 1. Working with the OB medical home site to develop a care plan for the infant and the mother that incorporates input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs. 2. Conduct follow up with the mother to ensure that the initial referral appointments with other providers are kept. 3. To the extent feasible, maintain ongoing contact with the mother following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow up ends when the member is no longer enrolled in the HMO. (pp. 95-106, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 5. Health education and disease prevention programs, including... prenatal care,... parenting skills... breast feeding promotion and support... (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

K. Additional Services for Pregnant Women 1. Tobacco Cessation The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the postpartum visit. 2. Mental Health and Substance Abuse Screening Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant women (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components: a. Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems. b. Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders. 3. Vaccines for Pregnant and Postpartum Women The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed. (pp. 172-173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HMOs must meet the following requirements with regard to women at high risk of a poor birth outcome. For this purpose, these women include: • Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age 1. The BadgerCare Plus HMO must implement the OB Medical Home initiative as detailed in Article IV, D of the contract, in the following counties: Dane, Rock, Milwaukee, Kenosha, Racine, Ozaukee, Washington, Waukesha. Medicaid SSI HMOs may choose to enroll Medicaid SSI pregnant women in participating clinics in these counties. 2. The HMO's Medical Director, or Department-approved representative, must participate in DHS' sponsored quality efforts during the period of the contract (e.g., best practices seminars). 3. The HMO must have a plan in place to identify women at high risk of a poor birth outcome. The plan must specifically address options for identifying high-risk women previously unknown to the BadgerCare Plus and Medicaid SSI program, (e.g., use of pregnancy notification form). The HMO may use the Department's Birth Outcome Registry Network (BORN) to identify women who are at risk of having a poor birth outcome or had a previous poor birth outcome. 4. The HMO must ensure that these members receive early and continuous care throughout the pregnancy and post-partum period. The HMO must ensure that appropriate referrals and timely follow-up are made for all identified needs (e.g. nutrition counseling, smoking cessation, or behavioral health). (p. 173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

10. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers... e. Prenatal Care Coordination (PNCC) Agencies The HMO must sign a memorandum of understanding (MOU) with all agencies in the HMO service area that are BadgerCare Plus-enrolled PNCC agencies. The purpose of the MOU is to ensure coordination of care between the HMO that provides medical services, and the PNCC agency that provides care coordination to ensure women are linked to the medical and non-medical services they need to have a healthy pregnancy outcome. In addition, the HMO must assign an HMO representative to interface with the care coordinator from the PNCC agency. The HMO representative shall work with the care coordinator to identify what BadgerCare Plus covered services, in conjunction with other identified social services, are to be provided to the member. The HMO is not liable for medical services outside of their provider network by the care coordinator unless prior authorized by the HMO. In addition, the HMO is not required to pay for services provided directly to the PNCC provider. The Department pays such services on a FFS basis. (p. 189, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁴ G. Utilization Management (UM)... Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement. (p. 166, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁵ K. Additional Services for Pregnant Women 1. Tobacco Cessation The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the postpartum visit... 3. Vaccines for Pregnant and Postpartum Women The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed. (pp. 172-173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the

prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services... d. Transition Plan (Transition of Care) All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care:... 3) Ensure that each member has a transition plan, as described below. a) Healthy Birth Outcome If the member has a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period: 1. The member shall have at least one postpartum followup appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines. (p. 95, 104-105, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract) **See "Prenatal Care" column for more details.**

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 4. Information on recommended checkups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such health problems as... postpartum depression. 5. Health education and disease prevention programs, including... postpartum depression... postpartum weight loss... (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁶ 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; followup 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, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

4.10 Utilization Review and Control In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid State Plan, such as medical necessity or for the purpose of utilization control, provided that:... 3. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used. (p. 19, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

1.2.4 Family Planning In accordance with 42 CFR §438.206(b)(7), 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.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. 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. The MCO may, however, at its discretion, impose a withhold on a contracted primary care provider for such family planning services. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services. 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. In addition, MCOs must ensure that network procedures for accessing family planning services are convenient and easily comprehensible to enrollees. MCOs must also educate enrollees regarding the positive impact of coordinated care on their health outcomes, so enrollees will prefer to access in-network services or, if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care. In addition, MCOs are required to provide timely reimbursement for out-of-network family planning and related STD services consistent with services covered in their contracts. The reimbursement must be provided at least at the applicable West Virginia Medicaid FFS rate appropriate to the provider type (current family planning services fee schedule available from BMS). The MCO, its staff, contracted providers and its

contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must keep family planning information and records confidential in favor of the individual patient, even if the patient is a minor. The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews, or coordination of benefits or subrogation must also keep family planning information and records received from non-participating providers confidential in favor of the individual patient even if the patient is a minor. Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services. 1.2.4.1 Conditions for Out-of-Network Reimbursement of Family Planning Services All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to Medicaid enrollees: 1. The family planning provider must be qualified to provide family planning services based on licensed scope of practice; 2. The family planning provider must submit claims on appropriate MCO-specific billing forms; and 3. The family planning provider must provide medical records sufficient to allow the MCO to meet its case management responsibilities. If an enrollee refuses the release of medical information, the out-of-network provider must submit documentation of such refusal. In order to avoid duplication of services, promote continuity of care, and achieve the optimum clinical outcome for Medicaid enrollees, MCOs must encourage out-of-network family planning providers to coordinate services with MCO providers and to educate MCO enrollees to return to MCO providers for continuity of care. If a non-participating provider of family planning services detects a problem outside of the scope of services listed above, the provider must refer the enrollee back to the MCO. Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The MCO is not responsible for the confidentiality of medical records maintained by non-participating providers. 1.2.4.2 Tubal Ligation In accordance with Senate Bill 716, the DHHR shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure. Tubal ligation services are excluded from MCOs' capitation rates but will remain covered Medicaid services for persons who are enrolled in MCOs. DHHR shall pay claims for tubal ligation on an FFS basis in accordance with West Virginia Department of Health and Human Resources, Bureau for Medical Services Policy 519.15, Women's Health Services. Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity. (pp. 60-62, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.7.3 Out-of-Network Services Subject to Article III, Section 2.7, Timely Payment Requirement, the MCO must make timely payment within thirty (30) calendar days for clean claims to out-of-network providers for Medically Necessary, covered services when:... 2. Services were for family planning and sexually transmitted diseases; (p. 86, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3.4.3.1 Enrollee Handbook Requirements The handbook must include the following information which must adhere to the standards set forth in this contract:... 10. 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. 99, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

5.3.3 Coordination of Care with Other Entities 5.3.3.1 Family Planning Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume one hundred percent (100%) financial risk for these services. BMS will not be responsible for any lapse in reimbursement for family planning services. Through its reimbursement of other providers, the MCO will be able to monitor enrollees' utilization of such services. Additionally, the MCO will ask in-network providers to educate enrollees about the release of necessary medical data to the MCO. The MCO must ensure that enrollees who seek family planning services from the plan are provided with counseling regarding methods of contraception; HIV and sexually transmitted diseases and risk-reduction practices; and options to pregnant enrollees who may wish to terminate their pregnancies. The MCO will make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to BMS. Pursuant to West Virginia Code §16-2B-1, the MCO shall not require multiple office visits or prior authorizations for a woman who selects long-acting reversible contraceptive (LARC) methods unless Medically Necessary. The MCO shall provide payment for LARC devices and their insertion, maintenance, removal, and replacement. The MCO may not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Enrollees shall be able to access patient-centered education and counseling on all FDA-approved birth control methods. (pp. 122-123, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

5.4.1 Service Authorization Continuity of Care... The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider. (p. 128, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MHT Medical Service: Family Planning Services & Supplies; DEFINITION: Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy; SCOPE OF BENEFITS: All family planning providers, services, and supplies; LIMITATION ON SERVICES: Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered. (p. A-3, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁷ Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the sixty (60)-day postpartum period following the end of pregnancy; see 42 CFR §440.210(a)(3). (p. 12, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.4.6 Right from the Start (RFTS) Providers Right from the Start (RFTS) is a West Virginia State program aimed at improving early access to prenatal care and lowering infant mortality, and improved pregnancy outcomes. The RFTS eligibility criteria and services provided are available from BMS. The MCO is encouraged, but not required, to contract with RFTS providers. However, if the MCO does not contract with RFTS providers, the MCO must provide the same level and types of services as those currently available through the RFTS program. This includes access to multidisciplinary care. BMS will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional Right from the Start providers at the Medicaid fee rate. The MCO may not place prior authorization requirements on RFTS services. (p. 79, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3.5.2 Health Education and Preventive Care... The MCO must provide programs of wellness education. Such programs may include... prenatal care... care of newborn infants and programs focused on the importance of physical activity in maintaining health. Under MHT and WVHB, the MCO must provide tobacco cessation benefits for pregnant women, adults, and children respectively. The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service except for bariatric surgery which is a covered benefit under the State Plan. (p. 102, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MEDICAL SERVICE: Prescription drug; DEFINITION: Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance; SCOPE OF BENEFITS:... prenatal vitamins (p. A-17, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁸ 1.2.5 Maternity Services Under the Newborns and Mothers Health Protection Act, the MCO may not: Limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time; or Require that a provider obtain authorization from the plan before prescribing this length of stay. This requirement must not preclude the MCO from requiring prior authorization or denying coverage for elective inductions and elective C-sections. (p. 62, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁹ Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the sixty (60)-day postpartum period following the end of pregnancy; see 42 CFR §440.210(a)(3). (p. 12, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3. ENROLLMENT & ENROLLEE SERVICES... In accordance with H.B. 2266 (2021), the MCO shall provide services to pregnant women and newborns up to one (1) year postpartum, effective July 1, 2021 or as soon as federal approval has occurred. (p. 91, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MHT MEDICAL SERVICE: Right from the Start Services (RFTS); DEFINITION: Services aimed at early access to prenatal care, lower infant mortality, and improved pregnancy outcomes; SCOPE OF BENEFITS: Care coordination and enhanced prenatal care services; LIMITATION ON SERVICES: Pregnant women (including adolescent females) through sixty (60) day postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services. (p. A-6, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

Table 1. Contractor coverage and performance obligations across the continuum of maternal health

This table allows readers to view the extent to which any single state addresses any one of the major domains of managed care and maternity care services within its state purchasing agreements, as well as the actual language used by the state in addressing any maternity care domain.*

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description†	Incl. in contract	Contract provides detailed description‡	Incl. in contract	Contract provides detailed description§	Incl. in contract	Contract provides detailed description**	Incl. in contract	Contract provides detailed description††	Incl. in contract	Contract provides detailed description‡‡
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
AZ	Y	Y ¹	Y	Y ²	Y	Y ³	Y	Y ⁴	Y	Y ⁵	Y	Y ⁶
CA	Y	Y ⁷	N	N	N	N	Y	Y ⁸	Y	N	Y	Y ⁹
CO	Y	Y ¹⁰	N	N	N	N	Y	Y ¹¹	Y	N	Y	N
DC	Y	Y ¹²	N	N	N	N	Y ¹³	N	Y ¹⁴	N	Y ¹⁵	N
DE	Y	Y ¹⁶	N	N	N	N	Y	Y ¹⁷	Y	N	Y	N
FL	Y	Y ¹⁸	N	N	Y	Y ¹⁹	Y	Y ²⁰	Y	N	Y	Y ²¹
GA	Y	Y ²²	Y	Y ²³	Y	Y ²⁴	Y	Y ²⁵	Y	Y ²⁶	Y	N
HI	Y	Y ²⁷	N	N	N	N	Y	Y ²⁸	Y	Y ²⁹	Y	Y ³⁰
IA	Y	Y ³¹	N	N	N	N	Y	N	Y	N	Y	N

* Note: All language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of July 2022, unless otherwise noted.

† This includes, but is not limited to, all FDA approved birth control methods, freedom of choice provider, family planning only coverage for select individuals (SPA or waiver), and related services coverage (e.g., STI or HIV counseling, screening, and treatment, preventive services such as mammograms).

‡ This includes, but is not limited to, preconception care coverage/initiatives (e.g., use of preconception risk screening), pre-pregnancy visits, counseling, support services for planning pregnancy, or fertility assistance.

§ This includes, but is not limited to, rapid pregnancy testing and notification, obligation to rapidly schedule an appointment to begin prenatal care, or nondirective pregnancy option counseling for confirmed pregnancy.

** This includes, but is not limited to, coverage/initiatives related to pregnancy such as group prenatal care, childbirth, and infant care classes, ultrasounds, prenatal vitamins, equipment to monitor gestation diabetes mellitus (GDM), equipment to monitor preeclampsia, pregnancy loss counseling and support, or others.

†† This includes, but is not limited to, hospital births, home births, birth centers, cesarean births, early elective deliveries, or LARC coverage immediately postpartum.

‡‡ This includes, but is not limited to, postpartum visits, enhanced postpartum or interconception care initiatives (e.g., care coordination, chronic care management model), or parent and child “dyadic” interventions covered under child’s Medicaid number (e.g., maternal depression screening in well-child visits and developmental services provided jointly to parent and child).

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description [†]	Incl. in contract	Contract provides detailed description [‡]	Incl. in contract	Contract provides detailed description [§]	Incl. in contract	Contract provides detailed description ^{**}	Incl. in contract	Contract provides detailed description ^{††}	Incl. in contract	Contract provides detailed description ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
IL	Y	Y ³²	Y	Y ³³	Y ³⁴	N	Y	Y ³⁵	Y	Y ³⁶	Y	Y ³⁷
IN	Y	Y ³⁸	N	N	Y	Y ³⁹	Y	Y ⁴⁰	Y	N	Y	Y ⁴¹
KS	Y	Y ⁴²	N	N	N	N	Y	Y ⁴³	Y ⁴⁴	N	Y ⁴⁵	N
KY	Y	Y ⁴⁶	N	N	N	N	Y	Y ⁴⁷	Y	N	Y	N
LA	Y	Y ⁴⁸	Y	Y ⁴⁹	N	N	Y	Y ⁵⁰	Y	Y ⁵¹	Y	Y ⁵²
MA	Y	Y ⁵³	Y	Y ⁵⁴	N	N	Y	Y ⁵⁵	Y	N	Y ⁵⁶	N
MD	Y	Y ⁵⁷	N	N	N	N	Y	Y ⁵⁸	Y	Y ⁵⁹	Y	Y ⁶⁰
MI	Y	Y ⁶¹	Y ⁶²	N	N	N	Y	Y ⁶³	Y	N	Y ⁶⁴	N
MN	Y	Y ⁶⁵	N	N	N	N	Y	Y ⁶⁶	Y ⁶⁷	N	Y ⁶⁸	N
MO	Y	Y ⁶⁹	N	N	N	N	Y	Y ⁷⁰	Y	Y ⁷¹	Y ⁷²	N
MS	Y	Y ⁷³	N	N	N	N	Y	Y ⁷⁴	Y ⁷⁵	N	Y ⁷⁶	N
ND	Y	Y ⁷⁷	N	N	N	N	Y ⁷⁸	N	Y	N	Y	N
NE	Y	Y ⁷⁹	N	N	N	N	Y	Y ⁸⁰	Y	Y ⁸¹	Y	Y ⁸²
NH	Y	Y ⁸³	N	N	N	N	Y	Y ⁸⁴	Y	N	Y	N
NJ	Y	Y ⁸⁵	N	N	N	N	Y	Y ⁸⁶	Y	Y ⁸⁷	Y	N
NM	Y	Y ⁸⁸	N	N	N	N	Y	Y ⁸⁹	Y ⁹⁰	N	Y ⁹¹	N
NV	Y	Y ⁹²	N	N	N	N	Y	Y ⁹³	Y	N	Y	N
NY	Y	Y ⁹⁴	N	N	Y ⁹⁵	N	Y	Y ⁹⁶	Y ⁹⁷	N	Y ⁹⁸	N
OH	Y ⁹⁹	N	N	N	N	N	Y	Y ¹⁰⁰	Y	Y	Y	N
OR	Y	Y ¹⁰¹	N	N	N	N	Y	N	Y	N	Y	N
PA	Y	Y ¹⁰²	N	N	N	N	Y	Y ¹⁰³	Y	Y	Y	Y ¹⁰⁴
RI	Y	Y ¹⁰⁵	N	N	N	N	Y	Y ¹⁰⁶	N	N	Y	Y ¹⁰⁷
SC	Y	Y ¹⁰⁸	N	N	N	N	Y	Y ¹⁰⁹	Y ¹¹⁰	N	Y ¹¹¹	N
TN	Y	Y ¹¹²	N	N	N	N	Y	Y ¹¹³	N	N	Y	Y ¹¹⁴
TX	Y	Y ¹¹⁵	Y	Y ¹¹⁶	N	N	Y	Y ¹¹⁷	Y	Y ¹¹⁸	Y	Y ¹¹⁹
UT	Y	Y ¹²⁰	Y	Y ¹²¹	N	N	Y	Y ¹²²	Y	Y ¹²³	Y	N

State	Family Planning		Preconception/ Interconception Care		Early Identification of Pregnancy		Prenatal Care		Birth/Delivery		Postpartum Care	
	Incl. in contract	Contract provides detailed description [†]	Incl. in contract	Contract provides detailed description [‡]	Incl. in contract	Contract provides detailed description [§]	Incl. in contract	Contract provides detailed description ^{**}	Incl. in contract	Contract provides detailed description ^{††}	Incl. in contract	Contract provides detailed description ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
VA	Y	Y ¹²⁴	N	N	N	N	Y	Y ¹²⁵	Y	Y ¹²⁶	Y	Y ¹²⁷
WA	Y	Y ¹²⁸	N	N	N	N	Y	Y ¹²⁹	Y	Y ¹³⁰	Y	N
WI	Y	Y ¹³¹	Y ¹³²	N	N	N	Y	Y ¹³³	Y	Y ¹³⁴	Y	Y ¹³⁵
WV	Y	Y ¹³⁶ⁱ	N	N	N	N	Y	Y ¹³⁷	Y	Y ¹³⁸	Y	Y ¹³⁹
Total	Y = 39 N = 0	Y = 38 N = 1	Y = 9 N = 30	Y = 7 N = 32	Y = 6 N = 33	Y = 4 N = 35	Y = 39 N = 0	Y = 35 N = 4	Y = 37 N = 2	Y = 17 N = 22	Y = 39 N = 0	Y = 16 N = 23

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 Demonstration Waiver, 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. [42 CFR 457.1230(d), 42 CFR 438.210(a)(4)(ii)(C)]. 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, or AHCCCS will disenroll members who are seeking these services from the Contractor and assign them to another Contractor. The Contractor shall submit a Sterilization Report as specified in AMPM Policy 420 and Section F, Attachment F3, Contractor Chart of Deliverables (p.78, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates... utilization of Long Acting Reversible Contraceptives (LARC)... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

III. POLICY Family planning services and supplies, when provided by the appropriate family planning providers, are covered for members, regardless of gender, who voluntarily choose to delay or prevent pregnancy. Maternity care providers also provide family planning services and supplies. Services provided should be within each provider's training and scope of practice. Family planning services and supplies include covered medical, surgical, pharmacological, and laboratory benefits specified in this Policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available, as specified in this Policy. Members may choose to obtain family planning services and supplies from any appropriate provider regardless of whether or not the family planning service providers are network providers. The Contractor shall not require prior authorization in order to allow members to obtain family planning services and supplies from an out-of-network provider. A. AMOUNT, DURATION, AND SCOPE Members whose eligibility continues may remain with their assigned maternity provider or exercise their option to select another provider for family planning services and supplies. 1. Covered family planning services and supplies for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives): a.

Contraceptive counseling, medication, and/or supplies, including, but not limited to oral and injectable contraceptives, LARC (Long-Acting Reversible Contraceptive)(including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), diaphragms, condoms, foams, and suppositories, b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning, c. Treatment of complications resulting from contraceptive use, including emergency treatment, d. Natural family planning education or referral to qualified health professionals, e. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception),and f. Sterilization: i. Clarification related to hysteroscopic tubal sterilization: 1) Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy, and 2) At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test, the member is considered sterile. 2. Coverage for the following family planning services are as follows: a. Pregnancy screening is a covered service, b. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions, c. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for members, regardless of gender, d. Sterilization services are covered regardless of member's gender when the requirements specified in this Policy for sterilization services are met (including hysteroscopic tubal sterilizations, if available), and e. Pregnancy termination is covered only as specified in AMPM Policy 410. 3. Limitations The following are not covered for the purpose of family planning services and supplies: a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility, b. Pregnancy termination counseling, c. Pregnancy terminations except as specified in AMPM Policy 410, and d. Hysterectomies for the purpose of sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements. Refer to AMPM Policy 820 for prior authorization requirements for FFS providers. B. CONTRACTOR REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES AND SUPPLIES The Contractor shall ensure that service delivery, monitoring, and reporting requirements are met. The Contractor shall: 1. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification shall be as specified in A.R.S. § 36.2904(L). The information provided to members shall include, but is not limited to: a. A complete description of covered family planning services and supplies available, including counseling regarding availability and benefits/risks of LARC and IPLARC, b. Information advising how to request/obtain these services, c. Information that assistance with scheduling is available, d. A statement that there is no copayment or other charge for family planning services and supplies as specified in ACOM Policy 431, and e. A statement that medically necessary transportation services as specified in AMPM Policy 310-BB is available. 2. Have policies and procedures in place to ensure that family planning providers, including maternity care providers, are educated regarding covered and non-covered services, family planning services and supplies, including LARC and IPLARC options. 3. Have family planning services and supplies that are: a. Provided in a manner free from coercion or behavioral/mental pressure, b. Available and easily accessible to members, c. Provided in a manner which assures continuity and confidentiality, d. Provided by, or under the direction of, a qualified physician or practitioner, and e. Documented in the medical record. In addition, documentation shall be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning services and supplies. 4. Incorporate medical audits for family planning services within quality management activities to determine conformity with acceptable medical standards. 5. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services. 6. Have written practice guidelines that detail specific procedures for the provision of LARC/IPLARC. (For more information on LARC, see "Arizona DRG Payment Policies" on the AHCCCS website at www.azahcccs.gov). These guidelines shall be written in accordance with acceptable medical standards. 7. Implement a process to ensure that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to the eligible member to increase the member's success with the device according to the member's reproductive goals. C. PROTOCOL FOR MEMBER NOTIFICATION OF PROVIDING FAMILY PLANNING SERVICES AND CONTRACTOR REPORTING REQUIREMENTS The Contractor is responsible for providing family planning services and supplies and notifying members regarding the availability of covered services. The Contractor shall establish processes to ensure the sterilization reports specified in this Policy comply with the procedural guidelines for encounter submissions. AHCCCS will notify all members eligible under the pregnancy category who become ineligible for full health care coverage. In addition, AHCCCS will provide information about AHCCCS covered family planning services and supplies to include: 1. Member notification of these covered services shall meet the requirements in AMPM Exhibit 400-3 and the following minimum requirements: a. As specified in A.R.S. § 36-2904(L), the Contractor shall notify members of reproductive age either directly or through the appropriate Health Care Decision Maker (HCDM), whichever is most appropriate, of the specific covered family planning services and supplies available to them, and a plan to deliver those services to members who request them. Notification shall include provisions for written notification, other than the member handbook, and verbal

notification during a member's visit with the member's primary care physician or primary care practitioner, b. For pregnant members, family planning notification shall be sent by the end of the second trimester and include information on LARC/IPLARC, c. Notification of family planning services and supplies shall include provision for written notification in addition to the member handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. Refer to AMPM Exhibit 400-3 and ACOM Policy 404 and 406 for further details, d. The Contractor shall conform to confidentiality requirements as specified in 45 C.F.R. 164.522(b) (i and ii), e. Notification is to be given at least once a year and shall be completed by November 1st. For members who enroll with a Contractor after November 1st, notification shall be sent at the time of enrollment, f. Notification shall include all of the family planning services and supplies covered through AHCCCS as well as instructions to members regarding how to access these services and supplies, g. As with other member notifications, notification shall be written at an easily understood reading level, h. The communications and correspondence shall be approved by AHCCCS, i. Notification shall be presented in accordance with cultural competency requirements as specified in ACOM Policy 405, j. The Contractor shall monitor compliance to ensure that maternity care providers verbally notify members of the availability of family planning services during office visits, and k. The Contractor shall report all members less than 21 years of age, undergoing a procedure that renders the member sterilized, using Attachment B, as specified in Contract. Documentation supporting the medical necessity for the procedure shall be submitted with the reporting form. D. FEE FOR SERVICE FAMILY PLANNING PROVIDER REQUIREMENTS FFS providers of family planning services and supplies shall make referrals to appropriate medical professionals for services that are beyond the scope of family planning services. Such referrals are to be made at the family planning provider's discretion. If the member is eligible for full health care coverage, the referral must be made to an AHCCCS registered provider. E. STERILIZATION The following AHCCCS requirements regarding member consent for covered sterilization services apply to Contractors and FFS providers as specified in 42 CFR 441.250 et seq. 1. The following criteria shall be met for the sterilization of a member to occur: a. The member is at least 21 years of age at the time the consent is signed (Attachment A), b. Member has not been declared mentally incompetent, c. Voluntary consent was obtained without coercion, and d. 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent shall have been given at least 30 days before the expected date of delivery. 2. Any member requesting sterilization shall sign an appropriate consent form (Attachment A) with a witness present when the consent is obtained. Consent for sterilization is not required for the placement of LARC or IPLARC. Suitable arrangements shall be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member shall first have been given a copy of the consent form and offered factual information that includes all of the following: a. Consent form requirements as specified in 42 CFR 441.250 et seq., b. Answers to questions asked regarding the specific procedure to be performed, c. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits, d. Advice that the sterilization procedure is considered to be irreversible, e. A thorough explanation of the specific sterilization procedure to be performed, f. A description of available alternative methods, g. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used, h. A full description of the advantages or disadvantages that may be expected as a result of the sterilization, and i. Notification that sterilization cannot be performed for at least 30 days post consent. 3. Sterilization consents may NOT be obtained when a member: a. Is in labor or childbirth, b. Is seeking to obtain, or is obtaining, a pregnancy termination, or c. Is under the influence of alcohol or other substances that affect that member's state of awareness. (pp. 1-6, Effective October 1, 2022, AMPM Policy 420, AHCCCS Medical Policy Manual, Chapter 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

² Well Preventative Care: Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older; refer to AMPM Policy 411. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program; Refer to AMPM Policy 430. (p. 91, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

B. WELL-WOMAN PREVENTIVE CARE SERVICES PROVIDER REQUIREMENTS Provider requirements for well-woman preventive care services include the following: 1. Covered services included as part of a well-woman preventive care visit: An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventive

care visit is inclusive of a minimum of the following:... x. Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes: (a) Reproductive history and sexual practices, (b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake, (c) Physical activity or exercise, (d) Oral health care, (e) Chronic disease management, (f) Emotional wellness, (g) Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and (h) Recommended intervals between pregnancies... (p. 3, Effective February 2021, AMPM Policy 411, AHCCS Medical Policy Manual, Chapter 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 1. Medically necessary preconception counseling. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

³ Maternity Services: The Contractor shall provide pregnancy identification,... for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives... (p. 81, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 2. Identification of pregnancy. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁴ Maternity Services: The Contractor shall provide... prenatal care, treatment of pregnancy related conditions... for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant... Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. Refer to AMPM Policy 410... The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal HIV/AIDS testing and the availability of medical counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter, to encourage pregnant women to be tested and instructions about where to be tested. The Contractor shall report to AHCCCS the number of pregnant women who have been newly diagnosed as HIV/AIDS-positive for each quarter during the Contract Year as specified in Section F, Attachment F3, Contractor Chart of Deliverables and AMPM Policy 410. (pp. 81-82, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for... prenatal... visits... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services, 2. Physician Assistants, 3. Nurse Practitioners, 4. Certified Nurse Midwives, and 5. Licensed Midwives. Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a

certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (p. 172, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 3. Medically necessary education and prenatal services for the care of pregnancy. 4. The treatment of pregnancy-related conditions. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁵ Maternity Services: The Contractor shall provide... labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives.... Members anticipated to have a low-risk delivery, may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice..... The Contractor shall allow women and their newborns to receive no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with an agreement by the mother, may discharge the mother or newborn prior to the minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the minimum 48 or 96 hour stay, whichever is applicable. (p. 81, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries... The Contractor shall implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence. The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 5. Labor and delivery services. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁶ Maternity Services: The Contractor shall... postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant... Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice... Refer to AMPM Policy 410. p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for... postpartum visits... The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services, 2. Physician Assistants, 3. Nurse Practitioners, 4. Certified Nurse Midwives, and 5. Licensed Midwives. Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (p. 172, Amendment #9, Effective October 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY... AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age. Maternity Care Services include, but are not limited to:... 6. Postpartum Care. (p. 2, Effective September 2021, AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL, CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH)

⁷ 2. Prior Authorizations and Review Procedures Contractor shall ensure that its Prior Authorization, concurrent review and retrospective review procedures meet the following minimum requirements:... Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. (no pg #, Effective FY 17-18, Utilization Management, Exhibit A, Attachment 5, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

9. Non-Contracting Family Planning Providers' Reimbursement Contractor shall reimburse non-contracting family planning Provider at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse noncontracting family planning Provider for services listed in Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy. 10. Sexually Transmitted Disease (STD) Contractor shall reimburse local health departments and non-contracting family planning Provider at no less than the appropriate Medi-Cal FFS rate, for the diagnosis and treatment of a STD episode, as defined in PL 96-09. Contractor shall provide reimbursement only if STD treatment Provider provide treatment records or documentation of the Member's refusal to release medical records to Contractor along with billing information. 11. HIV Testing and Counseling Contractor shall reimburse local health departments and non-contracting family planning Provider at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if local health departments and non-contracting family planning Provider make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to the Contractor. (no page #, Effective FY 17-18, Provider Compensation Arrangements, Exhibit A, Attachment 8, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

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 per Exhibit A, Attachment 13, Member Services. 1) Informed Consent Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with

requirements of Title 22 CCR Sections 51305.1 and 51305.3. 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) work 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 disease 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 and (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 Contractor's Provider Network and through the out-of-Network local health department and family planning Providers. D. Minor Consent Services Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the Provider Network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to: 4) Family planning. (no page #, Effective FY 17-18, Access and Availability, Exhibit A, Attachment 9, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

A. Member Rights and Responsibilities Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, and, upon request, Potential Enrollees. 1) Contractor's written policies regarding Member rights shall include the following: h) To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services and emergency services outside the Contractor's Network pursuant to the federal law.

F. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall complete Member Services Guide to DHCS for review and approval prior to implementing. Contract shall ensure that the Member Services Guide includes the following: 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 which 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. (no page #, Effective FY 17-18, Member Services, Exhibit A, Attachment 13, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

⁸ 7. Perinatal Services A. Prenatal Care Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services. B. Risk Assessment Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health

education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risk identified shall be followed up on by appropriate interventions, which must be documented in the medical record. C. Referral to Specialists Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

See Cal. Code Regs. Tit. 22, § 51348 - Comprehensive Perinatal Services for additional information on perinatal services.

⁹ 7. Pregnant Woman A. Prenatal Care Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services. B. Risk Assessment Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risk identified shall be followed up on by appropriate interventions, which must be documented in the medical record. C. Referral to Specialists Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services.

(d) Except where a capitated health system contract entered into by the Department provides otherwise, health education services shall include, but are not limited to:... (2) Written assessments of each patient's health education status. (A) A complete initial education assessment shall be performed at the initial visit or within four weeks thereafter and shall include an evaluation of:... postpartum self-care,... (4) Postpartum assessment, development of care plan, and interventions. (e) Except where a capitated health system contract entered into by the Department provides otherwise, psychosocial services shall include, but are not limited to:... (4) Postpartum reassessment, development of a care plan, and interventions. (f) Review and revisions of the care plan shall occur during... postpartum periods on a regular basis and will be based on repeated and ongoing assessments and evaluation of the client's status. Cal. Code Regs. Tit. 22, § 51348 - Comprehensive Perinatal Services (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate, California)

¹⁰ 1.1.16. Family Planning Services... 1.1.16.1. Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. The Contractor shall reimburse out-of-network family planning services at a rate equal to Medicaid fee-for-service reimbursement rates, or the Contractor's contractual reimbursement rates, whichever is higher. No referral is required. (p. 5, Effective January 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

1.1.32. Physician Services... 1.1.32.2.7. Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/member. See Family Planning under Covered Services. (p. 10, Effective January 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹¹ 14.2. Coverage of Specific Services and Responsibilities... 14.2.2.4. Wrap Around (Fee For Service) Benefits... 14.2.2.4.2... The Contractor shall also advise post-partum or breastfeeding or pregnant women of... enhanced prenatal care services... 14.3.41. Prenatal Plus - Enhanced program for high risk pregnant women that provides a care coordinator, dietitian and mental health professional. The program is offered through four packages with approved services as listed in 10 C.C.R. 2505 – 10 §8.748. (p. 91, 95, Effective January 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹² C.5.28.4.5 The Contractor shall place appropriate limits on services for the purpose of utilization control, provided that the furnished services can reasonably achieve their purpose as required in 42 C.F.R. § 438.210 (a)(3)(i)... Family planning services shall be provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning without coercion or mental pressure to be used consistent with 42 C.F.R. § 441.20. (p. 83, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

Table A: Medicaid Covered Services... Family planning services and supplies. Benefit Limit: Covered for individuals of child-bearing age as described in § 1905(a)(4)(C) of the Act, 42 U.S.C. § 1396d(a)(4)(C). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

Table D: Alliance Covered Services... Adult Wellness Services. Furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force (USPSTF): Family planning services and supplies (p. 102, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.29.2.2 Primary Care... C.5.29.2.3 Obstetric-Gynecological Care... C.5.29.2.3.2 The Contractor shall demonstrate that its Provider Network includes family planning providers to deliver timely access to Covered Services by enrollees seeking the respective services. (p. 112, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.29.10 Women's Health... C.5.29.10.2 In accordance with 42 C.F.R. § 431.51, all Enrollees have the right to receive family planning services from a provider of their choice, whether the provider is in or out of the Contractor's network. In addition, Enrollees do not need a referral to access family planning services. 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. 120, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹³ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁴ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁵ Table A: Medicaid Covered Services... Services: Pregnancy-related services... Benefit Limit: As described in 42 C.F.R. §§ 440.210(a)(2) and 440.210(a)(3). (p. 85, Effective October 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁶ 3.4.1.4 Per 42 CFR 438.210, the Contractor may place appropriate limits on a service:... 3.4.1.4.2.3. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. (p. 53, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.4.6.5 Family Planning 3.4.6.5.1 All members, except DHCP members (see Section 3.4.4 of this Contract, above), shall be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including non-participating providers who are DMAP-enrolled providers. (p. 73, Effective 2020, Addendum 1, MCO MSA, Delaware)

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. While family planning is a benefit for DHCP members, this “freedom of choice” option does not apply to DHCP members. (p. 198, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.14.2.8 Family Planning Education 3.14.2.8.1 The Contractor must provide its members with sufficient information to allow them to make an informed choice regarding the types of family planning services available, their right to access these services in a timely and confidential manner, and the freedom of members (other than DHCP members) to choose a qualified family planning provider both within and outside the Contractor’s provider network. (p. 270, Effective 2020, Addendum 1, MCO MSA, Delaware)

¹⁷ 3.4.6.6 Prenatal Care 3.4.6.6.1 The Contractor shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The Contractor’s program shall include participation and coordination with Smart Start. (p. 73, Effective 2020, Addendum 1, MCO MSA, Delaware)

¹⁸ I. Services to be Provided... C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 2A: Required MMA Services... (13) Family Planning Services and Supplies (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies (a) The Managed Care Plan shall furnish family planning services on a voluntary and confidential basis. (b) The Managed Care Plan shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications. (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. (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.) (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

F. Quality Enhancements The Managed Care Plan shall offer QEs to enrollees as specified below:... 4. Pregnancy-Related Programs... b. The Managed Care Plan shall ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

¹⁹ Section VI. Coverage and Authorization of Services... 3. Enrollee Screening and Education a. Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care. (p. 29, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies... (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²⁰ D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by “X” in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 3: Approved Expanded Benefits... Prenatal/Perinatal Visits (p. 5, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

Section VI. Coverage and Authorization of Services... 9. Additional Care Coordination/Case Management Requirements... e. Prenatal Care The Managed Care Plan shall: (1) Require care coordination through the gestational period according to the needs of the enrollee. (2) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care. (3) Assist enrollees in making delivery arrangements, if necessary. (p. 35, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

4. Pregnancy-Related Programs a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

5. Healthy Start Services a. The Managed Care Plan shall develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants. b. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes. (p. 40, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²¹ Section VI. Coverage and Authorization of Services... (7) Family Planning Services and Supplies... (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.) (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

4. Pregnancy-Related Programs a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services. (p. 39, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²² xxvi Family Planning Services: Family planning services and supplies include at a minimum: i. Education and counseling necessary to make informed choices and understand contraceptive methods; ii. Initial and annual complete physical examinations; iii. Follow-up, brief and comprehensive visits; iv. Pregnancy testing; v. Contraceptive supplies and follow-up care; vi. Diagnosis and treatment of sexually transmitted diseases; vii. and Infertility assessment. (p. 21, no date, RFP #DCH0000100, Georgia Families Contract)

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. In meeting this obligation, the Contractor 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. The Contractor shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not limit Members' or P4HB Participants' freedom of choice for family planning services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. 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. 4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. 4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum: 4.6.4.3.1 Education and counseling necessary to make informed choices and understand contraceptive methods; 4.6.4.3.2 Initial and annual complete physical examinations including a pelvic examination and Pap test; 4.6.4.3.3 Follow-up, brief and comprehensive visits; 4.6.4.3.3 Pregnancy testing; 4.6.4.3.5 Contraceptive supplies and follow-up care; 4.6.4.3.6 Diagnosis and treatment of sexually transmitted infections with the following exceptions: P4HB participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration; 4.6.4.3.7 For P4HB participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements); and 4.6.4.3.8 Infertility assessments with the following exception – P4HB participants are excluded from receiving this benefit. 4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age. (pp. 86-87, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

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

²⁴ 4.11.10 Case Management... 4.11.10.2 Case Management functions include, but are not limited to: 4.11.10.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO; (p. 155, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁵ 4.6.9 Perinatal Services 4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members... The Contractor shall have in place a system that provides, at a minimum, the following services: 4.6.9.1.1 Pregnancy planning and perinatal health promotion and education for reproductive-age women; 4.6.9.1.2 Perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and newborns and children up to five (5) months of age. The Contractor must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination; 4.6.9.1.3 Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation and translation services if necessary pursuant to Sections 4.3.10 and 4.3.11 of this Contract; 4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care; 4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and 4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems. 4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor

and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery. (p. 93, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁶ 4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery. (p. 93, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁷ 7. Family Planning Services a. 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. The Health Plan may not restrict a Member's free choice of family planning services and supplies providers. Family planning services include family planning drugs, supplies, and devices to include, but not be limited to, any FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity. Same day access to family planning services shall be provided, as needed, with no prior authorization. b. The Health Plan shall furnish all services on a voluntary and confidential basis to all Members. (p. 150, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²⁸ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services: 1) Prenatal care; 2) Radiology, laboratory, and other diagnostic tests; 3) Treatment of missed, threatened, and incomplete abortions; 4) Delivery of the infant and post-partum care; 5) Prenatal vitamins; 6) Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports; 7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on childbirth, breastfeeding, and infant care; 10) Counseling on healthy behaviors; and 11) Inpatient hospital services, physician services, other practitioner services, and any other services that impact pregnancy outcomes. c. The Health Plan is prohibited from limiting benefits for post-partum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. The Health Plan is not permitted to require that a provider obtain authorization from the Health Plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours. d. The Health Plan is prohibited from: 1) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA); 2) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or 3) Providing incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA. e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services: 1) Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care; 2) Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary; 3) Availability and accessibility of: a) Appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating women with complex perinatal diagnoses; and b) Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses. Perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program. (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²⁹ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents...b. The following services are covered under pregnancy-related services:... 4) Delivery of the infant and post-partum care;... c. The Health Plan is prohibited from limiting benefits for post-partum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. The Health Plan is not permitted to require that a provider obtain authorization from the Health Plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours. d. The Health Plan is prohibited from: 1) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA); 2) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or 3) Providing incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁰ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services:... 4)... post-partum care... 6) Screening, diagnosis, and treatment for pregnancy- related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports; 7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on childbirth, breastfeeding, and infant care; 10) Counseling on healthy behaviors;... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services: 1) Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care; 2) Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary;... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³¹ Table D3: Iowa Family Planning Network Covered Services Family Planning Benefits: Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. • Approved methods of contraception; • Sexually transmitted infection (STI) or sexually transmitted disease (STD) testing, Pap smears and pelvic exams; • Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider; and • Contraceptive management, patient education, and counseling. The laboratory tests done during an initial family planning visit for contraception may include a Pap smear, screening tests for STIs or STDs, or pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

Family Planning Related Benefits: "Family planning-related services and supplies" are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular federal medical assistance percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was defined or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include: • Colposcopy and procedures done with or during a colposcopy or repeat Pap smear performed as a follow-up to an abnormal Pap smear that was done as part of a routine periodic family planning visit. • Drugs for the treatment of STIs or STDs, except for HIV/AIDS and hepatitis, when the STI or STD is identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs and subsequent follow-up visits to rescreen for STIs or STDs based on the Centers for Disease Control and Prevention guidelines may be covered. • Drugs or treatment for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections, where these conditions are identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs may also be covered. • Other medical diagnosis, treatment, and preventative services that are routinely provided pursuant to family planning services in a family planning setting. • Treatment of major complications arising from a family planning procedure, such as: • Treatment of a perforated uterus due to an intrauterine device insertion; • Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or • Treatment of surgical or anesthesia-related complications during a sterilization procedure. (pp. 236-237, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

³² 1.1.79 Family Planning means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services appropriately provided within the Provider's scope of practice and competence. 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. (p.19, Effective 2018, State of IL Model Contract)

5.3 Pharmacy Requirements... 5.3.1.4 Contractor may determine its own utilization controls, including, but not limited to, step therapy and prior approval, unless otherwise prohibited under this Contract, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family planning drugs and devices pursuant to Attachment XXI. (pp. 67-68, Effective 2018, State of IL Model Contract)

5.3.2.8 Contractor may determine its own utilization controls, including therapy and prior authorization, unless otherwise prohibited under this Contract, the Department's PDL, or State law, to ensure appropriate utilization. Contractor shall utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and Attachment XXI. (p. 71, Effective 2018, State of IL Model Contract)

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, Effective 2018, State of IL Model Contract)

5.21.5.7 At a minimum, the Enrollee handbook must contain: ...how and the extent to which the Enrollee may obtain direct-access services, including Family-Planning services. (Page 110, 2022 State of IL Model Contract) 5.26.3.18 All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable: ...Family Planning and counseling. (p.120, Effective 2018, State of IL Model Contract)

5.29.3 Contractor shall pay for Family-Planning services, subject to sections 5.5 and 5.29.35.6 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, Effective 2018, State of IL Model Contract)

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, Effective 2018, State of IL Model Contract)

1.1.1 These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: 1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care; 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. At a minimum, the following areas shall be monitored for all populations: ...1.1.3.1.10 utilization of Family Planning services... 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC (pp. 227-229, Attachment XI QUALITY ASSURANCE, Effective 2018, State of IL Model Contract)

1.1.9 All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (pp. 227-239, Attachment XI QUALITY ASSURANCE, Effective 2018, State of IL Model Contract)

3.1.3 Family Planning and reproductive healthcare. Contractor shall ensure provision 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. Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. 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. 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: 3.1.3.1 a reproductive

life plan, which may include a preconception care risk assessment (see HFS Form 27, *Preconception Screening Checklist*, which can be found on Illinois.gov/hfs under the *Medical Programs Forums* section) and preconception and interconception care discussions; 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; 3.1.3.2 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; 3.1.3.5 basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, if indicated. (Infertility medications and procedures are not Covered Services.); 3.1.3.6 reproductive health exam if medically necessary to determine safety and provision of contraception; 3.1.3.7 sexually transmitted infection (STI) screenings in accordance with USPSTF A and B recommendations; 3.1.3.9 lab and screening tests that are clinically necessary for safe and prudent delivery of Family Planning and reproductive health services; 3.1.3.10 Cervical, breast and other cancer screening in accordance with USPSTFs A and B recommendations; 3.1.3.11 vaccines for preventable reproductive health in accordance with current CDC recommended immunization schedule, updated annually; 3.1.3.12 genetic counseling and testing, if clinically indicated. (pp. 308-309, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS OF CARE, Effective 2018, State of IL Model Contract)

3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items...3.1.3.13.3.5 visits close to the third (3rd) trimester should include... options for postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated. 3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: ... 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as... effective Family Planning. 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning... 3.1.3.14.1 At a minimum, Contractor shall provide and document an annual exam that includes... guidance related to reproductive health issues, Family Planning and management of identified chronic diseases must be addressed. 3.1.3.14.4 Cervical and breast screening per USPSTF A and B recommendations. (pp. 311-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS OF CARE, Effective 2018, State of IL Model Contract)

³³ 3.1.3. 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: 3.1.3.1 a reproductive life plan, which may include a preconception care risk assessment (see HFS Form 27, *Preconception Screening Checklist*, which can be found on Illinois.gov/hfs under the *Medical Programs Forums* section) and preconception and interconception care discussions. 3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. (p. 308 & 313, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

³⁴ 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁵ 5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management. (p. 88, Effective 2018, State of IL Model Contract)

5.20.1.1.5 Unexpected hospitalization due to complications of pregnancy shall be covered. (p. 102, Effective 2018, State of IL Model Contract)

1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.17 describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., ... prenatal care...). (p. 224, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

1.1.2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management, Disease Management). This written description must meet federal and State requirements, as outlined below. (p. 226, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.14 timeliness and frequency of prenatal visits; 1.1.3.1.15 postpartum care rate; 1.1.3.1.16 provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests; 1.1.3.1.17 birth outcomes; 1.1.3.1.18 birth intervals; 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.21 utilization of 17P; 1.1.3.1.22 referral to the Perinatal Centers, as appropriate; 1.1.3.1.23 length of hospitalization for the mother; 1.1.3.1.24 length of hospital stay for the infant; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant. (pp.228-229, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

1.1.9. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (p. 239, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

3.1.1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services to Enrollees under the age of twenty-one (21)... 3.1.1.5 Contractor shall inform pregnant women about the availability of EPSDT services for children under age twenty-one (21), including children eligible as newborns. 3.1.1.6 Contractor shall assist pregnant women and new mothers, or their legal guardians, to enroll their newborns in Medicaid and to identify a PCP for the newborn. It is suggested that plans use HFS Form 4691 as an educational tool, but plans may use other means, including direct assistance, to help in enrollment. (p. 306, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

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: 3.1.3.13.1 a comprehensive prenatal evaluation, examination, testing, and care in accordance with the latest standards recommended by ACOG, USPSTF and other leading academic and national clinical or specialty based organizations, which shall include: ongoing risk assessment and development of an Individualized Plan of Care (IPoC) most likely to result in a successful outcome of pregnancy and a healthy baby, and takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family; 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; 3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items: 3.1.3.13.3.1 risk detection by appropriate inquiry, testing and consultation if necessary, counseling and treatment if indicated for: various chronic medical conditions including hypertension and diabetes mellitus; STI/HIV; intimate partner violence; teratogen exposure; alcohol, tobacco,

and substance use including prescription opioids and marijuana; and, to prevent when possible, potential of preeclampsia and eclampsia, a stillbirth, prematurity, low birth weight, fetal alcohol syndrome, and neonatal abstinence syndrome among other issues. Contractor must put in place and be able to demonstrate that various evidence based strategies and interventions (including 17 P and referral to substance use, alcohol and tobacco abstinence programs, when indicated) to reduce adverse maternal and birth outcomes are operational; 3.1.3.13.3.2 screening for diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools); 3.1.3.13.3.3 health maintenance promotion, with attention to nutrition, exercise, dental care, CDC recommended immunizations, management of current Chronic Health Conditions, over-the-counter and prescription medication, breastfeeding counseling, appropriate weight gain in pregnancy, obesity counseling, signs and symptoms of common pregnancy ailments and management of the same, and provision of appropriate maternal education and support, including training classes to help with childbirth, breastfeeding, and various other helpful maternity education tools, platforms and materials; 3.1.3.13.3.4 routine laboratory screening per ACOG and USPSTF recommendations, physical exam, and dating by ultrasound for accurate gestational age. Every prenatal exam at a minimum should include weight and blood pressure check, fetal growth assessment, and fetal heart rate check. Genetic screening and counseling, if indicated, should be offered depending on risk factors (Enrollee's age, previous birth history, medical/family history, and ethnic background); and 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, circumcision, newborn care, car seat, sudden infant death syndrome (SIDS), the importance of waiting at least thirty-nine (39) weeks to deliver unless medical necessity or safety of mother and fetus dictates otherwise, referral to parenting classes and WIC, and transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy; 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (pp. 309-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. 3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes. (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁶ 5.20.1.1.5 ...Routine delivery at term outside the Contracting Area, however, shall not be covered if the Enrollee is outside the Contracting Area against medical advice, unless the Enrollee is outside of the Contracting Area due to circumstances beyond her control. Contractor must educate the Enrollee regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy. (p. 102, Effective 2018, State of IL Model Contract)

1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care. (p. 225, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.17 birth outcomes... 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery. (p. 229, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

3.1.3.13.5 Contractor shall require that all contracted hospitals and birthing centers have policies in place that safely reduce c-sections and early elective deliveries (EED). (p. 312, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁷ 1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.13 describes its process to assure... follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care. (p. 225, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.15 postpartum care rate... 1.1.3.1.17 birth outcomes; 1.1.3.1.18 birth intervals; 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.22 referral to the Perinatal Centers, as appropriate; 1.1.3.1.23 length of hospitalization for the mother; 1.1.3.1.24 length of hospital stay for the infant; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant. (pp. 228-229, Attachment XI: Quality Assurance, Effective 2028, State of IL Model Contract)

1.1.9 All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.17 prenatal, obstetrical, postpartum, and reproductive healthcare. (Page 227-239, Attachment XI QUALITY ASSURANCE, 2022 State of IL Model Contract)

3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items...3.1.3.13.3.5 visits close to the third (3rd) trimester should include... options for postpartum Family Planning for selection of most appropriate and safe contraceptive method with informed consent obtained prior to labor and delivery when indicated.... transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective Family Planning, pregnancy intervals, physical activity, SIDS, and the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials and WIC; 3.1.3.13.5.2 postpartum depression screening during the one (1)-year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools). After delivery and discharge, the Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)-week postpartum visit; 3.1.3.13.5.3 Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if Medically Necessary, to avoid interruption of care; 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease; and 3.1.3.13.5.5 Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery. (pp. 312-313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.3.14 Well-woman exam: 3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes. (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

³⁸ 6.2 Self-Referral Services. ... With the exception of family planning services and emergency services, when HIP members choose to receive self-referral services from IHCP-enrolled self-referral providers, they shall go to an in-network provider or receive prior authorization to go to an out-of-network provider. The Contractor is responsible for payment for self-referral services up to the applicable benefit limits and at a rate of 100% of the Medicare rate or 130% of Medicaid if there is no Medicare rate for in-network providers. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 9-7 (HIP) provides further detail regarding these benefits. Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services. Under the Contractor's HIP line of business, the Contractor shall provide all covered family planning services and supplies. (pp.64-65, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.1 Member Handbook. The HIP member handbooks shall include the following:Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers. (p.100, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

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

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

management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p.144, Amendment #14, Effective, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential... b. Additional Maternity Payments and Incentives. FSSA will reimburse Contractor \$60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire \$60 payment to the physician that completed the NOP form on behalf of the pregnant member. For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit \$40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c. NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA. (p. 193, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁰ 3.4 Pregnancy Coverage under HIP. Effective February 1, 2018, HIP members who become pregnant will receive maternity benefits through the HIP Maternity (MAMA) benefit plan. ... The Contractor will provide pregnancy, post-partum, and HIP benefits aligned with the dates and benefits specified on the 834... . Additional guidelines regarding the Contractor's responsibility to assist pregnant members obtain and maintain coverage are located in the HIP MCE Policies and Procedures Manual. (pp. 35-36, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.1 Covered Benefits and Services. In addition, HIP will cover additional pregnancy-only benefits which will only be available for pregnant HIP members enrolled in either the HIP Plus or HIP Basic plans. The additional pregnancy-only benefits are specified in the applicable ABP and include such services as nonemergency transportation, chiropractic manipulations, vision and dental. (p. 64, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. The Contractor shall educate pregnant women and work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. (p. 66, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.8 Disease Management...6.8.1 Population-Based Interventions. ...All pregnant members shall receive standard pregnancy care educational materials, OMPP-approved tobacco cessation materials and access information for 24-Hour Nurse Call Lines. Materials should be delivered through postal and electronic direct-to-consumer contacts, including Interactive Voice Recordings (IVR), as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest shall receive materials no less than bi-annually. The Contractor shall document the number of persons with conditions of interest, mailings and website hits. (pp. 80-82, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.10 Other Covered Benefits and Services. In addition to the benefits and services listed above, the Contractor shall also cover the following: ...The Contractor shall provide prenatal care programs targeted to avert untoward outcomes in high-risk pregnancies. (p. 83, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.15 Enhanced Services. The State encourages the Contractor to cover programs that enhance the general health and well-being of its HIP members, including programs that address preventive health, risk factors or personal responsibility. Enhanced services may include, but are not limited to, such items as: Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.). (p. 86, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.17 Opioid Treatment Program (OTP). The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups. OTP coverage will include those members as defined by OMPP and approved by CMS. The MCE will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix. Eligible members include... pregnant members. (p. 89, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.1 Member Handbook. The HIP member handbooks shall include the following: ... HIP pregnancy policies, including, a description of the HIP Maternity program (MAMA). (p. 100, Amendment #14, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

8.7.3 Education for HIP Providers. The Contractor shall also educate its HIP providers about its pregnancy-related services and policies. Such education shall emphasize that members will transition to the HIP Maternity (MAMA) benefit plan. (p. 132, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.1 Quality Management and Improvement Program. The Contractor's Quality Management and Improvement Program shall: ... *Participate in any state-sponsored prenatal care coordination programs. *Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. OMPP reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include: ... prenatal care. *Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes, as described in Section 9.2.2. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments and scheduling appointments for routine and preventive services such as prenatal care, disease screenings, compliance with behavioral health drug therapy, compliance with diabetes treatment and well-child visits. (pp.139-140, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.2 Member Incentive Programs. Contractors shall establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The Contractor will determine its own methodology for providing incentives to members, subject to OMPP review and approval. For example, the Contractor may offer member incentives for: *Attending all prenatal visits. (p. 143, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

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

management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p.144, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential. ... b. Additional Maternity Payments and Incentives. FSSA will reimburse Contractor \$60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire \$60 payment to the physician that completed the NOP form on behalf of the pregnant member. For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit \$40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c. NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA. (p. 193, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴¹ 3.4 Pregnancy Coverage under HIP... As of April 1, 2022, HIP Maternity benefits will continue for a twelve (12) month temporary postpartum period which begins on the last day of pregnancy. The Contractor will provide pregnancy, postpartum, and HIP benefits aligned with the dates and benefits specified on the 834. The Contractor shall communicate regularly with the member during the postpartum period... (pp. 35-36, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.10 Other Covered Benefits and Services. In addition to the benefits and services listed above, the Contractor shall also cover the following: * The Contractor shall provide newborn health, postpartum care and parenting education. (p. 84, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.1 Quality Management and Improvement Program. The Contractor's Quality Management and Improvement Program shall: ... *Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. OMPP reserves the right to identify additional conditions at any time, as the areas reflect the needs of the Indiana Medicaid populations. These areas may vary from one year to the next and from program to program. Examples of areas of clinical priority include: ... postpartum care. (pp. 139-140, Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴² 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. 2.32.1 All medically approved services prescribed by physician/ARNP/nurse midwife and physician's assistant including diagnosis, treatment, counseling, drug, supply, or device to individuals of childbearing age shall be covered. 2.32.2 For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR § 441.250-§ 441.259. 2.32.3 Sterilizations shall be provided in accordance with the Federally mandated guidelines and consent form. 2.32.3.1 The approved Sterilization consent form can be found on the KMAP website. 2.32.3.2 The form shall be available in English and Spanish, and the CONTRACTOR(S) shall provide assistance in completing the form when an alternative form of communication is necessary. 2.32.3.3 The CONTRACTOR(S) must assure that the Federal Sterilization Consent form required by CMS in 42.CFR § 441.250 - 441.259 is properly completed as described in the instructions and a copy of the Sterilization Consent form is obtained from the performing Provider before paying the service claim. The CONTRACTOR(S) must maintain a copy of the form in the event of audit. In the event of an audit the CONTRACTOR(S) will provide additional supporting documentation to ascertain compliance with Federal and State regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders. 2.32.3.4 Hysterectomies are covered when the requirements, stated in the State Provider Manuals, State Policy and 42 CFR § 441.250-§ 441.259, are met. (p. 10, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.5.9. NON-PARTICIPATING PROVIDERS... J. Ensure that the CONTRACTOR(S)' Provider network adheres to the following: ... 3. Demonstrates that its network includes sufficient family planning Providers to ensure timely access to Covered Services. (p. 83, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

10.7. MEMBER HANDBOOK REQUIREMENTS ... E. The content of the Member Handbook must include the following: ...19. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from Non-Participating Providers. This includes an explanation that the CONTRACTOR(S) cannot require a Member to obtain a referral before choosing a family planning Provider. (p. 141, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁴³ 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: ...2.1.2 Maternity services. ...2.24 Prenatal Health Promotion/Risk Reduction Enhanced Social Work Services. (p. 2 & 9, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

2.7 Prescription Drugs...2.7.2.1 The drugs that may be excluded from coverage or otherwise restricted include: ...2.7.2.1.6 Non-prescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A) of the SSA, agents approved by the Food and Drug Administration under the over-the-counter (OTC) monograph process for purposes of promoting, and when used to promote, tobacco cessation. 2.7.2.1.5 Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations (Vitamins and minerals should be provided where medically necessary for children). (p. 3, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

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

Reports and Data Elements. For each data type and report, the CONTRACTOR(S) must provide details as to how the data is captured and submitted (file formats, etc.), as well as which system(s) house the data and the existence of any data dictionaries associated with the data elements. The CONTRACTOR(S) shall provide an example of each report type. ...Health Risk Assessments Report. Number of completed health risk assessments, as well as a summary and analysis of the information collected as it pertains to chronic conditions, preventive care, prenatal care referrals including the month a pregnant Member was identified and screened, and relevant demographic and regional information. Report to include: • Number of Members screened • Number of Members refusing screen • Number of Members unable to contact for screen • Number of Members referred for an HRA • Number of Members with an HRA completed • Number of Members refusing an HRA • Number of Members with an HRA completed telephonically or in-person. (p. 1 & 9, no date, Attachment H: Reports and Data Elements)

5.5.7. BEHAVIORAL HEALTH PROVIDER NETWORK STANDARDS. ...D. For Members presenting for SUD services: ... 5. Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within twenty-four (24) hours of assessment. When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care. (p. 79, 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁴⁴ 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: ...2.1.2 Maternity services. (p. 2, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

⁴⁵ 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: ...2.25 Postpartum/Newborn Home Visit. (p. 9, no date, Attachment C: Services, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

⁴⁶ 1.1 General Definitions. ... Family Planning Services means counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. (p. 18, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.1 Required Functions. ...Q. Facilitating direct access to ...voluntary family planning; ... and testing for HIV, HIV-related conditions and other communicable diseases. (p. 88, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.2 Enrollee Handbook. The Enrollee Handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information: ... L. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services. (p. 90, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.7 Information Materials Requirements. ...I. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services, from Out-of-Network Providers; (p. 92, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

28.2.5 Family Planning Services. The Contractor shall contract with Network Providers who are qualified by experience and training to provide Family Planning Services. (p. 119, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

28.4 Provider Network Access and Adequacy. ... B. Specific to voluntary family planning, counseling and medical services as soon as possible within a maximum of thirty (30) Days. If not possible to provide complete medical services to Enrollees less than eighteen (18) years of age on short notice, counseling and a medical appointment as immediately as possible and within ten (10) Days. (p. 121, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

29.3 Payment to Out-of-Network Providers. The Contractor shall reimburse Out-of-Network Providers in accordance with Section 29.1 “Claims Payments” for the following Covered Services: ... C. Services provided for family planning; (p. 130, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

32.6 Voluntary Family Planning. The Contractor shall ensure direct access for any Enrollee to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I “Covered Services” to this Contract. The Contractor may not restrict an Enrollee’s choice of his or her provider for Family Planning Services. The Contractor must ensure access to any qualified provider of Family Planning Services without requiring a referral from the PCP. See Section 28.4 “Provider Network Access and Adequacy” for allowable wait times for appointments. The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and court orders for Enrollees less than eighteen (18) years of age pursuant to Title X. 42 C.F.R. 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et

seq., KRS 202A et seq., and KRS 214.185. All information shall be provided to the Enrollee in a confidential manner. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will ensure the Enrollee's privacy. (p. 146, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

38.2 Confidentiality of Records The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.15 "Health Insurance Portability and Accountability Act." The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. (p.168, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

⁴⁷ 22.1 Required Functions. ...Q. Facilitating direct access to ...maternity care for Enrollees under age eighteen (18)... (p. 88, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

22.2 Enrollee Handbook. The Enrollee Handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information: ... L. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services. (p. 90, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

32.5 Maternity Care. When a woman has entered prenatal care before enrolling with the Contractor, the Contractor shall make every effort to allow her to continue with the same prenatal care provider throughout the entire pregnancy. Contractor shall also establish procedures to ensure either prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant when they enroll. The Contractor shall provide maternity care that includes prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. All newborn Enrollees newborn screening shall be covered as specified in the Commonwealth of Kentucky metabolic screen. (p. 146, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

34.3 Population Health Management Program Tools... B. Health Risk Assessments (HRA). The Contractor shall conduct HRAs as follows... 2. Within thirty (30) Days of Enrollment if the Contractor has a reasonable belief an Enrollee is pregnant. If determined pregnant, the Contractor shall refer the Enrollee for appropriate prenatal care. (p. 155, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

38.2 Confidentiality of Records The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.15 "Health Insurance Portability and Accountability Act." The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. (p. 168, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

APPENDIX D. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES ...85. Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions. Describe activities of the EPSDT staff, including outreach, education, and care management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations. (p. 243, Effective 2021, Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

⁴⁸ 6.0 CORE BENEFITS AND SERVICES. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.10. Sexually Transmitted Infection (STI) Prevention. The MCO shall address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations. (p. 79, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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: 6.14.1.1. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits, this visit includes anticipatory guidance and education related to members' reproductive health/needs; 6.14.1.2. Contraceptive counseling to assist members in reaching an informed decision (including natural family planning, education follow-up visits, and referrals); 6.14.1.3. Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health; 6.14.1.4. Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered; 6.14.1.5. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; 6.14.1.6. Male and female sterilization procedures provided in accordance with 42 CFR Part 441, Subpart F; 6.14.1.7. Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and 6.14.1.8. Transportation services to and from family planning appointments provided all other criteria for NEMT are met. 6.14.2. Services shall include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection or treatment of STIs, and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs. 6.14.3. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). 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. 6.14.5. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network. 6.14.6. The MCO shall encourage family planning providers to communicate with PCP's once any form of medical treatment is undertaken. 6.14.7. The MCO shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one (1) week. 6.14.8. The MCO shall make certain that payments from LDH are not utilized for the services for the treatment of infertility. (pp. 81-82, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.33. Preconception/Inter-conception Care For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient 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 prior authorization shall not be required for approval. (p. 98, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.6. Direct Access to Women's Health Care ... 7.8.6.1. The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services. 7.8.6.2. 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. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this Contract. 7.8.6.3. MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network. 7.8.6.4. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services. 7.8.6.5. The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients. (pp. 129-130, Effective 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

12.12. MCO Member Handbook. 12.12.1.1. At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook (see Section 3.3.3): ...12.12.1.11. The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. (p. 217, Effective 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁴⁹ 6.33. Preconception/Inter-conception Care For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care, with special counseling on pregnancy prevention options for adolescent patients. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient 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 prior authorization shall not be required for approval. (p. 98, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.6. Direct Access to Women's Health Care ... 7.8.6.2. ...The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this Contract. (pp. 129-130, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵⁰ 6.0 CORE BENEFITS AND SERVICES. 6.1. General Provisions... 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: ... Pregnancy-Related Services. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.11. Prenatal Care Services. 6.11.1. The MCO shall ensure Medicaid members under its care who are pregnant, begin receiving care within the first trimester or within seven (7) days after enrolling in the MCO. (See Attachment C.) The MCO shall provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services, including specialized behavioral health services that are incidental to a pregnancy (in accordance with 42 CFR Part 440, Subpart B,) to all members. As noted in the Women's Health Services subsection, the pregnant member shall be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP. 6.11.2. The MCO shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members. 6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients

including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth. 6.11.4. The MCO shall ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to the MCO as well as appropriate referrals to the WIC program for nutritional assistance. (A sample WIC Referral Form may be found at this link). 6.11.5. The MCO shall develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO shall provide details of its plan in the MCO Marketing and Outreach Plan submitted to LDH for approval. Some goals of this program would be to: 6.11.5.1. Improve overall engagement in the maternity population and help women keep appointments and educate them about needed health screenings throughout pregnancy; 6.11.5.2. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources; and 6.11.5.3. Improve health decisions across the pregnant population based on available Statebased and MCO-based programs and services. (pp. 79-80, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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

6.19. Services for Special Populations 6.19.1. Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. Individuals with special health care needs include: ... 6.19.1.3. Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome. (p. 85, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.39. Case Management. 6.39.2. Case Management program functions shall include but not be limited to the following, all of which shall be addressed in the MCO's case management policies and procedures: ... 6.39.2.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, reproductive aged women with a history of prior poor birth outcomes and high-risk pregnant women; 6.40. Case Management Policies and Procedures... The MCO shall submit Case Management Program policies and procedures to LDH for approval annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements: 6.40.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: ... 6.40.3.2. High risk pregnant women. (p. 108, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8. Primary Care. ... 7.8.7. Prenatal Care Services 7.8.7.1. The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one. The MCO shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The MCO shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted (p. 130, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

14.0 QUALITY MANAGEMENT... 14.1.7 The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6. (p. 245, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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

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: ...6.13.1.3. Incentives for vaginal birth after cesarean (VBAC); ...6.13.1.5. Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and 6.13.1.6. Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age. (p. 81, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵² 6.0 CORE BENEFITS AND SERVICES. 6.1. General Provisions... 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: ... Pregnancy-Related Services. 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, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.13. Perinatal Services. ...6.13.2. The MCO shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated). (p. 81, Effective October 2019, Attachment B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵³ Section 2.4 Enrollment and Education Activities... f... The Enrollee Information, shall include, but not be limited to, a description of the following:... 7) The MCO Covered Services... that do not require authorization or a referral from the Enrollee's PCP, for example, family planning services... 8) The extent to which, and how, Enrollees may obtain benefits, including... family planning services, from out-of-network providers (p. 52, Effective 2022, 4th Amended and Restated Tufts MCO Contract)

F. Services for Specific Populations... In addition, the Contractor shall: ... 10. Provide or arrange family planning services as follows: 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; b. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the Contractor's Provider Network; c. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to: 1) All methods of contraception, including sterilization, vasectomy, and emergency contraception; 2) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and 3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination; d. Maintain sufficient family planning providers to ensure timely access to family planning services. (p. 132, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

J. Provider Education The Contractor shall establish ongoing Provider education, including but not limited to, the following issues:... 6. For PCPs, education and information on:... c. Issues, including but not limited to, the following: 1) Pre-conception health concerns, including... family planning guidance... (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

APPENDIX C: Exhibit 1: MCO Covered Services... Family Planning – family planning medical services, family planning counseling services, follow-up health care, outreach, and community education. Under Federal law, an Enrollee may obtain family planning services from any MassHealth provider of family planning services without the Contractor’s authorization. (p. 4, Effective 2022, Appendix C – Covered Services, 4th Amended and Restated Tufts MCO contract)

⁵⁴ J. Provider Education. The Contractor shall establish ongoing Provider education, including but not limited to, the following issues: ...6. For PCPs, education and information on:... c. Issues concerning women, including but not limited to, the following: 1) Pre-conception health concerns, including folic acid administration; family planning guidance; nutrition; osteoporosis prevention; HIV and STD prevention; and HIV testing prior to becoming pregnant. (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁵⁵ Section 2.5 Care Delivery, Care Coordination, and Care Management. A. General Care Delivery Requirements In accordance with all other applicable Contractor requirements, the Contractor shall ensure that all Enrollees receive care that is timely, accessible, and Linguistically and Culturally Competent. The Contractor shall: ...9. Develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS: ...2) Tobacco cessation programs, with targeted outreach for adolescents and pregnant women; 3) Childbirth education classes; 4) Nutrition counseling, with targeted outreach for pregnant women, older Enrollees, and Enrollees with Special Health Care Needs (p. 68, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Enrollee Outreach, Orientation, and Education The Contractor shall: ...2. The Contractor must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall: ... Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in Section 2.5. Condition and disease specific information must be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to: ... 9) Pregnant women with substance use disorders (pp. 70-71, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Services for Specific Populations. ...In addition, the Contractor shall: ... 8. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice... 10. Provide or arrange family planning services as follows: ...3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination; (p. 135, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Breast Pumps – to expectant and new mothers as specifically prescribed by their attending physician, consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014, including but not limited to double electric breast pumps one per birth or as medically necessary. (p. 1, Effective 2022, Appendix C, Exhibit 1: MCO Covered Services, 4th Amended and Restated Tufts MCO Contract)

c. Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) – 24- hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs. ... d. Clinical Support Services for Substance Use Disorders (Level III.5) – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care. ... d. Structured Outpatient Addiction

Program (SOAP) - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring. (pp. 17-19, Effective 2022, Appendix C – Covered Services, 4th Amended and Restated Tufts MCO Contract)

⁵⁶ F. Services for Specific Populations. ...In addition, the Contractor shall: ... 8. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice. (p. 132, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁵⁷ F. Service Authorization and Utilization Management. 1. To place appropriate limits on services for utilization control, provided that: ... c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used. (p. 11, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.01 Definitions. ... (58) "Family planning" means providing individuals with the information and means to prevent unwanted pregnancy and maintain reproductive health. (p. 62, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.20 MCO Payment for Self-Referred, Emergency, Physician, and Hospital Services. ... (2) An MCO shall reimburse out-of-plan providers to whom enrollees have self-referred for school-based services as described in COMAR 10.67.07.03 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.169, January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.02 Access Standards: Enrollee Handbook and Provider Directory. 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: (10) Information about the availability of EPSDT, prenatal care, family planning, and other wellness services, including education programs; (11) A statement that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider (p. 180, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.07 Access Standards: Clinical and Pharmacy Access. ... (ii) Initial assessments of pregnant and postpartum women and individuals requesting family planning services shall be scheduled to be completed within 10 business days of the request for an appointment; (iii) If the new enrollee is a person requesting family planning services, the MCO shall ensure that an initial appointment is scheduled to occur within 10 days of the date of the enrollee's request for an appointment (p. 199, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.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. B. An MCO may place appropriate limits on family planning services for the purpose of utilization control, provided that the services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. C. An MCO may not apply a copayment or coinsurance requirement for contraceptive drugs or devices. D. An MCO shall provide coverage for a single dispensing of a supply of prescription contraceptives for a 12-month period. (p. 216, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.28 Benefits — Self-Referral Services. A. An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.67.04.20, an out-of-plan provider chosen by the participant for the following services: (1) Family planning services specified in COMAR 10.67.04.20A(2), (6), and (7) (p. 225, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁵⁸ .02 Access Standards: Enrollee Handbook and Provider Directory. 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: (10) Information about the availability of EPSDT, prenatal care, family planning, and other wellness services, including education programs; (11) A statement that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider (p. 180, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

07 Access Standards: Clinical and Pharmacy Access. ... (ii) Initial assessments of pregnant and postpartum women and individuals requesting family planning services shall be scheduled to be completed within 10 business days of the request for an appointment (p. 200, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

D. Covered Services 1. To cover, for Enrollees: b. Doula services for pregnant and postpartum individuals as part of MCO-covered pregnancy-related benefits. c. Home visiting services for pregnant and postpartum individuals as well as other Enrollees identified as participating in home visiting services, as part of MCO-covered pregnancy-related benefits. (p. 9, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.20 MCO Payment for Self-Referral, Emergency, Physician, and Hospital Services. ... (4) An MCO shall reimburse out-of-plan providers rendering pregnancy-related services, as described in COMAR 10.67.06.28C and K, at the Medicaid rate. (p. 170, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate; (2) Prenatal risk assessment and development of an individualized plan of care that specifies the actions required to address each identified need and is appropriately modified during the course of care; (3) Enriched maternity services, including: (a) Prenatal and postpartum counseling and education; (b) Basic nutritional education; (c) Substance abuse treatment, as provided in Regulation .10 of this chapter; (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and (ii) Healthy Start services; (e) High-risk nutrition counseling services for nutritionally high-risk pregnant women; (f) Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers; and (g) Smoking cessation education and treatment. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.28 Benefits — Self-Referral Services. A. An MCO shall be financially responsible for reimbursing, in accordance with COMAR 10.67.04.20, an out-of-plan provider chosen by the participant for the following services: ... (3) Pregnancy-related services for women who are pregnant and, at the time of initial enrollment, have received prenatal care during their current pregnancy from an out-of-plan provider, and this pre-enrollment care consists of at least the following: (a) A full prenatal examination; (b) A risk assessment; and (c) Appropriate laboratory services (pp. 225-226, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁵⁹ .21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate;... B. When an enrollee recovering from childbirth elects to be discharged before 48 hours following a normal vaginal delivery or 96 hours following an uncomplicated cesarean section, the MCO is responsible for providing: (1) One home visit scheduled to occur within 24 hours after discharge; and (2) An additional home visit as may be prescribed by the attending provider. C. When an enrollee recovering from childbirth and her newborn enrollee remain in the hospital for at least as long as the period of time provided under §B of this regulation, the MCO shall provide a home visit as prescribed by the attending provider. D. An MCO shall provide for home visits required by §§B and C of this regulation to be performed by a registered nurse and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child, including: (1) An

evaluation of the presence of immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse physical symptoms of the infant; (2) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother; (3) Collection of a blood specimen for newborn screening if not previously completed; (4) Referrals for any medically necessary continuing health care services; and (5) Any other nursing services ordered by the referring provider. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.07 Benefits — Inpatient Hospital Services. ... D. Childbirth — Length of Stay and Home Visits. (1) Except as provided in §D(2) and (3) of this regulation, the criteria and standards used by an MCO in performing utilization review of hospital services related to maternity and newborn care, including length of stay, shall be in accordance with the medical criteria outlined in the Guidelines for Perinatal Care, which is incorporated by reference in COMAR 10.67.04.01. (2) Unless the enrollee decides, in consultation with her attending provider, that less time is needed for recovery, an MCO shall provide or reimburse the cost of hospitalization including at least the following length of stay for an enrollee recovering from childbirth: (a) 48 hours of inpatient hospitalization care following an uncomplicated vaginal delivery; or (b) 96 hours of inpatient hospitalization care following an uncomplicated cesarean section. (3) If the enrollee elects to be discharged earlier than the length of stay specified in §D(2) of this regulation, the MCO is required to provide a home visit or visits pursuant to Regulation .21B—D of this chapter. E. In addition to the mother's length of stay required to be afforded by §D(2) of this regulation, whenever a mother is required to remain hospitalized after childbirth for medical reasons and she requests that her newborn remain in the hospital while she is hospitalized, the MCO shall afford the newborn additional hospitalization while the mother remains hospitalized, for up to 4 days. F. If an enrollee is in the hospital at the time of disenrollment from the MCO, and remains eligible for Medical Assistance, the MCO is responsible for covering the remainder of that hospital admission following disenrollment. G. An MCO shall provide for a private hospital room when: (1) The enrollee's condition requires a need for isolation; or (2) The enrollee requires admission and only private rooms are available. H. Payment For Ancillary Services. (1) Effective January 1, 2009, an MCO shall pay for all medically necessary ancillary services provided on inpatient hospital days including those days for which the inpatient hospitalization is otherwise appropriately denied. (2) A denial of an inpatient ancillary service shall be based on the medical necessity of the specific ancillary service. (3) An MCO is not required to pay for ancillary services if the entire hospitalization in §H(1) of this regulation is appropriately denied. I. Transports between hospitals are covered by the MCO when: (1) A medically necessary covered service is not available at the hospital where an enrollee is being treated; and (2) The enrollee is not being discharged from the sending hospital. (pp. 212-213, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁶⁰ .08 Special Needs Populations — Pregnant and Postpartum Women. A. An MCO shall meet the standards set forth in this regulation for treating pregnant and postpartum women. B. An MCO shall ensure access to prenatal care for pregnant women and postpartum care for postpartum women by: (3) Arranging for an adequate network of providers including obstetricians, gynecologists, perinatologists, neonatologists, anesthesiologists, and advanced practice nurses who are capable of addressing complex maternal and infant health issues; and (4) Linking a pregnant woman with a pediatric provider before delivery. ... E. An MCO shall refer pregnant and postpartum women with a substance use disorder to the behavioral health ASO for substance use treatment within 24 hours of request. F. An MCO shall refer pregnant and postpartum women, infants, and children younger than 5 years old to the WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Program, and shall provide to WIC necessary medical information to determine WIC nutritional eligibility. G. An MCO shall follow, at a minimum, the American College of Obstetricians and Gynecologists (ACOG) guidelines for pregnant and postpartum women. H. An MCO shall provide risk-related medical and nonmedical preventive treatment services, including nutrition counseling by licensed nutritionists or dietitians and smoking cessation education and treatment for pregnant and postpartum women. I. An MCO shall provide HIV counseling, including a risk assessment and information about possible transmission of HIV to the fetus. J. An MCO shall offer its pregnant and postpartum enrollees voluntary HIV counseling and testing following the requirements of COMAR 10.67.06. K. An MCO shall arrange for the appropriate emergency transfer of pregnant women, newborns, and infants to tertiary care centers. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate; (2) Prenatal risk assessment and development of an individualized plan of care that specifies the actions required to address each identified need and is appropriately modified during the course of care; (3) Enriched maternity services, including: (a) Prenatal and postpartum counseling and education; (b) Basic nutritional education; (c) Substance abuse treatment, as provided in Regulation .10 of this chapter; (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and (ii) Healthy Start services; (e) High-risk nutrition counseling services for nutritionally

high-risk pregnant women; (f) Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers; and (g) Smoking cessation education and treatment. B. When an enrollee recovering from childbirth elects to be discharged before 48 hours following a normal vaginal delivery or 96 hours following an uncomplicated cesarean section, the MCO is responsible for providing: (1) One home visit scheduled to occur within 24 hours after discharge; and (2) An additional home visit as may be prescribed by the attending provider. C. When an enrollee recovering from childbirth and her newborn enrollee remain in the hospital for at least as long as the period of time provided under §B of this regulation, the MCO shall provide a home visit as prescribed by the attending provider. D. An MCO shall provide for home visits required by §§B and C of this regulation to be performed by a registered nurse and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child, including: (1) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse physical symptoms of the infant; (2) An evaluation of the presence of immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother; (3) Collection of a blood specimen for newborn screening if not previously completed; (4) Referrals for any medically necessary continuing health care services; and (5) Any other nursing services ordered by the referring provider. (pp. 218-219, Effective January 2022 Maryland HealthChoice Managed Care Organization Agreement)

⁶¹ G. Family Planning Services 1. Contractor must demonstrate that its network includes sufficient family planning Providers to ensure timely access to Covered Services. Family planning providers are providers who provide reproductive health care services to beneficiaries including but not limited to; family planning centers and clinics, Obstetrician/Gynecologists, and PCPs. 2. Contractor must ensure that Enrollees have full freedom of choice of family planning Providers, both in-network and Out-of-Network. a. Contractor may encourage the use of public providers in their network. 3. Contractor may encourage family planning Providers to communicate with PCPs once any form of medical treatment is undertaken. Contractor must allow Enrollees to seek family planning services, drugs, supplies and devices without prior authorization. 4. Regarding type, duration or frequency of drugs, supplies and devices for the purpose of family planning, Contractors may not be more restrictive than Medicaid FFS. 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. 6. Contractor must maintain accessibility and confidentiality for family planning services through promptness in scheduling appointments, particularly for minors. 7. Contractor must make certain Medicaid funding is not used for services for the treatment of infertility. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

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... I. Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis) (p. 48, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

E. Member Materials... 2. Member Handbook... I. 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:... xxxiii... family planning services, and how to access these services... 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. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

J. Confidentiality... 4. Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for... family planning services. (p. 118, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶² LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶³ V. Access and Availability of Providers and Services. H. Pregnant Women 1. Contractor must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice. 2. Contractor must allow pregnant women to receive all Medically Necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in Network Provider. 3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate. 4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

V. Access and Availability of Providers and Services. I. Maternity Care 1. Contractor must ensure an individual maternity care Provider is designated for each enrolled pregnant woman for the duration of her pregnancy and post-partum care. a. Maternity care Providers' scope of practice must include maternity care and meet the Contractor's credentialing requirements. b. A clinic or practice may be designated as the maternity care Provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care. 2. Contractor must allow an Enrollee's maternity care Provider to also be the Enrollee's PCP if primary care is within their scope of practice. (pp. 42-43, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

VI. Covered Services. B. Services Covered Under This Contract... u. Maternal and Infant Health Program (MIHP) services. (p. 49, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

HOME VISTING VI.... N. Maternal, Infant and Early Childhood Evidence Based Home Visiting Programs The Maternal and Infant Health Program (MIHP) is a home-visiting program for Medicaid eligible women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP Provider organizations must be certified by MDHHS and adhere to program policies, procedures, and expectations outlined in Medicaid Policy, the MIHP Program Operations Manual and Public Act 291 of 2012. 1. Contractor must refer all eligible Enrollees to an MIHP or when appropriate, other MDHHS approved evidence-based home-visiting program Other MDHHS approved programs are as follows: a. Nurse Family Partnership b. Healthy Families America c. Family Spirit (p. 62, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

2. Member Handbook... i. 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: ... xxix. Pregnancy care information that conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant (p. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶⁴ I. Maternity Care 1. Contractor must ensure an individual maternity care Provider is designated for each enrolled pregnant woman for the duration of her pregnancy and post-partum care. a. Maternity care Providers' scope of practice must include maternity care and meet the Contractor's credentialing requirements. b. A clinic or practice may be designated as the maternity care Provider, however, an individual PCP within the practice must be named and agree to accept responsibility for the Enrollee's care for the duration of the pregnancy and post-partum care to assure continuity of care. 2. Contractor must allow an Enrollee's maternity care Provider to also be the Enrollee's PCP if primary care is within their scope of practice. (pp. 42-43, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

V. Access and Availability of Providers and Services... H. Pregnant Women...4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Post-partum care (p. 185, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁶⁵ 2.56 Family Planning Service means a family planning supply (related drug or contraceptive device) or health service, including screening, testing, and counseling for sexually transmitted diseases, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to an Enrollee's condition of fertility. (pp. 20-21, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

3.10.3 Handbook... 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. 45, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

6.1 MEDICAL ASSISTANCE (PMAP) COVERED SERVICES..... The MCO shall provide services that shall include but are not limited to the following:... 6.1.16 Family Planning Services. 6.1.16.1 The MCO must comply with the sterilization consent procedures required by the federal government, and must ensure open access to Family Planning Services. [42 CFR §431.51 and Minnesota Statutes, §62Q.14] 6.1.16.2 The MCO may not restrict the choice of an Enrollee as to where the Enrollee receives the following services. [42 CFR §441.20 and Minnesota Statutes, §62Q.14]: • Voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services; • Diagnosis of infertility, including counseling and services related to the diagnosis (for example Provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results); • Testing and treatment of a sexually-transmitted disease; and • Testing for AIDS and other HIV-related conditions. 6.1.16.3 The MCO may require family planning agencies and other Providers to refer Enrollees back to the MCO under the following circumstances for other services, diagnosis, treatment and follow-up: • Abnormal pap smear/colposcopy; • Infertility treatment; • Medical care other than Family Planning Services; • Genetic testing; and • HIV treatment. (pp. 90, 98, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁶ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁷ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.5 Inpatient Hospitalization for Childbirth is covered. (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁸ 6.1.35 Obstetrics and Gynecological Services... 6.1.35.2 Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered. [Minnesota Statutes, §256B.0625, subd. 28b] 6.1.35.3 Prenatal Care Services. ... (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁹ 2.4 Health Plan Provider Networks:... 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. A listing of Family Planning and STD treatment providers is provided in Exhibit C and Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Local Public Health Agencies, Family Planning and STD Providers located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/>). (p. 30, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

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/>):... k. 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. (p. 54, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management:... e. Care Plans:... 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;... (p. 76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.12.16 Member Handbook:... Information on... family planning... 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 (p. 91, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.16 Provider Services... 2.16.1 Provider Services Staff... The health plan's provider services staff shall be responsible for the following:... e. Educating providers about conditions under which members may directly access services including, but not limited to,... family planning... services (p. 117, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care RFP)

2.18 Quality Assessment and Improvement:... 2.18.8 Internal Procedures: The health plan shall have an internal written quality assessment and improvement program procedures. The procedures shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, clinical areas relating to... family planning... as well as on key access or other priority issues for members such as reducing the incidence of STDs... The health plan shall implement mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. (p. 127, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

3.16 Confidentiality:... 3.16.6 The health plan shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services. (p. 194, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷⁰ 2.7.7 Additional Services: In addition to the services listed in the comprehensive benefits package herein, the health plan shall provide the following services to... pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98... a. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury); b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan; c. Diabetes self-management training for persons with gestational, Type I, or Type II diabetes; d. Hearing aids and related services; e. Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two (2) years, replacement lens(es) when there is a .50 or greater change and, for children under age twenty-one (21), replacement frames and/or lenses when lost, broken or medically necessary, and HCY/EPST optical screen and services; f. Podiatry services; g. Services that are included in the comprehensive benefits package, medically necessary, and not identified in the IFSP or IEP; and h. Therapy services (physical, occupational, and speech). (pp. 59-60, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management... d. General Eligibility and Assessment 1) The health plan shall screen all pregnant members for care management needs and offer care management to all pregnant members... e. Care Plans:... 3) In addition to the requirements listed below, the health plan shall include the following in the care plans of pregnant women: A risk appraisal form must be a part of the member's record. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd. Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in care management; Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment; Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21); Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in care management; Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation; Assistance in making transportation arrangements for prenatal care, delivery, and postpartum care; Referrals to prenatal or childbirth education where available; Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment; Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed; Assistance in identifying and selecting a medical care provider for both the mother and the child; Identification of feeding method for the child; Notifications to current health care providers when care management services are discontinued; Referrals for family planning services if requested; and Directions to start taking folic acid vitamin before the next pregnancy (pp. 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

23.2 Coordination of Benefits:... a. The health plan must provide... prenatal care for pregnant women... (p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷¹ 23.2 Coordination of Benefits:... a. The health plan must provide labor, delivery... (p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

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/>):... q. Maternity Benefits for Inpatient Hospital and Certified Nurse Midwife: 1) The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended. 2) The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with Federal and State law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and is documented in the member's medical record. 3) The health plan shall provide coverage for post-discharge care to the mother and her newborn. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use. (pp. 56-57, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷² 2.23.2 Coordination of Benefits... a. The health plan must provide... postpartum care... (<http://dss.mo.gov/business-processes/managedcare-2017/bidder-vendor-documents/>) p. 143, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷³ D. Member Handbook... The Member Handbook must include at a minimum the following information:... 7. Making appointments and accessing care:... e. 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; (p. 72, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

B. Provider Network Requirements... 7. Family Planning The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services. (p. 96, Effective July 2017, MSCAN Magnolia Health Plan inc. Managed Care Executed Contract)

⁷⁴ G. Additional Requirements for Communication with Contractor's Members... 1. Allowable Contractor Communication Activities... b. The Contractor is allowed to offer non-cash incentives to its Members for the purposes of rewarding for compliance in... prenatal visits... (p. 81, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁵ O. Reporting Maternity Admissions for Delivery Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, as required by the Division. Medicaid policy exempts certain maternity admissions for delivery from the reporting requirement and providers are not required to submit reports for these situations. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization time frame and the Medicare benefits are not exhausted. No review is required if the beneficiary's Medicaid eligibility is only for the Family Planning Waiver. The Contractor shall develop, implement, and maintain a maternity admission for delivery reporting process. The Contractor shall issue a written notification for issuance of a Prior Authorization Number to the requesting provider within two (2) business days from receipt of completed report. (p. 135, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁶ O. Reporting Maternity Admissions for Delivery Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn.... (p. 135, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷⁷ 3.4 Enrollee Orientation 3.4.1 Initial Contact – General Orientation... (E) During the initial contact, MCO's representative shall provide, at minimum, the following information to the Enrollee or Potential Enrollee: (2) Availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Out-of-Network Providers (p. 26, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

3.5.4 Enrollee Handbook... (B) At a minimum, in accordance to 42 CFR § 438.10(g)(2) and any other content as required by STATE, the Enrollee handbook shall explain in clear terms the following:... (4) The extent to which, and how, Enrollees may obtain benefits, including family planning services, from Out-of-Network Providers (p. 29, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

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). 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. MCO is required to reimburse Out-of-Network Providers for family planning services. (p. 36, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

5.1.4 Out-of-Network Services... B) Enrollees must have the option of obtaining Medically Necessary Covered Services from any Out-of-Network Provider, if the following conditions exist:... (10) The Enrollee seeks Family Planning Services; (p. 48, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁷⁸ Coverage (438.210) MCO must provide for all medically necessary and appropriate Medicaid covered services in sufficient amount, duration, and scope to achieve the purpose of the service (consistent with 438.210(a)(1)). MCO must provide a comprehensive health care services benefit package. The covered services will include all services that North Dakota requires be made available to enrollees in North Dakota Medicaid expansion, including but not limited to:.... Maternity... care (pp. 19-20, Amendment D, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁷⁹ B. Covered Services and Benefits... 16. Family Planning Services a. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the choice of provider from whom/which the member may receive family planning services and supplies. At a minimum, the MCO must provide coverage for the following family planning services: i. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits. This visit includes anticipatory guidance and education related to members' reproductive health/needs. (p. 62, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸⁰ Prenatal and Maternity Care Services a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis. B. The MCO must cover nurse-midwife services that are medically necessary...C. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸¹ Prenatal and Maternity Care Services a. The MCO must cover ...deliveryC. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸² Prenatal and Maternity Care Services a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis. B. The MCO must cover nurse-midwife services that are medically necessary...C. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours... (p. 2375, SPB RFP Revised, Effective September 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁸³ 2.1.47 Family Planning Services 2.1.47.1 "Family Planning Services" means services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include: 2.1.47.1.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases; (p. 20, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.1.4 Member Handbook... 4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not limited to, the following information:... 4.4.1.4.3.2. Benefits. 4.4.1.4.3.2.1 How and where to access any benefits provided, including... Family Planning Services... 4.4.1.4.3.3. Service Limitations:... 4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider... (pp. 121-122, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.3 Member Rights 4.4.3.1 The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:... 4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers; (p. 130, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.7.6 Women's Health... 4.7.6.2 The MCO shall provide access to Family Planning Services as defined in Section 2.1.47 (Definitions) 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. 4.7.6.3 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)] (p. 170, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.11.6.17 Neonatal Abstinence Syndrome... 4.11.6.17.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:... 4.11.6.17.6.6. Information on family planning options; (p. 252, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

⁸⁴ 4.9.4.6 Healthy Behavior Incentive Programs 4.9.4.6.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:... 4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members with risk of having a child with NAS (p. 189, Exhibit A, Amendment #8, Effective FY 2023, Granite State Health Plan Inc. Medicaid Care Management Services Contract Contract)

⁸⁵ 4.1.2 BENEFIT PACKAGE A. 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 (p. 10, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Family Planning--The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Abortions (and related services) and infertility treatment services are excluded. (p. 14, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

LARC--Long-acting reversible contraceptives (LARC) are a safe and highly effective method of family planning that provide contraception for an extended period without requiring member action (or compliance). They include intrauterine devices (IUDs) and subdermal contraceptive implants. Both methods are reversible and can be removed at any time if member chooses. (p. 17, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Referral Services--those health care services provided by a health professional other than the primary care practitioner and which are ordered and approved by the primary care practitioner or the Contractor. 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. (p. 28, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

4.2.2 FAMILY PLANNING SERVICES AND SUPPLIES A. General. Except where specified in Section 4.1, the Contractor's MCO enrollees are permitted to obtain family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The Contractor shall reimburse family planning services provided by non-participating Network providers based on the Medicaid fee schedule. All Providers must be registered with New Jersey Medicaid as 21st Century Cures Act Providers in order to provide services to NJ FamilyCare members. B. Non-Participating Providers. The Contractor shall cooperate with non-participating family planning providers accessed at the enrollee's option by establishing cooperative working relationships with such providers for accepting referrals from them for continued medical care and management of complex health care needs and exchange of enrollee information, where appropriate, to assure provision of needed care within the scope of this contract. The Contractor shall not deny coverage of family planning services for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider. (p. 29, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

5.8.2 ENROLLEE NOTIFICATION/HANDBOOK... 5. A notification of the enrollee's right to obtain family planning services from the Contractor's network of providers of family planning services, 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. (p. 12, Article 5, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

⁸⁶ D. Perinatal Risk Assessment Form. 1. An obstetrical Provider or other approved licensed health care Provider, including nurse midwives, shall complete the DMAHS uniform Perinatal Risk Assessment form (the form) during the first prenatal visit with a pregnant Member and shall update the form in the third trimester. 2. The Contractor shall require its Providers to submit the form (see sample in Appendix A.4.2.3) and the update to DMAHS, its contracted designee or the health information network. Beginning January 1, 2021, consistent with N.J.S.A. 30:4D-7z, no Provider may receive reimbursement for prenatal services provided to the Member until the form is completed and submitted for that Member. If there is a pattern of late submission of the forms and updates, the Provider shall be counseled in writing and verbally to submit them timely. (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

F. Centering. The Contractor shall provide pregnant female Members the option of attending "Centering" group prenatal care at a site accredited by the Centering Healthcare Institute. The center shall utilize the Centering Pregnancy model and incorporate the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each visit. The program consists of ten (10) prenatal visits, each 90 minutes - two hours long, where Providers engage in health assessments and group education/discussion that covers topics including but not limited to, nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care. Sessions are held in a group setting consisting of 2-20 women. (p. 31, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). (p. 50, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

⁸⁷ 4.2.3 Women's Health Services... B. The Contractor shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time and the provisions of N.J.S.A. 26:2J-4.9 are met. 1. The Contractor shall not provide monetary payments or rebates to mothers to encourage them to accept less than the minimum protections provided for in this Article. 2. The Contractor shall not penalize, reduce, or limit the reimbursement of an attending provider because the provider provided care in a manner consistent with this Article. (pp. 29-30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).

E. Non-medically indicated early elective deliveries. 1. Beginning January 1, 2021, consistent with N.J.S.A. 30:4D-9.2, no Provider shall be reimbursed by the Contractor for a non-medically indicated early elective delivery performed at a hospital on a pregnant woman earlier than the 39th week of gestation. A "non-medically indicated early elective delivery" means the artificial start of the birth process through medical interventions or other methods, also known as labor induction, or the surgical delivery of a baby via a cesarean section for purposes or reasons that are not fully consistent with established standards of clinical care as provided by the American College of Obstetricians and Gynecologists 2. The Contractor shall support education efforts for health care Providers and women and their support networks, and prohibit coverage of such medical interventions which are not medically necessary by clinical standards. During 2019, the Contractor must advise all of its Providers of pregnancy-related services of the risks of early elective deliveries and the prohibition on payment for such (below) 3. The Contractor shall provide accessible educational materials to inform pregnant women, their support networks, and Providers about the risks of a non-medically indicated early elective delivery. (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract).

⁸⁸ 4.5.8 Family Planning Services 4.5.8.1 Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall implement written policies and procedures, previously approved by HSD, that define how Members are educated about their right to family planning services, freedom of choice (including access to Non-Contract Providers) and methods for accessing family planning services. 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: 4.5.8.1.1 HIV and other sexually transmitted diseases and risk reduction practices; 4.5.8.1.2 Birth control pills and devices (including Plan B); and 4.5.8.1.3 That Members can self-refer to Non-Contracted family planning providers (p. 89, no date, New Mexico Amended Version Sample RFP, 2022).

4.8.9.2 Local Department of Health Offices 4.8.9.2.1 The CONTRACTOR shall make best efforts to contract with public health providers for family planning services and other clinical preventive services not otherwise available in the community such as prenatal care or perinatal case management and those defined as public health services under State law, NMSA 1978, §§ 24-1-1 et. seq. 4.8.9.2.2 The CONTRACTOR shall make best efforts to contract with local and district public health offices for family planning services. (p. 115, no date, New Mexico Amended Version Sample RFP)

4.10.2.3 Family Planning Non-Contract Providers The CONTRACTOR shall reimburse family planning Non-Contract Providers for the provision of service to Members at a rate set by HSD. (p. 127, no date, New Mexico Amended Version Sample RFP)

4.10.2.9 Pharmacy Services... 4.10.2.9.7 The CONTRACTOR shall reimburse family planning clinics, SBHCs and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to Members and billed using HCPC codes and CMS 1500 forms (p. 130, no date, New Mexico Amended Version Sample RFP)

Attachment 5: Adult Benefit Plan Covered Services... Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives (Sterilization reversal is not covered. Infertility treatment is not covered.) (p. 314, no date, New Mexico Amended Version Sample RFP)

⁸⁹ 4.5.9 Prenatal Care Program 4.5.9.1 The CONTRACTOR shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. (p. 89, no date, New Mexico Amended Version Sample RFP)

4.8.9.2 Local Department of Health Offices 4.8.9.2.1 The CONTRACTOR shall make best efforts to contract with public health providers for... other clinical preventive services not otherwise available in the community such as prenatal care or perinatal case management... 4.8.9.2.3 The CONTRACTOR may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal care or prenatal case management. (p. 115, no date, New Mexico Amended Version Sample RFP)

4.8.15.3 The CONTRACTOR shall contract with the DOH Families First and Children's Medical Services (CMS) programs for case management related activities. 4.8.15.3.1 Families First Program:... 4.8.15.3.1.1 Prenatal members are typically seen four times during the pregnancy/postpartum and the postpartum visit is conducted in the Member's home with the member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit. (p. 120, no date, New Mexico Amended Version Sample RFP)

4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize participation. (p. 160, no date, New Mexico Amended Version Sample RFP)

4.22.1.2 Specific Requirements... 4.22.1.2.1 The following reward activities are under consideration for the Member Incentive program:... Perinatal (1st trimester, ongoing prenatal, and postpartum visits (p. 219, no date, New Mexico Amended Version Sample RFP)

Attachment 5: Adult Benefit Plan Covered Services... Over-the-counter medicines – prenatal drug items... (p. 315, no date, New Mexico Amended Version Sample RFP)

Attachment A: Adult Benefit Plan Covered Services... Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, New Mexico Amended Version Sample RFP, 2022).

⁹⁰ Attachment A: Adult Benefit Plan Covered Services... Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, no date, New Mexico Amended Version Sample RFP)

⁹¹ 4.8.15.3.1 Families First Program: The DOH Families First program provides case management functions to Prenatal and Pediatric members. 4.8.15.3.1.1 Prenatal members are typically seen four times during the pregnancy/postpartum and the postpartum visit is conducted in the Member's home with the member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit. (p. 120, no date, New Mexico Amended Version Sample RFP)

4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize participation. (p. 160, no date, New Mexico Amended Version Sample RFP)

4.22.1.2 Specific Requirements... 4.22.1.2.1 The following reward activities are under consideration for the Member Incentive program:... Perinatal (1st trimester, ongoing prenatal, and postpartum visits) (p. 219, no date, New Mexico Amended Version Sample RFP)

Adult Benefit Plan Services Included Under Centennial Care...Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care (p. 315, no date, New Mexico Amended Version Sample RFP)

⁹² 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:... 7.4.2.1.15. Family Planning Services;... 7.4.2.1.43. Special Clinics (e.g., Comprehensive Rehabilitation Facility, Genetics, Family Planning, Methadone Public Health Clinic, Community Health Clinic (State Health Division), School Based Health Centers, Special Children's Clinic, TB Clinic, HIV, Substance Abuse Agency Model); (pp. 99-102, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.4.2.7. Family Planning Services 7.4.2.7.1. The Contractor is prohibited from restricting the Member's free choice of Family Planning Services, supplies, and Providers. Federal regulations grant the right to any Member of childbearing age to receive Family Planning Services from any qualified Provider, even if the Provider is not part of the Contractor's Network. The Contractor may not require family planning services to be prior authorized. Family Planning Services are provided to Members who want to control family size or prevent unwanted pregnancies. Family Planning Services may include education, counseling, physical examinations, birth control pills, intrauterine devices, implants, injections, patches, rings, diaphragms, condoms, and other birth control supplies. 7.4.2.7.2. Pursuant to MSM Chapter 600, tubal ligations and vasectomies are included for Members twenty-one (21) years of age or older. Tubal ligations and vasectomies to permanently prevent conception are not covered for any Member under the age of twenty-one (21) or any Member who is adjudged mentally incompetent or is institutionalized. Hysterectomy is not a covered Family Planning Service. 7.4.2.7.3. At a minimum, the Contractor must reimburse qualified Out-of-Network Providers for Family Planning Services rendered to its Members at the FFS rate paid by the State. The Contractor will be responsible for coordinating and documenting Out-of-Network family planning services provided to its Members and the amounts paid for such services. (pp. 106-107, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

Members must be allowed to self-refer for family planning (in or Out-of-Network)...services within the Contractor's Network; (p. 175, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁹³ 7.5.5. Health Needs Assessment The Contractor must conduct a Health Needs Assessment Screening for all new Members with the following timeframes from the date of enrollment with the Contractor: 7.5.5.1. The Contractor must arrange for or conduct an initial screening assessment of new Members, to confirm the results of a positive identification and to determine the need for Care Coordination and/or Case Management services within sixty (60) Calendar Days of enrollment. Screening assessment for pregnant women, children with special health care needs, adults with special health care needs must be conducted within thirty (30) Calendar Days;... 7.5.5.4. The Contractor will submit its Health Needs Assessment Screening form and screening-related data for the State upon request. The State reserves the right to standardize the Health Needs Assessment Screening form across Contractors. The Health Needs Assessment tool must, at a minimum, address the following:... 7.5.5.4.4. Pregnancy screen, as applicable. (p. 143, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.10. High Risk Maternal Case Management 7.5.6.7.10.1 The Contractor will make a good faith effort to screen Medicaid and CHIP pregnant Members for maternal high risk factors. 7.5.6.7.10.2 Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, Personal Care Services or Home Health care, substance abuse services, and Care Coordination services, in addition to maternity care. 7.5.6.7.10.3 All Case Management requirements and standards outlined within Section 7.5.6.7 apply to the Contractor's High Risk Maternal Care Management Program. 7.5.6.7.10.4 Any identification of high-risk factors will require the PCP, OB/GYN Provider, Case Manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Contractor's High Risk Maternal Case Management Program. 7.5.6.7.10.5. The Contractor must demonstrate ongoing and active efforts to educate Providers on how to make referrals to the Contractor's High Risk Maternal Case Management Program for Members identified as pregnant for screening. 7.5.6.7.10.6. As appropriate, the Contractor must assist the Member in contacting appropriate agencies for Care Coordination of noncovered/carved-out plan services or community health information. The Contractor's Case Manager will begin medical Case Management services for those risk factors identified. 7.5.6.7.10.7. The State and/or the External Quality Review Organization (EQRO) will conduct on-site reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies. (pp. 152-153, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.15. Case Management Priority Conditions The Contractor must, at a minimum, provide Case Management to Members with the following conditions or status. The priority list is not exhaustive and Case Management should be offered to Members who health condition warrant Case Management Services... 7.5.6.7.15.11. High Risk Pregnancy including Members who are pregnant and have a SUD or history of a SUD;... (p. 159, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁹⁴ 10.10 Family Planning and Reproductive Health Services. 10.10.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. 10.10.a.i. MMC Enrollees may receive such services from any qualified Medicaid provider, regardless of whether the provider is a Participating or a Non-Participating Provider, without referral from the MMC Enrollee's PCP and without approval from the Contractor. 10.10.a.ii. FHPlus Enrollees may receive such services from any Participating Provider if the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, or from any qualified Medicaid provider if such services are not included in the Contractor's Benefit Package, as specified in Appendix M of this Agreement, without referral from the FHP Enrollee's PCP and without approval from the Contractor. 10.10.b. The Contractor shall permit Enrollees to exercise their right to obtain Family Planning and Reproductive Health services. 10.10.b.i. If the Contractor includes Family Planning and Reproductive Health services in its Benefit Package, the Contractor shall comply with the requirements in Part C.2 of Appendix C of this Agreement, including assuring that Enrollees are fully informed of their rights. 10.10.b.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. (pp. 10-7-to-10-8, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10.17 Contractor Responsibilities Related to Public Health... b) The Contractor will inform Enrollees about HIV testing services available through the Contractor's Participating Provider network and HIV testing services available when performed as part of a Family Planning and Reproductive Health encounter. HIV testing rendered outside of a Family Planning and Reproductive Health encounter, as well as services provided as the result of an HIV+ diagnosis, will be furnished by the Contractor in accordance with standards of care. The HIV testing provided shall be done in accordance with all Public Health Laws, including Article 27-F. (p. 10-26, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10.31 Coordination of Services a) The Contractor shall coordinate care for Enrollees, as applicable, with:... iii) family planning clinics... (p. 10-32, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

15.2 Appointment Availability Standards a) The Contractor shall comply with the following minimum appointment standards, as applicable... xii) Initial family planning visits: within two (2) weeks of request. (p. 15-2, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

1. Family Planning and Reproductive Health Services a) Family Planning and Reproductive Health services mean the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. I) Family Planning and Reproductive Health services include the following medically-necessary services, related drugs and supplies which are furnished or administered under the supervision of a physician, licensed midwife or certified nurse practitioner during the course of a Family 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); B) emergency contraception and follow up; C) sterilization; D) screening, related diagnosis, and referral to a Participating Provider for pregnancy; 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. II) Family Planning and Reproductive Health services include those education and counseling services necessary to effectively render the services. Iii) Family Planning and Reproductive Health services include medically-necessary ordered contraceptives and pharmaceuticals: The contractor is responsible for pharmaceuticals and medical supplies such as IUDS and Depo-Provera that must be furnished or administered under the supervision of a physician, licensed midwife, or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit. B) When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit: I) Screening, related diagnosis, ambulatory treatment and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology. Ii) Screening, related diagnosis and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension and breast disease. Iii) Screening and treatment for sexually transmissible disease. Iv) HIV testing and pre- and post-test counseling.

2. Free Access to Services for MMC Enrollees 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. B) The Family Planning and Reproductive Health services listed above are the only services which are covered under the Free Access policy. Routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care are not covered under the Free Access policy, and are the responsibility of the Contractor.

3. Access to Services for FHPlus Enrollees a) FHPlus 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 Services encounter, from either the Contractor pursuant to C.2 below or any appropriate Medicaid health care provider pursuant to C.3 below, as applicable. No referral from the PCP or approval by the Contractor is required to access such services. B) The Contractor is responsible for routine obstetric and/or gynecologic care, including hysterectomies, pre-natal, delivery and post-partum care, regardless of whether Family Planning and Reproductive Health services are included in the Contractor's Benefit Package.

C.2 Requirements for MCOs that Include Family Planning and Reproductive Health Services in Their Benefit Package 1. Notification to Enrollees a) 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. The notification must contain the following: i) Information about the Enrollee's right to obtain the full range of Family Planning and Reproductive Health services, including HIV counseling and testing when performed as part of a Family Planning and Reproductive Health encounter, from the Contractor's Participating Provider without referral, approval or notification. ii) MMC Enrollees must receive notification that they also have the right to obtain Family Planning and Reproductive Health services in accordance with MMC's Free Access policy as defined in C.1 of this Appendix. There is no Free Access policy for FHPlus Enrollees. iii) A current list of qualified Participating Family Planning Providers who provide the full range of Family Planning and Reproductive Health services within the Enrollee's geographic area, including addresses and telephone numbers. The Contractor may also provide MMC Enrollees with a list of qualified Non- Participating providers who accept Medicaid and provide the full range of these services. iv) Information that the cost of the Enrollee's Family Planning and Reproductive Health care will be fully covered, including when a MMC Enrollee obtains such services in accordance with MMC's Free Access policy... 3. Consent and Confidentiality a) The Contractor will comply with federal, state, and local laws, regulations and policies regarding informed consent and confidentiality and ensure Participating Providers comply with all of the requirements set forth in Sections 17 and 18 of the PHL and 10 NYCRR Section 751.9 and Part 753 relating to informed consent and confidentiality. B) Participating Providers may share patient information with appropriate Contractor personnel for the purposes of claims payment, utilization review and quality assurance, unless the provider agreement with the Contractor provides otherwise. The Contractor must ensure that any Enrollee's, including a minor's, use of Family Planning and Reproductive Health services remains confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure. 4. Informing and Standards... b) The Contractor will inform its Participating Providers that they must comply with professional medical standards of practice, the Contractor's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Task Force on Preventive Services and the New York State Child/Teen Health Program. These standards and laws recognize that Family Planning counseling is an integral part of primary and preventive care. (pp, C-1 – C-5, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁵ Family Planning and Reproductive Health Care... If the Contractor excludes Family Planning and Reproductive Health services from its Benefit Package . . . the Contractor is required to comply with the requirements of Appendix C.3 of this Agreement and still provide the following services:...screening, related diagnosis, and referral to Participating Provider for . . . pregnancy. (p.C-2, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁶ 10.11 Prenatal Care and Elective Deliveries Less Than 39 Weeks Gestation a) The Contractor agrees to provide or arrange for comprehensive prenatal care services to be provided in accordance with standards and guidelines established by the Commissioner of Health pursuant to Section 365-k of the Social Services Law. (p. 10-8, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

13.6 Notification of Enrollee Rights... b) The Contractor agrees to make all reasonable efforts to conduct a brief health screening, within sixty (60) days of the Enrollee's Effective Date of Enrollment, to assess the Enrollee's need for any special health care (e.g., prenatal.. services)... Reasonable efforts are defined to mean at least (3) attempts, with more than one method of contact being employed. If a special need is identified, the Contractor shall assist the Enrollee in arranging an appointment with his/her PCP or other appropriate provider. (p. 13-6, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

16.3 Incentivizing Enrollees to Complete a Health Goal a) Upon approval by SDOH, the Contractor may offer its Enrollees incentives for completing a health goal, such as finishing all prenatal visits,... Additionally, the Contractor may offer its Enrollees incentives to promote the delivery of preventive care services, as defined in 42 CFR 1003.101. SDOH will determine if the incentive

meets the requirements at 42 CFR 1003.101 and outlined in DHHS OIG Special Advisory Bulletin “Offering Gifts and Other Inducements to Beneficiaries. (p. 16-4, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

10. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas... c) For Medicaid Managed Care and Family Health Plans... vi) The following drugs are not covered: 1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy. (p. K-23, Effective March 2019, Appendix K, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

14. Home Health Services... d) The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. Criteria for medical necessity are as follows: i) High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or ii) Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or iii) Women otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or iv) Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance use, unsafe housing and nutritional risk. Home health service visits may be provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). The home health visit must be ordered by the woman’s attending (treating) physician and documented in the plan of treatment established by the woman’s attending physician. All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above. The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records: i) A comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit; ii) Timely notification to treating providers and case manager concerning significant changes in the woman or infant’s condition; iii) Referral and coordination with appropriate health, mental health and social services and other providers; iv) Review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and v) An appropriate discharge plan. (pp. K-26-K-27, Effective March 2019, Appendix K, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁷ App’x C.1. C.1.3. Access to Services for FHPlus Enrollees. C.1.3.b. The Contractor is responsible for... delivery... care.... regardless of whether Family Planning and Reproductive Health services are included in the Contractor’s Benefit Package. (pp. C-3, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁸ App’x C.1. C.1.3. Access to Services for FHPlus Enrollees. C.1.3.b. The Contractor is responsible for . . . post-partum care, regardless of whether Family Planning and Reproductive Health services are included in the Contractor’s Benefit Package. (p. C-3, Appendix C, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

⁹⁹ Basic Benefit Package... Services covered by the MCP benefit package shall include:... g. Family planning services and supplies (p. 88, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

22. Healthcheck and Pregnancy Related Services. Healthchek, Ohio’s early and periodic screening, diagnostic and treatment (EPSDT) and Pregnancy Related Services programs are outlined in OAC rules 5160:1-2-15, 5160:1-2-16, and 5160-1-14... b. Informing Members about Pregnancy Related Services (PRS): i. Upon the identification of a member as pregnant, the MCP shall deliver

to the member within 5 calendar days a PRS form as designated by ODM. ii. The MCP may be required to communicate with the member's local CDJFS agency any requests made by the member for county-coordinated services and supports (e.g. social services). (p. 29, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

42. Information Required for MCP Websites... b. The MCP provider website shall include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions:... xi. Prominent, easily understood information on its website for members and providers regarding the optimization of pregnancy outcomes. This shall include information for providers, trusted messengers (e.g., community health workers), and patients about the prevention of preterm birth through the use of progesterone treatment by linking to the Ohio Perinatal Quality Collaborative's information about progesterone best practices at (<https://www.opqc.net/prematurity-prevention?adlt=strict>) and the Ohio Department of Health's progesterone-messaging toolkit located at (GoWhenYouKnow.org). The MCP shall include a link to the official ODM notification of pregnancy and risk assessment form (PRAF 2.0) located at <https://medicaid.ohio.gov/Provider/PRAF> with a statement encouraging MCP contracted providers to complete and submit the form to assist pregnant women in maintaining Medicaid eligibility and connecting to needed services and supports (e.g., home visiting). (p. 56, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

10. Specialized Services for High Risk Populations. The MCP may provide or arrange for specialized (or nontraditional) services to be delivered via different models in the community, including home visiting, centering, community hub, community workers, etc., as appropriate, for high risk populations identified by the MCP or ODM. The MCP is responsible for ensuring that the community services are culturally competent, meet the member's needs, honor member preference, and do not duplicate other services paid for by the MCP and/or ODM. At a minimum, if a member is pregnant or capable of becoming pregnant, resides in a community serviced by a qualified community hub, has been recommended to receive HUB pathway services by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCP or ODM, the MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub: a. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and b. Care coordination performed for the purpose of ensuring that the member is linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services. (p. 163, Appendix K Quality of Care, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

Rule 5160:1-2-16, Medicaid: pregnancy related services (PRS). A) The purpose of this rule is to outline the responsibilities of the administrative agency to inform medicaid-eligible pregnant women about the benefits and importance of pregnancy related services (PRS), to make requested or needed referrals to support services, and to provide non-medical services promoting healthy birth outcomes in accordance with 42 C.F.R. 440.210 (as in effect January 1, 2014). (B) Definitions. (1) "Individual" for the purpose of this rule, means a medicaid-eligible individual who is pregnant, as verified by either self-declaration or medical verification, including the sixty days post-partum period. (2) ODM 03515 "Pregnancy Related Services Implementation Plan" (PRSIP) (rev. 1/2015) means the document submitted by an administrative agency describing how it delivers PRS to pregnant women in its county and which entity is responsible for ensuring the delivery of PRS. (3) "PRS coordinator" means the administrative agency employee who is responsible for the implementation of PRS. (4) "Support services" are non-medical services offered or provided by the administrative agency to assist the individual and may include arranging or providing transportation, making medical appointments, accompanying the individual to medical appointments, and making referrals to community and other social services. Support services will be coordinated with the individual's medicaid-contracting managed care plan (MCP), where applicable. (C) The individual (or the individual's parent(s), guardian or legal custodian, as applicable) may: (1) Complete and sign the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014) to verify understanding of PRS and Healthchek services; (2) Complete, sign, and return the ODM 03528 to identify her own and her children's need for services. (D) Administrative agency responsibilities. The administrative agency shall: (1) Inform individuals in its county about PRS within sixty days of the eligibility determination. Informing methods shall be written, oral or a combination of written and oral methods, as described below: (a) Provide the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014). (b) Provide information about: (i) The benefits and importance of early and continual prenatal and postpartum care. (ii) The services covered by PRS as described in Chapter 5160-4 of the Administrative Code. (iii) The benefits of healthchek services as described in 5160:1-2-05 of the Administrative Code. (iv) Transportation services and scheduling assistance available to individuals, if needed and upon request, in accordance with Chapter 5160-15 of the Administrative Code. (v) Availability of transportation services through the individual's MCP. The transportation services shall be provided by the administrative agency if not available from the MCP. (vi) Transportation services and scheduling assistance available to infants during the first year of life. (vii) Medical and non-medical support

services to include but not limited to: (a) "The Help Me Grow" (HMG) program; (b) The special supplemental food program for women, infants and children (WIC); (c) Maternal and child health clinics; (d) Local health departments; (e) Social services and other community services. (viii) Availability of assistance for scheduling medical appointments, as requested by the individual. (ix) A list of medicaid prenatal care providers, if requested, available to the community and/or information about medicaid-contracting MCPs. (2) Inform individuals enrolled in a MCP that they should contact the MCP for medical care options and referrals. (3) Re-inform the individual of the benefits of healthchek services as soon as possible after the infant's birth. (4) Refer the individual to support services as requested verbally, in writing, or via the ODM 03528 and ensure: (a) Referrals are made, as needed, for medical and non-medical support services. (b) Coordination between the individual, medical provider, MCP or other entity where the referral is made. (c) Transportation assistance is provided to individuals, as requested. (d) Individuals in need of non-medicaid covered medical services are referred to community, medical or other social services. This includes providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual. (5) Establish contact with the individual upon notification from the medical provider or MCP that the individual has missed appointments or there are other problems in the delivery of care and inform the individual's medical provider or MCP about the outcome of the contact. (6) Provide a copy of the ODM 03528 (if applicable) and the ODM 03535 "Prenatal Risk Assessment Form" (if applicable) (rev. 7/2014) to the individual's MCP. (7) Make a second attempt to contact the individual by alternate means if written information about PRS sent to the individual is returned as undeliverable. (8) Submit a new or amended ODM 03515 "Pregnancy Related Services Implementation Plan" (rev. 1/2015) to Ohio department of medicaid (ODM), including but not limited to, when there has been a change of agency address, director, PRS coordinator or where the responsibility for PRS is organizationally located within the agency. The ODM 03515 shall be submitted to ODM within ten business days of the change. (9) Obtain a HIPAA compliant signed authorization for release of information, ODM 03397 "Authorization for the Release or Use of Protected Health Information (PHI) or Other Confidential Information" (rev. 8/2014), when additional medical information is needed from the individual. (10) Maintain a listing of fee-for-service providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual. It is recognized that the ability of the administrative agency to recruit and maintain an adequate provider network depends on the existence of appropriate providers within a reasonable geographic area. (11) Maintain documentation in a case file for each eligible individual. The file shall consist of permanent records, either hard copy or electronically stored, containing the following information, when appropriate: (a) Copy of the ODM 03528, ODM 03535, or other referral forms received by the county; (b) Copy of correspondence received and sent; (c) Documentation of agency contacts with the individual, both attempted and established; (d) Documentation of the MCP in which the individual is enrolled; (e) Information received from another county when the individual is an intercounty transfer; (f) Documentation of all service requests, steps taken by the administrative agency, and whether the individual received services; and (g) Records of transportation services provided. (E) Each administrative agency PRS coordinator, or such coordinator's designee(s), shall attend annual and other pertinent trainings offered by ODM. Verification of attendance shall consist of documentation of roll call and sending an evaluation form to the state email box within three days of the video conference or training. Verification of attendance at onsite training shall be documented by the PRS coordinator or such coordinator's designee(s) by signing the attendance log.

¹⁰¹ 3. Authorization or Denial of Covered Services... (3) Contractor can require Members and Subcontractors to obtain Prior Authorization for Covered Services from Contractor provided that such Prior Authorization:...(ii) is in accordance with 42 CFR 438.210(4) and 42 CFR 441.20 as follows:... (b) without limiting a Member's right under Para. b, Sec. 6 of this Ex, B, Part 2 of the Contract, family planning services are provided in a manner that protects and enables a Member's freedom to choose a method of family planning (p. 53, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

6. Covered Service Components: Preventive Care, Family Planning, Sterilization & Hysterectomies and Post Hospital Extended Care... b. Family Planning Services Members may receive Covered Services for Family Planning Services from any OHA Provider as specified in the Social Security Act, Section 1905 (42 U.S.C. 1396d), 42 CFR 431.51 and as defined in OAR 410-120-0000 and 410-130-0585. In the event Members choose 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. (pp. 66-67, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁰² V. Program Requirements... 6. Self-Referral/Direct Access... 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, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Home Visiting Program The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Proposals submitted for the Home Visiting Program must encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers. I. Home Visiting Program Requirements and Goals... C. Home Visiting activities must be primarily focused on:... 10. Family planning, which includes access to counseling for available contraceptive options, childbirth-spacing education, and support to attain contraceptives if requested by mother... Q. The PH-MCO or contracted Home Visiting agency must follow-up with all provided referrals to ensure risks and needs are addressed. All families must receive information on... family planning... if needed... T. The Maternal Needs and Risk Assessment must include at a minimum the following:... family planning... (p. B(5a)-1, 5(5a)-4, Effective January 2022, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

Family Planning Services Procedure. Procedures which may be included with a Family Planning comprehensive visit, a Family Planning clinic problem visit, or a Family Planning Clinic routine visit: Insertion, implantable contraceptive capsules • Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only) • Removal, Implantable contraceptive capsules • Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only) • Destruction of vaginal lesion(s); simple, any method (females only) • Biopsy of vaginal mucosa; simple (separate procedure) (females only) • Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only) • Colposcopy (vaginocopy); separate procedure (females only)A • Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettageA • Colposcopy (vaginocopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)B • Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)B • Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only) • Cauterization of cervix; electro or thermal (females only) • Cauterization of cervix; cryocautery, initial or repeat (females only) • Cauterization of cervix; laser ablation (females only) • Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only) • Alpha-fetoprotein; serum (females only) • Nuclear molecular diagnostics; nucleic acid probe, each • Nuclear molecular diagnosis; nucleic acid probe, each • Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each • Fluorescent antibody; screen, each antibody • Immunoassay for infectious agent antibody; quantitative, not elsewhere specified • Antibody; HIV-1 • Antibody; HIV-2 • Treponema Pallidum, confirmatory test (e.g., FTA-abs) • Culture, chlamydia • Cytopathology, any other source; preparation, screening and interpretation • Progestasert I.U.D. (females only) • Depo-Provera injection (once per 60 days) (females only) • ParaGuard I.U.D. (females only) • Hemoglobin electrophoresis (e.g., A2, S, C) • Microbial Identification, Nucleic Acid Probes, each probe used • Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

Procedures Which May Be Included with a Family Planning Clinic Problem Visit: • Gonadotropin, chorionic, (hCG); quantitative • Gonadotropin, chorionic, (hCG); qualitative • Syphilis test; qualitative (e.g., VDRL, RPR, ART) • Culture, bacterial, definitive; any other source • Culture, bacterial, any source; anaerobic (isolation) • Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography • Culture, bacterial, urine; quantitative, colony count • Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection • Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types • Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes) • Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites • Smear, primary source, with interpretation; wet and dry mount, for ova and parasites • Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision • Level IV - Surgical pathology, gross and microscopic examination • 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) • Breast cancer screen (females only) • Mammography, bilateral (females only) • Genetic Risk Assessment (p. F-1 – F-3, Effective January 2022, Exhibit F, Pennsylvania HealthChoices Physical Health Agreement)

Opioid Use Disorder Centers of Excellence... C. The following services, when provided as clinically appropriate and included or reflected in the individual member's care plan, constitute community-based care management services covered by procedure code G9012... 3. Referrals Facilitating referrals to necessary and appropriate clinical services according to the member's care plan, including:... 2... Family Planning Services (p. G-2, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

PH-MCO Member Handbook... B. In compliance with 42 C.F.R. §438.10(g), the content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. At a minimum, the Member handbook shall include:... 7. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PH-MCO cannot require a Member to obtain a referral before choosing a family planning provider. (p. DD-2, Effective January 2022, Exhibit DD, Pennsylvania HealthChoices Physical Health Agreement)

¹⁰³ 15. New Member Orientation The PH-MCO must have written policies and procedures for new Members or a written orientation plan or program that includes: Orienting new Members to their benefits (e.g., prenatal care...) (p. 76, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Home Visiting Program... I. Home Visiting Program Requirements and Goals... C. Home Visiting activities must be primarily focused on: 1. Maternal... promotion and prevention 2. Parent/caregiver education and support... 8. Reducing disparities in perinatal health... 12. Increasing screenings for Maternal/Caregiver depression and anxiety... D. The objective of the Home Visiting Program is to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality, especially in individuals identified to be at risk... R. The home visitor must complete maternal... risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. The plan of care addresses the family's needs, applies the family's strengths and is outcome focused. The plan of care includes family-specific objectives, interventions and goals based on identified needs and risks. If any safety concerns are identified for the parent/caregiver or child, a safety plan must be included... T. The Maternal Needs and Risk Assessment must include at a minimum the following: demographic information, pregnancy health history, chronic disease health history, other health history (sexually transmitted infections, prescription drugs, oral health), family planning, prenatal care, nutrition, breastfeeding, tobacco, alcohol and drug use, stressors, social support, mental health (depression, anxiety), intimate partner violence and social determinants of health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), and parenting... V. The following domains must be addressed in assessments for all families:... Perinatal and Child Health Outcomes: Examples of factors that indicate risks under this domain include mother's utilization of adequate and timely prenatal care, was the mother counseled about family planning options, is the mother breastfeeding, current or past maternal postpartum depression, infant preterm birth, low birth weight, NICU admission and status of well child visit utilization... W. The Home Visiting Program must minimally address the following: 1. Maternal Physical Assessment 2. Infant Physical Assessment 3. Maternal Depression and Anxiety Screening 4. Childbirth Preparation including obtaining prenatal care if needed 5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol) 6. Tobacco Use Assessment 7. Lactation Care 8. Parent/Caregiver-Infant Care and interaction 9. Well Child Screening and Visits Assessment 10. Family Planning 11. Home Assessment 12. Intimate Partner/Interpersonal Violence Risk Assessment 13. Parent/Caregiver Skills Education 14. Positive Parenting Practices 15. Nutrition Counseling 16. Physical recovery from birth 17. Chronic disease management 18. Health promotion 19. Postpartum health 20. Safe Sleep practices 21. Assessment and Development of Home Visiting Plan 22. Social Determinants of Health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain) 23. Referral to support programs (Home Visiting Programs, Health coverage, SNAP, housing, employment, transportation, WIC) 24. Child Safety Education 25. Child Development Screening 26. Age Appropriate Immunizations 27. EPSDT scheduling and education 28. Early language and literacy activities 29. Maternal and Infant Lead Screening and education (p. B(5a)-2, B(5a)-4-6, Effective January 2022, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

¹⁰⁴ Ex.B(5a). The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Ex.B(5a).I. Home Visiting Program Requirements and Goals. Ex.B(5a).I.C. Home Visiting activities must be primarily be focused on: Ex.B(5a).I.C.1. Maternal and Infant Health promotion and prevention . . . Ex.B.(5a).I.C.11. Increasing postpartum healthcare visits. Ex.B.(5a).I.C.12. Increasing screenings for Maternal/Caregiver depression and anxiety; Ex.B(5a).I.W. The Home Visiting Program must minimally address the following: 16. Physical recovery from birth. (pp. B(5a)-1, Exhibit B(5a), Pennsylvania HealthChoices Physical Health Agreement)

¹⁰⁵ 2.05.02.02 Enrollment in Extended Family Planning The Contractor agrees to offer an Extended Family Planning program (with premiums to be paid by EOHHS for women up to two hundred fifty percent (250%) FPL to persons who obtain Title XIX eligibility due to a pregnancy ("SOBRA-Extension" eligible) and who would lose eligibility sixty (60) days post-partum or sixty (60) days

following birth or loss of the pregnancy. EOHHS will notify the Contractor of a member's change of eligibility to Extended Family Planning. The Contractor must have written policies and procedures for informing eligible members of this benefit. (p. 58, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.05.10.01 Required information The New Member packet will be written at no higher than a sixth-grade level and contain at least the following:... Information that enrollment Medicaid Managed Care does not restrict the choice of provider from whom the member may receive family planning services and supplies... Members may obtain benefits, including family planning services, from out-of-network providers. (pp. 63-64, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.06.01 Description of Comprehensive Benefit Package 2.06.01.01 General... The comprehensive benefit package includes Medically Necessary... family planning services... (p. 73, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

Prenatal Tracking, Follow-up and Outreach The Contractor agrees to have written policies and procedures for educating enrollees about the importance of early prenatal care and is encouraged to offer incentives to women who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits. In addition, the Contractor agrees to do the following:... Ensure that family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six week post-partum visit. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

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. These policies and procedures must also include that members may see out of network providers for these services. (p. 109, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.09.06 Access for Women The Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services and supplies. (pp. 118-119, Effective January 202, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.12.03.02 Utilization Review... The Contractor is permitted to conduct utilization review and place appropriate limits on services supporting member with ongoing or chronic conditions so long as services are authorized in a manner that reflects the member's ongoing needs for such services and supports. The Contractor may also conduct utilization review for family planning services but only in a manner that protects the member's freedom to choose their method of family planning. (p. 129, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

2.12.03.04 Confidentiality... The Contractor will have available in its network providers willing to provide confidential family planning and STI services to adolescents. (p. 134, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service).

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS Services below are covered for all members based on medical necessity criteria. Contractor is responsible for ensuring access and quality of care to services listed in ATTACHMENT A. The Contractor will provide services which increase the member's opportunities to remain at home and out of an institutional setting. The Contractor

is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health. The Contractor will recognize that services in entitled “scope of benefits” are provided as examples and do not represent an all-inclusive list of benefits.... SERVICE: Family Planning Services... SCOPE OF BENEFIT (ANNUAL) Including but not limited to:... 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 F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription. (p. 272, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

ATTACHMENT F Extended Family Planning Program 1. Eligibility Requirements. Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, meeting the eligibility criteria below into the demonstration who have a family income at or below 253 percent of the FPL and who are not otherwise enrolled in Medicaid or Children’s Health Insurance Plan (CHIP). Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 253 percent of the FPL at the time of annual redetermination are auto enrolled in the Extended Family Planning group. 2. Primary Care Referral. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services. 3. Eligibility Redeterminations. The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the State’s option, redeterminations may be administrative in nature. 4. Disenrollment from the Extended Family Planning Program. If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program. 5. Extended Family Planning Program Benefits. Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including: a. Approved methods of contraception; b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams; Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception. c. Members covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription d. Drugs, supplies, or devices related to women’s health services described above that are prescribed by a health care provider who meets the State’s provider enrollment requirements (subject to the national drug rebate program requirements); and e. Contraceptive management, patient education, and counseling. 6. Family Planning-Related Benefits. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State’s regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a “family planning-related” problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning related services and supplies include: a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered. c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered. d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer. e. Treatment of major complications (including anesthesia) arising from a family planning procedure such as: i. i. Treatment of a perforated uterus due to an intrauterine device insertion; Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or i. Treatment of surgical or anesthesia-related complications during a sterilization procedure. 7. Services. Services provided through the Extended Family Planning program are paid either through a capitated managed care delivery system or fee for service (FFS). (pp. 300-302, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁶ 2.06. IN-PLAN SERVICES. 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. Prenatal Tracking, Follow-up and Outreach. The Contractor agrees to have written policies and procedures for educating enrollees about the importance of early prenatal care and is encouraged to offer incentives to women who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits.

Tobacco Cessation The Contractor agrees to have written policies and procedures to assess members for smoking behavior, particularly... pregnant women... The Contractor will arrange for tobacco cessation programs and services to be offered to all members at convenient times and in accessible locations and will cover tobacco cessation supplies specified in ATTACHMENT A. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.07.06.02 Adolescent Self-Sufficiency Collaborative Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. The ASSC provides: (1) case management services, including home visiting, and intensive case management to minor parents focusing on parenting education and life-skills development;... (pp. 90-91, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.09.08 Health Risk Assessments For all members, the Contractor will conduct a Health Risk Assessment with the member, caregiver or guardian. The Health Risk Assessment will be used to identify members who require short term care coordination or intensive care management for medical, behavioral or social needs. The Contractor will:... (2) ensure the administration of the Health Risk Assessment to pregnant women and members with complex and serious medical or behavioral conditions within thirty (30) days of the date of identification. (p. 119, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

B. Crisis Stabilization Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner. These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service... I. Education, Support, and Consultation to Client's Families and Other Major Supports Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:... 5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to: a) Services to help clients throughout pregnancy and the birth of a child (p. 358, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁷ 2.06. IN-PLAN SERVICES. 2.06.01.09. Enhanced Services.... In addition, the Contractor agrees to do the following: . . . Schedule or assure that its PCPs or prenatal care providers schedule a post-partum visit nor more than six (6) weeks after delivery. Ensure that family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six week post-partum visit. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.15.01.08 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. The Contractor will provide quarterly reporting regarding payments as stipulated by R.I. General Law Chapter 40-8, Section 40-8-13.4. (p. 157, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁰⁸ 3.12.2 Member Handbook The CONTRACTOR shall:... 3.12.2.5. At a minimum, include the following information within the Member handbook:... 3.12.3.5.13. The extent to which, and how, members may obtain benefits, including Family Planning Services and supplies from out-of-network Providers: 3.12.2.5.13.1 The CONTRACTOR may not require an Enrollee to obtain a referral before choosing a Family Planning Provider. (p. 37, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

4. CORE BENEFITS AND SERVICES. 4.1.5.4. Family Planning Services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of Family Planning to be used consistent with §441.20. (p. 55, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

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, (4) health education, prevention and counseling services related to alternative birth control and prevention as prescribed and rendered by various Providers. and 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. 4.2.12.3. May encourage but not require Members to receive Family Planning Services through an in-network Provider or by appropriate referral as to promote the integration/coordination of these services. (pp. 63-64, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹⁰⁹ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include prenatal . . . services . . . for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹⁰ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include delivery. . . services . . . for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹¹ 4. CORE BENEFITS AND SERVICES. 4.2.18. Maternity Services. Maternity care benefits and services include . . . postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹¹² Amend. 7. 22. Section A.2.14.1.6 shall be amended by deleting the word "and" after Section A.2.14.1.6.4 and adding a new A.2.14.1.6.5 as follows and renumbering the remaining Section accordingly, including any references thereto. 2.14.1.6.5. Assure family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. (p. 29, no date, Amendment 7, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

2.17.4 Member Handbook... 2.17.4.6 Each member handbook shall, at a minimum, be in accordance with the following guidelines:... 2.17.4.6.1 0 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract 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. 29, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

51. Section A.2.13.7 shall be amended as follows: A.2.13.7 Local Health Departments... 2.13.7.2 The CONTRACTOR shall recognize that public health nurses employed by the local health departments are appropriately trained and practice within a scope of protocols developed by the state. The protocols allow public health nurses from across the licensure spectrum to provide services specific to diagnosis, treatment and delivery of preventive services under the general, but not necessarily onsite, supervision of a physician. These services include, but may not be limited to... family planning and sexually transmitted disease treatment. TennCare is a state operated program and is not bound by Medicare policy regarding the interpretation of billing codes, therefore,

in accordance with the training and protocols the state's public health nurses practice within, the CONTRACTOR shall allow public health nurses to bill using the same CPT codes, related to the aforementioned services, as would be used if the service was delivered by an advance practice nurse. (no page, no date, Amendment 5, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

A.2.7.5 Preventive Services 2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to, ... family planning services... in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section A.2.6.7 of this Contract (see TennCare rules and regulations service codes). (p. 62, January 2014, United Healthcare Plan of the River Valley dba UnitedHealthCare Community Plan, Executed Agreement, Tennessee)

¹¹³A.2.8.4 Risk Level and Program Content and Minimum Interventions... 2.8.4.4 Low Risk 2.8.4.4.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with rising risk and chronic care needs. The goal of the cohorts is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support. The Low-Risk cohorts shall include a maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Low Risk Minimum Interventions 1. Four documented non-interactive communications each year. The communications shall address self-management education emphasizing the following: A. Increasing the members knowledge of chronic health conditions B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of health conditions E. Self-efficacy & support 2. Offering of individual support for self-management if member desires to become engaged. 3. Availability of 24/7 NurseLine. 4. Availability of health coaching.

2.8.4.4.2 Low Risk Maternity 2.8.4.4.3 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into High Risk Maternity. 2.8.4.4.4 The CONTRACTOR shall provide to members eligible for Low Risk Maternity the following minimum standard interventions:... 1. Screening for risk factors to include screening for mental health and substance use. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract. 2. One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health. 3. Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management. 4. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. 5. Referrals to appropriate community-based resources and follow-up for these referrals.

2.8.4.5 High Risk 2.8.4.5.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with high risk needs. The goal of the cohorts is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. The High Risk cohorts shall include a high risk maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition. C. Development and implementation of individualized care plan. D. Problem solving techniques E. The emotional impact of member's condition F. Self-efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs

2.8.4.6 High Risk Maternity Program 2.8.4.6.1 The CONTRACTOR shall provide to members enrolled in High Risk Maternity the following minimum standard interventions:... One interactive contact to the member per month of pregnancy to provide intense case management including the following: Development of member support relationship by face to face visit or other means as appropriate. Monthly interactive contacts to support and follow-up on patient self-management. If prenatal visits have not been kept more frequent calls are required. Comprehensive HRA to include screening for mental health and substance abuse. Development and implementation of individualized care plan to include information on pregnancy, newborn, and inter-conception health. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. Referrals to appropriate community-based resources and follow-up for these referrals. If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including Tennessee Tobacco QuitLine. (p. 44-46, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

A.2.7.5 Preventive Services 2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to,... prenatal care... These services shall be exempt from TennCare cost sharing responsibilities described in Section A.2.6.7 of this Contract (see TennCare rules and regulations for service codes). 2.7.5.2 Prenatal Care 2.7.5.2.1 The CONTRACTOR shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section A.2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections A.2.9.2.2 and A.2.9.2.3 regarding prior authorization of prenatal care. 2.7.5.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from a PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Contract. 2.7.5.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section A.2.11.4 of this Contract. (p. 62, January 2014, United Healthcare Plan of the River Valley dba UnitedHealthCare Community Plan, Executed Agreement, Tennessee)

¹¹⁴ 2.8.4 Risk Level and Program Content and Minimum Interventions... 2.8.4.4.2 Low Risk Maternity 2.8.4.4.3 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into High Risk Maternity. 2.8.4.4.4 The CONTRACTOR shall provide to members eligible for Low Risk Maternity the following minimum standard interventions:...t 4. Follow-up to assure member is established with a provider, receives...postpartum visits, and postpartum depression screening.

2.8.4.5 High Risk 2.8.4.5.1 For all eligible members, the CONTRACTOR shall provide cohorts designed to manage members with high risk needs. The goal of the cohorts is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. The High Risk cohorts shall include a high risk maternity program with the goal to engage pregnant women into timely prenatal and postnatal care and aim for delivery of a healthy, term infant without complications. Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member's condition. C. Development and implementation of individualized care plan. D. Problem solving techniques E. The emotional impact of member's condition F. Self-efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs.

2.8.4.6 High Risk Maternity Program 2.8.4.6.1 The CONTRACTOR shall provide to members enrolled in High Risk Maternity the following minimum standard interventions:... Follow-up to assure member is established with a provider, receives...postpartum visits, and postpartum depression screening... (pp. 44-46, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹¹⁵ 8.1.22.2. Family Planning - Specific Requirements. The MCO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family services. The MCO must ensure that Members have the right to choose any Medicaid participating family planning Provider, whether the Provider chosen by the Member is in or outside the Provider Network. The MCO must provide Members access to information about available Providers of family planning services and the Member's right to choose any Medicaid family planning Provider. The MCO must provide access to confidential family planning services. The MCO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid fee-for-service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program and will reimburse Out-of-Network family planning Providers in accordance with HHSC's administrative rules. The MCO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider. The MCO

must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor. The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding state and federal laws governing Member confidentiality, including minors. Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member confidentiality for family planning services. (pp. 159–160, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; p. 8-153, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; p. 8-189, Effective March 1, 2022, Document Version 2.16, Attachment B-1 – HHSC STAR Health MCO RFP, Section 8, Texas).

8.1.24.2 Family Planning – Specific Requirements... As described in Section 8.1.33, the MCO must also have procedures in place to educate the following Members about family planning programs, including the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs: 1. Pregnant Women in Medicaid who will lose eligibility after delivery 2. Young pregnant adults in Children's Medicaid who will have aged out of Children's Medicaid by the time of delivery (p. 8-153, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

8.1.33 Coordination with Other State Health and Human Services Programs The MCO must coordinate with other state Health and Human Services (HHS) Programs in each Service Area, or each Texas Health and Human Service Region, regarding the provision of essential public healthcare services. The MCO must meet the following requirements:... 13. Educate Providers and Members about primary and family planning services available through the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs (p. 8-189, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas)

¹¹⁶ 8.1.22.4. Perinatal Services. The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services: 1. Pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents; 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; Access to appropriate levels of care based on risk assessment, including emergency care. (p. 163., Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; p. 8-157, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; p. 8-167, Effective March 1, 2022, Document Version 2.16, Attachment B-1 – HHSC STAR Health MCO RFP, Section 8, Texas)

¹¹⁷ Services included under the MCO capitation payment... Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center... 21. Prenatal Care (pp. 7-8, Effective March 1, 2022, Document Revision V1.39, Attachment B-2 – STAR+PLUS, Dallas and Tarrant Service Areas RFP, STAR+PLUS, Covered Services; pp. 3-4, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; pp. 4-5, Effective March 1, 2022, Document V2.16, Attachment B-2 – HHSC STAR Health MCO RFP, STAR Health Covered Services, Texas)

8.1.22.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; 3. Access to appropriate levels of care based on risk assessment, including emergency care; 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of

dealing with complicated perinatal problems; and 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services... The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include service management under Section 8.1.13 and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate... The MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born... The MCO must notify Providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network Providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises. (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; pp. 8-157-8-158, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

8.1.22.11 Case Management for Children and Pregnant Women The MCO must coordinate services with Case Management for Children and Pregnant Women. This coordination includes, but is not limited to, client education, outreach, case collaboration and referrals to Case Management for Children and Pregnant Women. The MCO is required to follow referral procedures as outlined by the State. Referrals to Case Management for Children and Pregnant Women are to be based upon guidelines provided by the State, assessment, plan of care, change in client's physical, mental or psychosocial condition or at client's request. Annually, all MCO Care Coordination/Case Management Staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion. (p. 167, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions, pp. 8-167-8-168, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

¹¹⁸ 8.1.22.4. Perinatal Services... The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the Newborn Member, and may not place limits on the duration of such care. (p. 164, Effective March 1, 2022, Document Revision V1.39, Attachment B-2 – STAR+PLUS, Dallas and Tarrant Service Areas RFP, STAR+PLUS, Covered Service; p. 8-158, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; Texas)

¹¹⁹8.1.22.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... 2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age; 3. Access to appropriate levels of care based on risk assessment, including emergency care; 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services... The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include service management under Section 8.1.13 and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate... The MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born... The MCO must notify Providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network Providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises. (pp. 163-164, Effective March 1, 2022, Document Revision V1.39, , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions; pp. 8-157-8-158, Effective March 1, 2022, Document V1.16, Attachment B-2 – HHSC STAR Kids MCO RFP, STAR Kids Covered Services; Texas)

¹²⁰ 3.5 Member Orientation 3.5.1 Initial Contact - General Orientation (A) Within 30 days of Enrollment, the Contractor shall conduct an in-person welcome intake visit with the Enrollee. During the welcome intake visit the Contractor shall:... (6) explain the availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Non-Network Providers; (pp. 21-22, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 21, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE); (p. 23, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

3.6.5 Enrollee Handbook... (C) The Enrollee handbook shall contain information:... (17) on the extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from Non-Network Providers; (18) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider; (p. 26, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 24, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE); (p. 29, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

4.1 General Provisions 4.1.1 Basic Standards... (E) The Contractor may place appropriate limits on a service on the basis of criteria applied under the State Plan such as Medical Necessity, or for the purpose of utilization control, provided:... (3) family planning services are provided in a manner that protects and enables an Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. (p. 33, Effective July 2021, Attachment B – MODEL, Utah Medicaid HOME Program Contract; p. 311, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE))

1.3.25 Family Planning Services (A) Family planning services are Covered Services. Family planning services include disseminating information, counseling, and treatments relating to family planning services. (B) Family planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law. (C) Birth control services include information and instructions related to the following: (1) birth control pills; (2) Norplant (removal only); (3) Depo Provera; (4) IUDs; (5) barrier methods including diaphragms, male and female condoms, and cervical caps; (6) vasectomy or tubal ligations; (7) NuvaRing®; and (8) office calls, examinations, or counseling related to contraceptive devices. (D) Family planning Covered Services for Non-Traditional Enrollees are the same as Traditional Enrollees family planning Covered Services except the following are not Covered Services: (1) Norplant; (2) infertility drugs; (3) in-vitro fertilization; and (4) genetic counseling. (p. 10, Effective July 2021, Attachment C – Covered Services, Utah Medicaid HOME Program Contract; p. 9, Effective January 2018, Attachment C – Traditional, pp. 9-10, Attachment D – Non-Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

1.18 Family Planning Services This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law. The following family planning services are not covered: (A) Norplant (B) Infertility drugs (C) In-vitro fertilization (D) Genetic counseling (no page #, Effective July 2021, Molina CHIP Attachment C – Covered Services, Utah CHIP Model Contract Managed Care Entity (MCE))

¹²¹ 1.3.25 High-Risk Prenatal Services... (B)... Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others. (p. 10, Effective January 2018, Attachment C – Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹²² 1.3.25 High-Risk Prenatal Services (A) The Contractor shall ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility. (B) In the determination of the Provider and facility to which a high risk prenatal Enrollee shall be referred, care shall be taken to ensure that the Provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as

impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others. (C) Enrollees who are pregnant shall be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not be moderate or high risk shall be evaluated for change in risk status throughout their pregnancy. (D) The Contractor shall have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers shall be consistent with standards of practice and linked to the Contractor's care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care providers shall be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy. (E) The Contractor's healthy pregnancy programs shall also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The Contractor shall refer to and coordinate care with the prenatal care providers concerning the treatment plan and risk factors. The Contractor's risk assessments shall be overseen by the Contractor's Medical Director. (F) Assessment tools used by prenatal care providers and the Contractor shall include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the Contractor and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care. (G) The Department recommends Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The Department recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk shall receive care coordination/case management services. (H) The Department recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on: (1) evidence of clinical hepatitis during pregnancy; (2) injection drug use; (3) occurrence during pregnancy or a history of STDs; or (4) judgment of the health care provider. (I) When a woman is found to be HBsAg-positive, the Contractor shall provide HBIG and HB vaccine at birth. Initial treatments shall be given during the first 12 hours of life. The Contractor shall comply with all other requirements as specified in Utah Administrative Code R386-702-9. (J) The Department recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Health Code 26-6-20. Testing for STDs shall be repeated in the 3rd trimester for Enrollees at high risk for exposure. (K) The Department also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The Contractor shall encourage providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to: (1) universal testing with an opt-out approach (testing of all pregnant women and not just those who appear to be at high risk for HIV; (2) flexibility in the consent process; and (3) prevention and referral through education during prenatal care. (L) Prenatal care providers shall have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy shall be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive shall receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns. (M) Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women: (1) perinatal care coordination (T1017) (2) prenatal and postnatal home visits (3) group prenatal and postnatal education (4) nutritional assessment and counseling (5) prenatal and postnatal psychosocial counseling (N) Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness shall be referred to an appropriate mental health care provider. (pp. 10-12, Effective January 2018, Attachment C – Traditional, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹²³⁴ 4.5 Covered Services, Maternity 4.5.1 Maternity Stays (A) The Contractor is responsible for paying for and providing post-delivery care services to an Enrollee and their newborn as follows: (1) inpatient care for a minimum of 48 hours of inpatient care following a normal vaginal delivery; (2) inpatient care for a minimum of 96 hours of inpatient care following a caesarean section; and (3) the Contractor shall not require the Provider attending the Enrollee and their newborn to obtain authorization from the Contractor in order to keep the Enrollee and their newborn in the inpatient setting for the periods of time described in Article 4.5.1 (A)(1) or (2). (B) The Contractor shall not be required to provide coverage for post-delivery inpatient care for an Enrollee and their newborn during the periods described in Article 4.5.1(A)(1) or (2) if: (1) the attending Provider, in consultation with the Enrollee, discharges the Enrollee and the newborn prior to the expiration of the time periods described in Article 4.5.1(A)(1) or (2); and (2) the Contractor provides Timely Post-Delivery Follow-Up Care. (C) Post-delivery care shall be provided to a Enrollee and their newborn by a

registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in a hospital. (p. 35, Effective July 2021, Molina CHIP Attachment B – Special Provisions, Utah CHIP Model Contract Managed Care Entity (MCE))

¹²⁴ 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)]... 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. 120, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.1. L Out-of-Network Services... b. The Contractor shall cover and pay for... family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract. (p. 138, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.1.N Out-of-State Services The Contractor is not responsible for services obtained outside the Commonwealth except under the following circumstances:... b. Family planning where it is a general practice for members in a particular locality to use medical resources in another State (p. 140, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2 Covered Services... The Contractor shall ensure that coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210:... 5. The Contractor shall ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20; (p. 147, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

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. In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 CFR § 431.51(b)(2), as amended, the Contractor may not restrict a member's choice of provider for family planning services, drugs, supplies, or devices. Federal law (42 CFR § 441.20) requires that the Contractor also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. Code of Virginia § 54.1-2969 (E), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization. As required by section 1902(a)(23)(B) of the Act, the Contractor cannot require the member to obtain a referral prior to choosing a provider for family planning services. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral. 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. Outpatient Coverage The Contractor must provide coverage for all LARC devices, The Contractor shall not impose service authorization requirements or quantity limits on LARCs. The Contractor shall reimburse practitioners for evaluation/management (E/M) visits, where the practitioner and member discuss contraceptive options, in addition to same day LARC insertion or removal procedures. The Contractor must reimburse practitioners for LARC devices and procedures at a rate no less than the Medicaid fee schedule. (pp. 172-173, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2. X Prenatal Care Requirements... The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g.... family planning) (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services – Part 1 – Medical Benefits.... Family Planning Services... services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its members by network and out-of-network providers. Individuals enrolled in Plan First are excluded from Medallion 4.0 program participation (unless implemented as an Enhanced Benefit as listed in the RFP). (p. 349, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Attachment III – Network Provider Agreement Requirements... At a minimum, MCO Contracts with Providers must include the following:... The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

Attachment XIV – FAMIS Addendum.. K. Family Planning FAMIS covered services include drugs and devices provided under the supervision of an in-network physician. Code of Virginia, § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization. (p. 427, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁵ 8.2.W 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: Ensure access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant women; Ensure an increase in post-partum care including maternal mental health screenings; Reduce early elective deliveries; Support lower C-Section rates; Increase family planning access; Increase HEDIS scores related to maternity; Implement Addiction and Recovery Treatment Services (ARTS), specifically for pregnant women with substance use disorder; Increase screenings for SUD for both high risk and non high risk mothers (Monthly Maternal Reports); Increase outreach and education, including the use of social media, to pregnant women; and, Collaborate with the Department on initiatives targeted to pregnant women. When the Department determines a pregnant woman's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum woman, the Contractor shall: Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290; Cover services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; and Cover prenatal and infant programs as outlined in this contract.

8.2. X Prenatal Care Requirements The Contractor shall have written policies and procedures that outline how the Contractor will provide access to prenatal services for all pregnant women, including identifying and tracking high risk members. At a minimum, the policies and procedures must outline how the following requirements will be met: Within ten (10) days of identification, the Contractor shall send information to pregnant women to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services; The Contractor shall cover all obstetric and gynecological services as stated in Section 8.2.DD; The Contractor shall ensure that the travel time and distance standards stated in Section 4.6 are met; The Contractor shall ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant members as follows:... The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g., reducing preterm birth, breast feeding, applying for WIC, safe sleep practices, and family planning), etc.; The Contractor shall ensure that every pregnant member is advised of the value of HIV testing as set forth in 12 VAC 30-50-510 and shall request that each pregnant member consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Pregnant members shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record; The Contractor shall ensure preauthorization requirements do not apply to basic prenatal care as stated in Section 8.1.D; The Contractor shall cover the services of certified nurse-midwives as stated in Section 8; The Contractor shall disseminate information about the WIC Program to potentially eligible women, infants, and children. A. Promotion and Incentives The Contractor shall promote and incent access and adherence to timely and adequate prenatal services as may be appropriate based on aid category or eligibility. B. Promotion and Incentives The Contractor shall promote and incent access and adherence to timely and adequate prenatal services as may be appropriate based on aid category or eligibility. C. Ancillary Services a. Certified

Nurse-Midwife The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260. b. Smoking Cessation Services The Contractor shall ensure tobacco cessation services, education, outreach and pharmacotherapy are covered for all pregnant individuals (12VAC30-50-60). c. Day and Residential Treatment for Substance Abuse Day and residential treatment for substance use for pregnant and postpartum women shall be covered as outlined in the ARTS requirements. d. Expanded Prenatal Care Services The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510: Nutritional assessment, counseling, and follow-up, as well as blood glucose meters. Addiction and recovery treatment services. Patient education in areas such as labor and delivery, Lamaze, planned parenthood, smoking cessation, substance abuse, and child rearing. Household maintenance services for pregnant women, primarily in third trimester, who need bed rest. D. High Risk Pregnancy Requirements The Contractor shall have written policies and procedures that outline how the Contractor differentiates pregnant women according to risk status. The methods applied to assess the risk of a pregnant member shall be evidence-based and developed in accordance with guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). At a minimum, the process must consider: The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.; Previous pregnancy complications and adverse birth outcomes; History of or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use); History of, or a current positive screen for, depression, anxiety and/or other behavioral health concerns; The member's personal safety (e.g., housing situation, violence). The Contractor shall have methods in place to monitor high-risk maternity programs and track members who are deemed by the Contractor as being "high-risk." The Contractor shall also continue to monitor, as deemed appropriate, the risk status of pregnant members not originally considered "high-risk" for potential enrollment in the Contractor's high-risk maternity programs. The Contractor shall report monthly to the Department information outlined on the Managed Care Technical Manual on the status of both their high-risk maternity programs and services rendered for all other pregnant and postpartum women. (pp. 190-192, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

g. Maternity Reporting Maternity Policies and Procedures The Contractor shall submit its maternity program policies and procedures and a plan to support positive birth outcomes to the Department in accordance with the requirements outlined in the MCTM. This report shall also include accomplishments, challenges, and partnerships during the previous contract year as well as copies of educational, training, and informational materials that the Contractor provided to OBGYNs. Maternity Program Summary Report The Contractor shall submit reporting related to maternity services, including measures demonstrating services for both its high-risk and non high-risk prenatal and postpartum members to the Department in accordance with the requirements outlined in the MCTM. (p. 196, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services - Part 1 - Medical Benefits... Service: Pregnancy-Related Services... The Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor shall cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements. (pp. 353-364, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁶ 8.2.S Hospital Services... e. General Obstetrical Hospital The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and follow-up visits as set forth in 12 VAC 30-50-220. (p. 187, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

12 VAC 30-50-100:...E. Mandatory lengths of stay. 1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2 VAC 30-50-220... C. Maternity length of stay and early discharge. 1. If the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care," 4th Edition, August 1997, as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The mother and newborn, or the newborn alone if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of his choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments' clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

¹²⁷ 8.2.W Maternity Care... When the Department determines a pregnant woman's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum woman, the Contractor shall: Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290; (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

Summary of Covered Services - Part 1 - Medical Benefits... Service: Pregnancy-Related Services... The Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor shall cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements. (pp. 353-364, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹²⁸ 16 BENEFITS... 16.1.7 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the Enrollee's right to choose the method of family planning to be used is protected. (p. 295, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17 General Description of Contract Services... 17.1.31.4 The Contractor may enter into contractual agreements with... family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. (p. 312, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.2 Enrollee Self-Referral 17.2.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington... 17.2.4. The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to Enrollees up to the limits described herein. 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. 17.2.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or IHCP Providers as Participating Providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract. 17.2.7 The services to which an Enrollee may self-refer are: 17.2.7.1 Family planning services and supplies, and sexually transmitted disease screening and treatment services provided at participating or non-Participating Providers, including but not limited to family planning agencies, such as Planned Parenthood. 17.2.7.2... family planning services through and if provided by a local health department. 17.2.7.3...family planning... services through and if provided by a school-based health center. (p. 316, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.3.3 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL... 17.3.3.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL... 17.3.3.2.5 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. Coverage of contraceptive drugs, devices and supplies must include: 17.3.3.2.5.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA approved to be dispensed over-the-counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits. 17.3.3.2.5.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit. 17.3.3.2.5.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months. 17.3.3.2.5.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the Enrollee requests a smaller supply. 17.3.3.2.5.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs. (pp. 319-320, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹²⁹ 17.3.3 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL... 17.3.3.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL:... 17.3.3.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care; (p. 319, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.4 Excluded and Non-Contracted Services... 17.4.3 The following Covered Services are provided by the state and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication, or Contractor publications... 17.4.3.15 Prenatal Genetic Counseling (p. 329, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

Scope of Benefits... Service: Health Care Professional Services... Services include, but are not limited to: Maternity care, delivery, and newborn care services; Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers (p. 5, Exhibit M-1, Revised September 2021, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹³⁰ Scope of Benefits... Service: Health Care Professional Services... Services include, but are not limited to: Maternity care, delivery, and newborn care services; Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers (p. 5, Exhibit M-1, Revised September 2021, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹³¹ Article IV: Services A. BadgerCare Plus and/or Medicaid SSI Services... 2. Medical Necessity:... Per 42 CFR §438.210(a)(4), the HMO can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and DHS 101.03(96m) or place appropriate limits on a service for the purpose of utilization control provided that:... c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. (p. 67, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

10. Family Planning Services and Confidentiality of Family Planning Information BadgerCare Plus and Medicaid SSI Plan members: a. The HMO must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or assigned to the member. 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. c. All information and medical records relating to family planning shall be kept confidential including those of a minor. (p. 78, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... Health education and disease prevention programs, including... family planning, teen pregnancy, sexually transmitted disease prevention,... (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus and/or Medicaid SSI.) (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HMOs must meet the following requirements with regard to women at high risk of a poor birth outcome. For this purpose, these women include: Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age... 5. 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. 173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

11. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers. a. Community-Based Health Organizations The Department encourages the HMO to contract with community-based health organizations for the provision of care to BadgerCare Plus and/or Medicaid SSI members in order to ensure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services. (p. 187, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³² D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women... e. HMO Responsibilities... 3) OB Medical Home Sites... d) Provide appropriate best practice medical care for high-risk pregnant women, which may include... 4. Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens. (p. 100, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HMOs must meet the following requirements with regard to women at high risk of poor birth outcomes. For this purpose, these women include Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age... 6. The HMO must have a plan in place for interconception care to ensure that the member is healthy prior to a subsequent pregnancy. At a minimum, the plan must address the needs of high-risk women with chronic conditions such as diabetes and hypertension. (p. 174, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³³ D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services. The HMO, in partnership with the medical home sites, shall be guided by four core principles: • Having a

designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries; • Providing ongoing care over the duration of the pregnancy and postpartum period; • Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and • Coordination of care across a person's conditions, providers and settings. Additional information regarding the OB Medical Home Initiative may be found on the ForwardHealth Portal (click the link to be directed to the website): OB Medical Home Initiative 1. Requirements a. Target Population The target population for the OB Medical Home Initiative is pregnant BadgerCare Plus and Medicaid SSI members who are at high-risk for a poor birth outcome. A poor birth outcome is defined as: 1) Preterm birth – gestational age less than 37 weeks 2) Low birth weight – birth weight less than 2,500 grams (5 lbs. 8 oz.) 3) Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life 4) Stillbirth – a fetal demise after 20 weeks gestation b. Members eligible to participate in the OBMH Initiative Documentation must confirm that the member is within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria: 1) Listed on the Department's Birth Outcome Registry Network (BORN) of high-risk women 2) Less than 18 years of age 3) African American 4) Homeless 5) Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy whether the symptoms be current or historical. The reason(s) for the member's medical home eligibility must be documented in the medical record. c. Payment Structure Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department currently issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site. Medical record reviews by the Department's External Quality Review Organization (EQRO) will be used to verify eligibility. If the EQRO is unable to verify any of the criteria as required by the OB Medical Home Initiative, the clinic is ineligible for the enhanced payment for those women. To receive the initial \$1,000, at minimum, the clinic must clearly document that all the following criteria are met. The member: 1) Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy. She must also be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation). Enrollment in the OB Medical Home means being entered into the OBMH registry. 2) Has attended a minimum of 10 medical prenatal care appointments with the OB care provider, 3) Has a member centric, comprehensive care plan that has been reviewed by the member and, at minimum, the OB provider, 4) Has been continuously enrolled in the OB medical home and receiving services during her pregnancy, and 5) Has continued enrollment through 60 days postpartum, including the date of the scheduled 60 day medical postpartum visit, and any documentation of no shows or appointment refusals. The Department will issue an additional \$1,000 (for a total of \$2,000) if the mother has a healthy birth outcome as defined by the Department. Pregnancy loss prior to 20 weeks will not be eligible for the OBMH incentive, as limited care coordination and delivery of other services has occurred. Providers will still receive payment for the medical prenatal care through the usual claim submission process. d. External Quality Review The Department has established a process for verifying that members enrolled in the OB Medical Home Initiative meet the requirements. The Department's EQRO will conduct chart reviews that: 1) Verify enrolled members meet the defined contract requirements; 2) Collect data to support potential future program refinements; and 3) Collect data to support program evaluation. The HMO is responsible for working with the medical home sites, external PNCC providers, hospitals and any other care provider that may or should have documentation of OB medical home services to ensure required documentation is submitted to the Department's EQRO in a timely manner. For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH members. If the patient is not on the record review list, the EQRO will not access those records. The Department does not provide additional reimbursement to HMOs or clinics for submission of medical records. HMOs are encouraged to define responsibilities of each party, which may include reimbursement policies and reporting requirements, in their subcontracts or agreements with medical home providers. e. HMO Responsibilities 1) HMO representative The HMO must designate a staff person to oversee the execution of the OB Medical Home Initiative. The HMO designee will be responsible for representing the HMO regarding inquiries pertaining to the initiative and will be available during normal business hours. The HMO representative will be responsible for ensuring the medical home is implemented in accordance with the contract. 2) HMO Outreach and Member Engagement HMOs must actively seek to identify and engage eligible members for participation in the OBMH. At a minimum, this should include a variety of strategies, e.g., working with existing organizations having similar goals, increasing public awareness about the OB Medical Home Initiative and its services, screening new members for eligibility, reviewing the BORN report periodically and working with colleagues to develop and implement creative strategies such as health fairs or street teams. 3) OB Medical Home Sites HMOs must distribute communications from DHS to its participating clinics and are accountable for ensuring contracted OB medical home sites meet the requirements below. The OB Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must: a) Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB care provider) will work together to identify the prenatal and psychosocial needs of the member to ensure that she will have a healthy birth outcome. b) Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and wait times according to Art. V of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week. c) Use an electronic health record system to

manage patient data to: 1. Document medical home enrollment date, 2. Organize clinical information, 3. Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy, 4. Track patient test results, 5. Identify abnormal patient test results, 6. Systematically track referrals and follow up, and 7. Document birth outcomes. d) Provide appropriate best practice medical care for high-risk pregnant women, which may include: 1. Consultation from a maternal fetal specialist and close monitoring and surveillance; 2. To the extent it is covered by ForwardHealth (such as through in person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. 3. Progesterone therapy, as appropriate; 4. Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens. e) Adopt and implement evidence-based guidelines that are based on, but not limited to, screening, treatment and management of the following chronic medical conditions: 1. Asthma 2. HIV/AIDS 3. Cardiac disease 4. Diabetes mellitus 5. Hypertension 6. Pulmonary disease 7. Behavioral health, including A. Depression B. Smoking C. Substance Abuse 8. Morbid Obesity The HMO and medical home sites must have clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists and community resources. f) Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following: 1. Integrating initial and periodic screening into information gathering, 2. Incorporating identified social needs (and strengths) into the comprehensive care plan, 3. Effective strategies for addressing social factors, including the following: • Identifying pertinent community resources, including personal supports; • Referral to community health worker services; • Developing effective working/referral relationships with these resources; • Communication and information sharing (e.g., obtaining written authorization from the member where necessary); • Obtaining periodic feedback from members and community resources to ensure identified resources continue to be relevant and appropriate. 4. Systematic electronic tracking and follow-up on community and social determinants of health referrals to ensure referral completion. g) Actively support and promote patient self-management. h) Demonstrate cultural competency among provider and office staff. 4) Documentation Requirements The medical home should retain electronic documentation to support the provision of the medical home services outlined in this section of the contract. f. Care Coordination – General Requirements A key component of the OB Medical Home Initiative is the coordination of care for the member. Each medical home site must have a designated care coordinator on-site (located where the member's OB care provider is located) to do the following: 1) Establish a relationship with the member and maintain regular face-to-face contact throughout the pregnancy; 2) Communicate with the member and other care providers to identify needs and assist in developing a member-centric care plan and keeping the plan up-to-date; 3) Make referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provide follow up. The care coordinator may be an employee of the medical home site or of the HMO, under contract, or under a Memorandum of Understanding/Agreement. All care coordinators must be easily accessible on a regularly established schedule for members participating in the OB medical home. To ensure continuity of care, the care coordinator shall work with the member to obtain the appropriate release forms, and contact the office(s) of any PCP, with whom the participating member had/has an ongoing relationship, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member. HMOs and medical home sites must use the OB Medical Home Registry, provided by the Department and hosted by the Department's External Quality Review Organization, to track enrollment in the OB Medical Home. a. Information Gathering and Comprehensive Assessment of Need Prior to the development of a comprehensive care management plan, the OB care provider must communicate with pertinent health care providers, the member and others as appropriate, to identify the member's strengths and care coordination needs. Information gathering activities include: 1) Obtaining pertinent information from the initial prenatal clinic visit, the OB care provider, the member's PCP, HMO or other source; 2) Taking the member's history to identify social factors that could have a negative impact on the health and well-being of the mother and baby; 3) Identifying the member's strengths and social support. b. Comprehensive Care Plan The care coordinator must ensure that each medical home member has a comprehensive care plan. The OB care provider must be central to the development of the care plan. To the maximum extent possible, the member and the member's PCP (if different from the OB care provider) must also be included in the development of the care plan. The care plan must address the medical and non-medical needs identified during the information gathering process and must include: 1) A listing of key health and community resources specific to the member's needs; 2) A prioritized plan of action that reflects the member's preferences and goals; 3) Timeframes for addressing (and following-up on) each identified need; 4) Strategies to encourage patient self-care and adherence to treatment recommendations (e.g., assisting the member in identifying selfmanagement goals and in communicating with her obstetric care provider, offering home visits, checking in with the member between visits, referring members to group classes, and sharing culturally sensitive and appropriate materials). The care coordinator should offer home visits. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members, who decline the initial offer, should be asked again throughout the pregnancy. The offer attempts and refusals must be documented in the medical record. The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, and any home visiting agency/provider the member may be working with, to track progress on the care plan and ensure coordinated care. The care plan must be developed by the OB care provider, the care coordinator, and the member. The provider must attest to the agreement and understanding

of the care plan by the respective parties and document, including the date, within the EHR. The plan must be reviewed and updated as the member's health and circumstances change. c. Ongoing Monitoring and Follow-up Ongoing monitoring and follow-up include activities and contacts that are necessary to implement and maintain the care plan. These activities include: 1) Ensuring services are being furnished in accordance with the member's care plan; 2) Making referrals, which includes related activities such as assisting with scheduling follow-up appointments; 3) Tracking and following up on all referrals, including referrals to community resources; 4) Flagging critical referrals to ensure immediate follow-up on overdue reports (e.g., following up on laboratory and imaging results to determine the need for additional services). a) Referrals are not complete without timely follow up with the member and/or with the service provider to track the results of the referral. 5) Communicating with the member, the OB care provider and other individuals instrumental to the member's care and support, to assess the usefulness of key community resources and to ensure the care plan is meeting the member's needs. 6) Reviewing and updating the care plan, as necessary, following each health care encounter or home visit. 7) Assisting in removing barriers to care, e.g., offering flexible scheduling and assessing and addressing communication gap between the health care provider and the member. d. Transition Plan (Transfer of Care) All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care: 1) Engage the member in the transfer of care, to the maximum extent possible. 2) Collaborate with the HMO to ensure continuity of care for the mother and newborn following medical home discharge. For example, the medical home could summarize and share issues related to the need for ongoing support, outstanding test results, community referrals, upcoming appointments, and any unmet needs or concerns from the member's care plan. 3) Ensure that each member has a transition plan, as described below. a) Healthy Birth Outcome If the member has a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period: 1. The member shall have at least one postpartum followup appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines. 2. Ensure that the member is connected to a PCP and has an appointment as appropriate with a PCP. 3. Ensure that the member has identified a PCP for the newborn and has made an initial appointment. 4. The care coordinator shall contact the member's PCP to inform her/him of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum. 5. The care coordinator shall educate the member on interconception care specific to her needs. b) Poor Birth Outcome In addition to items listed under healthy birth outcome above, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following: 1. Working with the OB medical home site to develop a care plan for the infant and the mother that incorporates input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs. 2. Conduct follow up with the mother to ensure that the initial referral appointments with other providers are kept. 3. To the extent feasible, maintain ongoing contact with the mother following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow up ends when the member is no longer enrolled in the HMO. (pp. 95-106, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 5. Health education and disease prevention programs, including... prenatal care,... parenting skills... breast feeding promotion and support... (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

K. Additional Services for Pregnant Women 1. Tobacco Cessation The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the postpartum visit. 2. Mental Health and Substance Abuse Screening Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant women (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components: a. Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems. b. Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders. 3. Vaccines for Pregnant and Postpartum Women The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed. (pp. 172-173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

L. Improving Birth Outcomes HMOs must meet the following requirements with regard to women at high risk of a poor birth outcome. For this purpose, these women include: • Women with a previous poor birth outcome (e.g., preterm infant, low birth weight, high birth weight, or infant death) • Women with a chronic condition that could negatively affect their pregnancy (e.g., diabetes, severe hypertension) • Women under 18 years of age 1. The BadgerCare Plus HMO must implement the OB Medical Home initiative as detailed in Article IV, D of the contract, in the following counties: Dane, Rock, Milwaukee, Kenosha, Racine, Ozaukee, Washington, Waukesha. Medicaid SSI HMOs may choose to enroll Medicaid SSI pregnant women in participating clinics in these counties. 2. The HMO's Medical Director, or Department-approved representative, must participate in DHS' sponsored quality efforts during the period of the contract (e.g., best practices seminars). 3. The HMO must have a plan in place to identify women at high risk of a poor birth outcome. The plan must specifically address options for identifying high-risk women previously unknown to the BadgerCare Plus and Medicaid SSI program, (e.g., use of pregnancy notification form). The HMO may use the Department's Birth Outcome Registry Network (BORN) to identify women who are at risk of having a poor birth outcome or had a previous poor birth outcome. 4. The HMO must ensure that these members receive early and continuous care throughout the pregnancy and post-partum period. The HMO must ensure that appropriate referrals and timely follow-up are made for all identified needs (e.g. nutrition counseling, smoking cessation, or behavioral health). (p. 173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

10. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers... e. Prenatal Care Coordination (PNCC) Agencies The HMO must sign a memorandum of understanding (MOU) with all agencies in the HMO service area that are BadgerCare Plus-enrolled PNCC agencies. The purpose of the MOU is to ensure coordination of care between the HMO that provides medical services, and the PNCC agency that provides care coordination to ensure women are linked to the medical and non-medical services they need to have a healthy pregnancy outcome. In addition, the HMO must assign an HMO representative to interface with the care coordinator from the PNCC agency. The HMO representative shall work with the care coordinator to identify what BadgerCare Plus covered services, in conjunction with other identified social services, are to be provided to the member. The HMO is not liable for medical services outside of their provider network by the care coordinator unless prior authorized by the HMO. In addition, the HMO is not required to pay for services provided directly to the PNCC provider. The Department pays such services on a FFS basis. (p. 189, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁴ G. Utilization Management (UM)... Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The HMO may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement. (p. 166, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁵ K. Additional Services for Pregnant Women 1. Tobacco Cessation The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the postpartum visit... 3. Vaccines for Pregnant and Postpartum Women The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed. (pp. 172-173, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the

prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services... d. Transition Plan (Transition of Care) All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care:... 3) Ensure that each member has a transition plan, as described below. a) Healthy Birth Outcome If the member has a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period: 1. The member shall have at least one postpartum followup appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines. (p. 95, 104-105, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract) **See "Prenatal Care" column for more details.**

H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 4. Information on recommended checkups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such health problems as... postpartum depression. 5. Health education and disease prevention programs, including... postpartum depression... postpartum weight loss... (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹³⁶ 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; followup 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, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

4.10 Utilization Review and Control In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid State Plan, such as medical necessity or for the purpose of utilization control, provided that:... 3. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used. (p. 19, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

1.2.4 Family Planning In accordance with 42 CFR §438.206(b)(7), 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.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. 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. The MCO may, however, at its discretion, impose a withhold on a contracted primary care provider for such family planning services. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services. 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. In addition, MCOs must ensure that network procedures for accessing family planning services are convenient and easily comprehensible to enrollees. MCOs must also educate enrollees regarding the positive impact of coordinated care on their health outcomes, so enrollees will prefer to access in-network services or, if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care. In addition, MCOs are required to provide timely reimbursement for out-of-network family planning and related STD services consistent with services covered in their contracts. The reimbursement must be provided at least at the applicable West Virginia Medicaid FFS rate appropriate to the provider type (current family planning services fee schedule available from BMS). The MCO, its staff, contracted providers and its

contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must keep family planning information and records confidential in favor of the individual patient, even if the patient is a minor. The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews, or coordination of benefits or subrogation must also keep family planning information and records received from non-participating providers confidential in favor of the individual patient even if the patient is a minor. Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services. 1.2.4.1 Conditions for Out-of-Network Reimbursement of Family Planning Services All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to Medicaid enrollees: 1. The family planning provider must be qualified to provide family planning services based on licensed scope of practice; 2. The family planning provider must submit claims on appropriate MCO-specific billing forms; and 3. The family planning provider must provide medical records sufficient to allow the MCO to meet its case management responsibilities. If an enrollee refuses the release of medical information, the out-of-network provider must submit documentation of such refusal. In order to avoid duplication of services, promote continuity of care, and achieve the optimum clinical outcome for Medicaid enrollees, MCOs must encourage out-of-network family planning providers to coordinate services with MCO providers and to educate MCO enrollees to return to MCO providers for continuity of care. If a non-participating provider of family planning services detects a problem outside of the scope of services listed above, the provider must refer the enrollee back to the MCO. Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The MCO is not responsible for the confidentiality of medical records maintained by non-participating providers. 1.2.4.2 Tubal Ligation In accordance with Senate Bill 716, the DHHR shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure. Tubal ligation services are excluded from MCOs' capitation rates but will remain covered Medicaid services for persons who are enrolled in MCOs. DHHR shall pay claims for tubal ligation on an FFS basis in accordance with West Virginia Department of Health and Human Resources, Bureau for Medical Services Policy 519.15, Women's Health Services. Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity. (pp. 60-62, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.7.3 Out-of-Network Services Subject to Article III, Section 2.7, Timely Payment Requirement, the MCO must make timely payment within thirty (30) calendar days for clean claims to out-of-network providers for Medically Necessary, covered services when:... 2. Services were for family planning and sexually transmitted diseases; (p. 86, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3.4.3.1 Enrollee Handbook Requirements The handbook must include the following information which must adhere to the standards set forth in this contract:... 10. 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. 99, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

5.3.3 Coordination of Care with Other Entities 5.3.3.1 Family Planning Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume one hundred percent (100%) financial risk for these services. BMS will not be responsible for any lapse in reimbursement for family planning services. Through its reimbursement of other providers, the MCO will be able to monitor enrollees' utilization of such services. Additionally, the MCO will ask in-network providers to educate enrollees about the release of necessary medical data to the MCO. The MCO must ensure that enrollees who seek family planning services from the plan are provided with counseling regarding methods of contraception; HIV and sexually transmitted diseases and risk-reduction practices; and options to pregnant enrollees who may wish to terminate their pregnancies. The MCO will make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to BMS. Pursuant to West Virginia Code §16-2B-1, the MCO shall not require multiple office visits or prior authorizations for a woman who selects long-acting reversible contraceptive (LARC) methods unless Medically Necessary. The MCO shall provide payment for LARC devices and their insertion, maintenance, removal, and replacement. The MCO may not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Enrollees shall be able to access patient-centered education and counseling on all FDA-approved birth control methods. (pp. 122-123, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

5.4.1 Service Authorization Continuity of Care... The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider. (p. 128, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MHT Medical Service: Family Planning Services & Supplies; DEFINITION: Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy; SCOPE OF BENEFITS: All family planning providers, services, and supplies; LIMITATION ON SERVICES: Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered. (p. A-3, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁷ Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the sixty (60)-day postpartum period following the end of pregnancy; see 42 CFR §440.210(a)(3). (p. 12, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.4.6 Right from the Start (RFTS) Providers Right from the Start (RFTS) is a West Virginia State program aimed at improving early access to prenatal care and lowering infant mortality, and improved pregnancy outcomes. The RFTS eligibility criteria and services provided are available from BMS. The MCO is encouraged, but not required, to contract with RFTS providers. However, if the MCO does not contract with RFTS providers, the MCO must provide the same level and types of services as those currently available through the RFTS program. This includes access to multidisciplinary care. BMS will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional Right from the Start providers at the Medicaid fee rate. The MCO may not place prior authorization requirements on RFTS services. (p. 79, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3.5.2 Health Education and Preventive Care... The MCO must provide programs of wellness education. Such programs may include... prenatal care... care of newborn infants and programs focused on the importance of physical activity in maintaining health. Under MHT and WVHB, the MCO must provide tobacco cessation benefits for pregnant women, adults, and children respectively. The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service except for bariatric surgery which is a covered benefit under the State Plan. (p. 102, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MEDICAL SERVICE: Prescription drug; DEFINITION: Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance; SCOPE OF BENEFITS:... prenatal vitamins (p. A-17, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁸ 1.2.5 Maternity Services Under the Newborns and Mothers Health Protection Act, the MCO may not: Limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time; or Require that a provider obtain authorization from the plan before prescribing this length of stay. This requirement must not preclude the MCO from requiring prior authorization or denying coverage for elective inductions and elective C-sections. (p. 62, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹³⁹ Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the sixty (60)-day postpartum period following the end of pregnancy; see 42 CFR §440.210(a)(3). (p. 12, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

3. ENROLLMENT & ENROLLEE SERVICES... In accordance with H.B. 2266 (2021), the MCO shall provide services to pregnant women and newborns up to one (1) year postpartum, effective July 1, 2021 or as soon as federal approval has occurred. (p. 91, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MHT MEDICAL SERVICE: Right from the Start Services (RFTS); DEFINITION: Services aimed at early access to prenatal care, lower infant mortality, and improved pregnancy outcomes; SCOPE OF BENEFITS: Care coordination and enhanced prenatal care services; LIMITATION ON SERVICES: Pregnant women (including adolescent females) through sixty (60) day postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services. (p. A-6, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

Table 2. Coverage and performance obligations related to augmentations of medical care for perinatal persons

This table allows readers to view the extent to which any single state addresses any one of the major domains of managed care and maternity care services within its state purchasing agreements, as well as the actual language used by the state in addressing any maternity care domain.* *Note: Some states choose to carve out services such as mental/behavioral health and dental, and may otherwise not be included in the MCO contract.*

State	Case management and care coordination		Mental health services		SUD services		Nutrition services		Oral health services	
	General provisions incl. In contract	Maternity-specific provision incl. in contract [†]	General provisions incl. In contract	Maternity-specific provision incl. in contract [‡]	General provisions incl. In contract	Maternity-specific provision incl. in contract [§]	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{**}	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
AZ	Y ¹	N	Y ²	Y ³	Y ⁴	Y ⁵	Y	Y ⁶	Y ⁷	N
CA	Y ⁸	N	Y ⁹	N	Y ¹⁰	N	Y	Y ¹¹	Y ¹²	N
CO	Y ¹³	N	Y ¹⁴	N	Y ¹⁵	Y ¹⁶	Y	Y ¹⁷	Y	N
DC	Y ¹⁸	N	Y ¹⁹	Y ²⁰	Y ²¹	N	N	Y ²²	Y ²³	N
DE	Y ²⁴	Y ²⁵	Y ²⁶	N	Y ²⁷	N	N	N	N	N
FL	Y ²⁸	Y ²⁹	Y ³⁰	N	Y	N	Y	Y ³¹	N	N
GA	Y ³²	N	Y ³³	N	Y	N	Y	Y ³⁴	Y ³⁵	N
HI	Y	Y ³⁶	Y ³⁷	Y ³⁸	Y ³⁹	Y ⁴⁰	Y ⁴¹	Y ⁴²	Y ⁴³	N
IA	Y ⁴⁴	N	Y ⁴⁵	N	Y ⁴⁶	Y ⁴⁷	Y ⁴⁸	Y ⁴⁹	N	N
IL	Y ⁵⁰	Y ⁵¹	Y ⁵²	Y ⁵³	Y ⁵⁴	Y ⁵⁵	Y	Y ⁵⁶	Y ⁵⁷	N
IN	Y ⁵⁸	Y ⁵⁹	Y ⁶⁰	Y ⁶¹	Y ⁶²	Y ⁶³	Y ⁶⁴	N	Y ⁶⁵	Y ⁶⁶
KS	Y ⁶⁷	N	Y ⁶⁸	N	Y ⁶⁹	Y ⁷⁰	Y ⁷¹	Y ⁷²	Y ⁷³	N

* Note: All language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of July 2022, unless otherwise noted.

[†] This includes perinatal care coordination/case management, maternal health homes, coordination and linkages with primary care, and evidence-based home visiting.

[‡] This includes screenings and referrals and all appropriate mental health treatments during perinatal period.

[§] This includes screenings and referrals, all appropriate SUD treatments during perinatal period, and peer support services.

^{**} This includes screenings and referrals to WIC, SNAP, lactation consultant, etc., coverage for lactation services and supplies, and coverage or other support related to infant formula.

^{††} This includes dental care covered as a pregnancy-related service and oral health services (e.g., scope is comprehensive/extensive, limited, or emergency only).

State	Case management and care coordination		Mental health services		SUD services		Nutrition services		Oral health services	
	General provisions incl. In contract	Maternity-specific provision incl. in contract [†]	General provisions incl. In contract	Maternity-specific provision incl. in contract [‡]	General provisions incl. In contract	Maternity-specific provision incl. in contract [§]	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{**}	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
KY	Y ⁷⁴	N	Y ⁷⁵	N	Y ⁷⁶	N	Y	Y ⁷⁷	Y ⁷⁸	N
LA	Y ⁷⁹	Y ⁸⁰	Y ⁸¹	N	Y ⁸²	Y ⁸³	Y ⁸⁴	Y ⁸⁵	Y ⁸⁶	N
MA	Y ⁸⁷	N	Y ⁸⁸	N	Y ⁸⁹	Y ⁹⁰	Y ⁹¹	Y ⁹²	Y ⁹³	N
MD	Y ⁹⁴	Y ⁹⁵	Y ⁹⁶	Y ⁹⁷	N	Y ⁹⁸	N	Y ⁹⁹	N	N
MI	Y ¹⁰⁰	Y ¹⁰¹	Y ¹⁰²	N	Y ¹⁰³	N	N	Y ¹⁰⁴	Y ¹⁰⁵	Y ¹⁰⁶
MN	Y ¹⁰⁷	Y ¹⁰⁸	Y ¹⁰⁹	Y ¹¹⁰	Y ¹¹¹	N	N	Y ¹¹²	Y ¹¹³	Y ¹¹⁴
MO	Y ¹¹⁵	Y ¹¹⁶	Y ¹¹⁷	N	Y ¹¹⁸	Y ¹¹⁹	Y	Y ¹²⁰	Y ¹²¹	Y ¹²²
MS	Y ¹²³	Y ¹²⁴	Y ¹²⁵	Y ¹²⁶	Y ¹²⁷	Y ¹²⁸	Y ¹²⁹	Y ¹³⁰	Y ¹³¹	N
ND	Y ¹³²	N	Y ¹³³	N	Y ¹³⁴	N	N	N	N	N
NE	Y ¹³⁵	Y ¹³⁶	Y ¹³⁷	Y ¹³⁸	Y	Y ¹³⁹	Y ¹⁴⁰	Y ¹⁴¹	N	Y ¹⁴²
NH	Y ¹⁴³	Y ¹⁴⁴	Y ¹⁴⁵	N	Y ¹⁴⁶	Y ¹⁴⁷	Y ¹⁴⁸	N	N	N
NJ	Y ¹⁴⁹	N	Y ¹⁵⁰	Y ¹⁵¹	Y ¹⁵²	N	Y ¹⁵³	Y ¹⁵⁴	Y ¹⁵⁵	N
NM	Y ¹⁵⁶	Y ¹⁵⁷	Y ¹⁵⁸	Y ¹⁵⁹	Y ¹⁶⁰	Y ¹⁶¹	Y ¹⁶²	Y ¹⁶³	Y ¹⁶⁴	N
NV	Y ¹⁶⁵	Y ¹⁶⁶	Y ¹⁶⁷	Y ¹⁶⁸	Y ¹⁶⁹	Y ¹⁷⁰	Y ¹⁷¹	Y ¹⁷²	Y ¹⁷³	N
NY	Y	Y ¹⁷⁴	Y ¹⁷⁵	Y ¹⁷⁶	Y ¹⁷⁷	N	Y ¹⁷⁸	Y ¹⁷⁹	Y ¹⁸⁰	N
OH	Y ¹⁸¹	N	Y ¹⁸²	Y ¹⁸³	Y ¹⁸⁴	N	N	N	Y ¹⁸⁵	N
OR	Y ¹⁸⁶	N	Y ¹⁸⁷	Y ¹⁸⁸	Y ¹⁸⁹	Y ¹⁹⁰	Y ¹⁹¹	N	Y ¹⁹²	Y ¹⁹³
PA	Y ¹⁹⁴	Y ¹⁹⁵	Y ¹⁹⁶	Y ¹⁹⁷	Y ¹⁹⁸	Y ¹⁹⁹	Y	Y ²⁰⁰	Y	N
RI	Y ²⁰¹	Y ²⁰²	Y ²⁰³	N	Y ²⁰⁴	N	Y ²⁰⁵	Y ²⁰⁶	Y ²⁰⁷	N
SC	Y	Y ²⁰⁸	Y ²⁰⁹	N	Y	N	N	N	Y	N
TN	Y ²¹⁰	Y ²¹¹	Y ²¹²	Y ²¹³	Y	Y ²¹⁴	Y ²¹⁵	N	Y	N
TX	Y	Y ²¹⁶	Y ²¹⁷	Y ²¹⁸	Y	Y ²¹⁹	Y ²²⁰	Y ²²¹	N	N
UT	Y ²²²	Y ²²³	Y ²²⁴	Y ²²⁵	Y ²²⁶	N	N	Y ²²⁷	N	N
VA	Y ²²⁸	Y ²²⁹	Y ²³⁰	Y ²³¹	Y ²³²	Y ²³³	Y ²³⁴	Y ²³⁵	N	N
WA	Y ²³⁶	N	Y	Y ²³⁷	Y	Y ²³⁸	Y ²³⁹	Y ²⁴⁰	Y	N

State	Case management and care coordination		Mental health services		SUD services		Nutrition services		Oral health services	
	General provisions incl. In contract	Maternity-specific provision incl. in contract [†]	General provisions incl. In contract	Maternity-specific provision incl. in contract [‡]	General provisions incl. In contract	Maternity-specific provision incl. in contract [§]	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{**}	General provisions incl. In contract	Maternity-specific provision incl. in contract ^{††}
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
WI	Y ²⁴¹	Y ²⁴²	Y	Y ²⁴³	Y	N	Y ²⁴⁴	Y ²⁴⁵	Y	N
WV	Y ²⁴⁶	N	Y ²⁴⁷	N	Y ²⁴⁸	N	Y ²⁴⁹	Y ²⁵⁰	Y ²⁵¹	N
Total	Y = 39 N = 0	Y = 24 N = 15	Y = 39 N = 0	Y = 22 N = 17	Y = 38 N = 1	Y = 22 N = 17	Y = 30 N = 9	Y = 31 N = 8	Y = 29 N = 10	Y = 6 N = 33

¹ Care Management Program: The Contractor shall ensure the provision of care management to assist members who may or may not have a chronic disease but have physical or behavioral health needs or risks that need immediate attention. This care coordination shall assure members get the services they need to prevent or reduce an adverse health outcome. Care management should be short term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. The Contractor shall employ care managers to perform Contractor care management functions as required in AMPM Chapters 500 and 1000. Contractor care managers should have expertise in member self-management approaches, member advocacy, navigating complex systems and communicating with a wide spectrum of professional and lay persons including family members, physicians, specialists and other health care professionals. The Contractor shall coordinate care with other AHCCCS Contractors and PCPs that deliver services to Title XIX/XXI members [42 CFR 438.208(b)(3)-(4)]. The Contractor shall ensure that Contractor care managers are trained on Social Determinants of Health (SDOH) issues and shall have training requirements in place to educate Contractor staff and providers regarding SDOH support addressing the socioeconomic needs of members. The Contractor shall establish care coordination and Service Planning processes for members designated as having a CRS condition as specified in AMPM Policy 560. If the Contractor intends to delegate a portion of the Care Management functions, prior approval is required. Request for approvals shall be submitted as specified in ACOM Policy 438. Refer to AMPM Policy 1020. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438.240(b)(4)]. The Contractor shall implement procedures to deliver primary care to and coordinate health care service for members. These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member [42 CFR 438.208]. The Contractor must assure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and referral of quality of care/service concerns. (p. 151, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

² 9. SCOPE OF SERVICES The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal and State laws, Section 1115 Demonstration Waiver, regulations, Contract, and policies, including those incorporated by reference in this Contract. The services are specified in detail in AHCCCS rules including but not limited to AHCCCS regulations in A.A.C. R922 Article 2, 12, and 13, the AHCCCS Medical Policy Manual (AMPM), AHCCCS Behavioral Health Covered Service Guide, and the AHCCCS Contractor Operations

Manual (ACOM), all of which are incorporated herein by reference, and may be found on the AHCCCS website [42 CFR Part 457 and 42 CFR Part 438]. To be covered, services must be medically necessary and cost effective. Covered services are briefly specified below. See also AMPM Exhibit 300-1 and AMPM Exhibit 300-2A. The Contractor shall ensure the coordination of services it provides with services the member receives from other entities. The Contractor shall ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements including, but not limited to, 45 CFR Parts 160 and 164, Subparts A and E, and Arizona statute, to the extent that they are applicable [42 CFR 438.208 (b)(2),(b)(4), and b(6), 42 CFR 457.1230(c), and 42 CFR 438.224]. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [Section 1903(i) final sentence and 1903(i)(16) of the Social Security Act]. Services must be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. The Contractor shall provide the same standard of care for all members, regardless of the member's eligibility category. The Contractor shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished [42 CFR 434.6(a)(4)]. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member [42 CFR 457.1230(d), 42 CFR 438.210(a)(3)(ii)]. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 457.1230(d), 42 CFR 438.210(a)(3)(i), 42 CFR 438.210(a)(4)]. The Contractor is prohibited from avoiding costs for services covered in its Contract by referring members to publicly supported health care resources [42 CFR 457.1201(p)]. (pp. 64-65, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Behavioral Health Services: The Contractor shall provide medically necessary behavioral health services to all members in accordance with AHCCCS policies and A.A.C. R9-22, Article 12. Refer also to the AMPM Policy 310-B, AMPM Exhibit 300-2A, and the Behavioral Health Services Matrix. Behavioral Health services include but are not limited to the following: **Adult Behavioral Health Therapeutic Homes:** A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan, as appropriate. Refer to AMPM Policy 320-X. The Contractor shall develop, and publish to its website, Adult Behavioral Health Therapeutic Homes (ABHTH) admission, continued stay, and discharge criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320-X. The Contractor shall submit the criteria for prior approval as specified in Attachment F3, Contractor Chart of Deliverables. **Behavior Analysis:** Behavior Analysis services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Refer to AMPM Policy 320-S. **Behavioral Health Day Program Services:** Include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance use/abuse programs. **Behavioral Health Residential Facility Services:** Services provided by a licensed behavioral health service agency that provides treatment to an individual experiencing a behavioral health symptom that: 1. Limits the individual's ability to be independent, or Causes the individual to require treatment to maintain or enhance independence (A.A.C. R9-10-101). Refer to AMPM Policy 320-V. The Contractor shall develop, and publish to its website, admission criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320V. The Contractor shall submit the criteria for prior approval as specified in Attachment F3, Contractor Chart of Deliverables. **Crisis Services:** The Regional Behavioral Health Authorities (RBHAs) within the Contractor's geographic service area(s) are responsible for the delivery of crisis services, including telephone and community-based mobile response, and facility-based stabilization (including observation), and all other associated covered services delivered within the first 24 hours of a crisis episode. Refer to AMPM Policy 310-B, Exhibit 300-2A, and Behavioral Health Services Matrix. The RBHAs are responsible for notifying the member's assigned health plan within 24 hours of a member engaging in crisis services so subsequent services can be initiated by the Contractor of Enrollment. The Contractor of Enrollment is responsible for all other medically necessary services and continuing care related to a crisis episode, which may include follow-up stabilization services, after the initial 24 hours covered by the RBHA. The Contractor shall: 1. Ensure a robust system of care and sufficient provider network of facilities to transition a member from receiving crisis services, such as Behavioral Health Residential Facilities (BHRFs), Residential Treatment Centers (RTCs), respite care, and other ongoing care options, when continuing services are required, 2. Ensure timely follow up and care coordination, including care coordination for Medication Assisted Treatment (MAT) for members after receiving crisis services, whether the member received services within, or outside the Contractor's GSA at the time services were provided, to ensure stabilization of the member and appropriate delivery of ongoing necessary treatment and services, 3. Ensure prior authorization is not required for emergency behavioral health services (A.A.C. R9-22-210.01), including crisis services, 4. Develop policies and procedures to ensure timely communication with RBHAs for members that have engaged in crisis services, and 5. Ensure Contractor staff are available 24 hours per day, seven days per week to receive notification of member engagement in crisis services and to provide member post- 24

hour crisis stabilization services, care coordination, and discharge planning, as appropriate. 6. Upon notification of a member engaging in crisis services, the Contractor shall: a. Immediately assess the member's needs, identify the supports and services that are necessary to meet those needs, and connect the member to appropriate services, b. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more restricted setting, and c. Engage peer and family support services when responding to post-crisis situations, as preferred and identified by the member. 7. Track member crisis system utilization and refer repeat and/or frequent users of crisis services to the Contractor's care management and/or high needs/high cost program as specified in Section D, Paragraph 23, Medical Management, and 8. Address preventable crisis system and inpatient psychiatric utilization through various strategies, including but not limited to, extended availability of outpatient treatment services, after hours member care options, development of member specific crisis and safety plans, and ensuring engagement of outpatient treatment providers in responding to post-crisis care and treatment. Court Ordered Evaluation and Court Ordered Treatment: The Contractor shall develop a collaborative process with the counties to ensure coordination of care, information sharing, and timely access to pre-petition screening, Court Ordered Evaluation (COE), and Court Ordered Treatment (COT) services provided. Title XIX/XXI funds shall not be used to reimburse COE services. Reimbursement for pre-petition screening and COE services are the responsibility of the County pursuant to A.R.S. §36-545. The county's financial responsibility ends with the filing of a petition for COT. Counties maintain financial responsibility of any services provided under COE until the date and time the petition for COT is actually filed. Some counties have an agreement with AHCCCS under A.R.S. §36-545.07 to provide those services for the county. If such an agreement exists, the RBHA Contract includes those services within the scope of the RBHA's responsibilities. Refer to ACOM Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE, and ACOM Policy 423 for clarification regarding the financial responsibility for the provision of specific behavioral health treatment/care when such treatment is ordered as a result of a judicial ruling, involving driving under the influence (DUI), domestic violence, or other criminal offense. Refer to AMPM Policy 320-U For additional information regarding behavioral health services refer to A.A.C. R9-22 Article 2 and Article 12. Refer to network requirements regarding COE Providers and care coordination under Section D, Paragraph 26, Network Development. For purposes of care coordination, the Contractor shall submit a report of all members under outpatient Court Ordered Treatment (COT) to AHCCCS. The Contractor shall submit the Outpatient Commitment COT Monitoring Report (one combined deliverable for all lines of business) as specified in Attachment F3, Contractor Chart of Deliverables. The Outpatient Commitment COT Monitoring Report shall contain the following information: 1. Health plan sub population, health plan sub population description, 2. Record number, 3. Contractor ID, Name, 4. Date by year and month, 5. Member name and demographics, 6. Member CIS and/or AHCCCS identification number, 7. New or existing court order and court order description, 8. COT start date, end date, court order reason and court order reason description, 9. Re-Hospitalization, re-hospitalization description and date, 10. Incarcerated and date, 11. Court order expired, 12. COT review and court order treatment review description, 13. Transferred to IHS, 14. Non-compliant, 15. Court order amended due to non-compliance, 16. Contractor contact person, email address, 17. Behavioral health category, behavioral health category description, 18. Age, age band, age band description, and 19. Funding source, funding source description. The Contractor and its providers must comply with State recognized tribal court orders for members. When tribal providers are also involved in the care and treatment of court ordered tribal members, the Contractor and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT and when members are transitioned to services on the reservation, as applicable. The Contractor is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members. See also, AMPM Policy 320-U and ACOM Policy 423. The Contractor shall develop policies and training that outline the Contractor's role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must address the processes provided for in A.R.S. Title 36, Chapter 5, Article 4: 1. Involuntary pre-petition screening, evaluation, and treatment processes, 2. Processes for tracking the status of court orders, 3. Execution of court orders, and 4. Judicial review processes. The Contractor shall develop and make available to providers information regarding specifically where a behavioral health provider would refer an individual for a voluntary or involuntary evaluation. Inpatient Behavioral Health Services for Members in an IMD who are between the Ages of 21 and 64: The Contractor may provide members aged 21-64 inpatient treatment in an Institution for Mental Diseases, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for no more than 15 cumulative days during the calendar month. AHCCCS considers the following provider types to be IMDs: B1-Residential Treatment CTR-Secure (17+Beds), B3-Residential Treatment Center-Non-Secure, B6Subacute Facility (17+Beds), and 71-Psychiatric Hospital. When the length of stay is no more than 15 cumulative days during the calendar month, AHCCCS shall pay the Contractor the full monthly capitation [42 CFR 438.6(e)]. The Contractor may not require the member to use an IMD. Services may be provided in an IMD only when the services meet the requirements for in lieu of services at 42 CFR 457.1201(e) and 42 CFR 438.3(e)(2)(i)-(iii). When the length of stay in the IMD is more than 15 cumulative days during the calendar month, AHCCCS shall recoup the full monthly capitation from all Contractors regardless of whether the Contractor is responsible for inpatient behavioral health services and regardless of whether the Contractor authorized the IMD stay. AHCCCS shall pay all Contractors pro-rated capitation based on any days during the month the

member was not an inpatient in the IMD when the IMD stay(s) exceeds 15 days. When the length of stay in the IMD is more than 15 cumulative days during the calendar month, the Contractor must provide the member all medically necessary services during the IMD stay that are covered under this Contract and that would be Title XIX compensable but for the IMD stay. The Contractor shall submit encounters for all services provided during the IMD stay. The Contractor shall submit notification of an IMD Placement Exceeding 15 Days as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 109 for further information on the IMD 15 day limit. Inpatient Services: Inpatient services provided by a licensed behavioral health agencies including the following: 1. Hospitals (including room and board) 2. Subacute Facilities 3. Residential Treatment Centers (RTC) These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services. In accordance with 42 CFR 438.3(e)(2)(i)-(iii), the Contractor may provide services in alternative inpatient settings that are licensed by ADHS/DLS, in lieu of services in an inpatient hospital. Non-Title XIX/XXI Behavioral Health Services: Service provision for Non-Title XIX/XXI services for Contractor enrolled members is provided by the RBHAs. Non-title XIX/XXI services include room and board, mental health services (formerly known as traditional healing), auricular acupuncture, child care, and supportive housing rent/utility subsidies and relocation services. The Contractor shall have established processes in place to refer members to the RBHA for Non-Title XIX/XXI services. The Contractor shall assist members with how to access these services and shall coordinate care for the member as appropriate. Out of State Placements for Behavioral Health Treatment: The Contractor shall notify AHCCCS of out of state placements and submit progress updates of members who remain in out of state placement for behavioral health treatment as specified in AMPM Policy 450 and Section F, Attachment F3, Contractor Chart of Deliverables. Rehabilitation Services: The Contractor shall provide rehabilitation services, which include the provision of educating, coaching, training, and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Rehabilitation services include: 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training, 2. Cognitive Rehabilitation, 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion), and 4. Supported Employment [Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)]. Support Services: Support services are provided to facilitate the delivery of, or enhance the benefit received from, other behavioral health services. These services include but are not limited to: 1. Provider Case Management, 2. Personal Care Services, 3. Home Care Training Family Services (Family Support), 4. Self-Help/Peer Services (Peer Support), 5. Therapeutic Foster Care (TFC), 6. Unskilled Respite Care, and 7. Transportation. Therapeutic Foster Care: Services provided by a licensed behavioral health service agency that provides treatment to an individual experiencing a behavioral health symptom that maximizes the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan as appropriate. Refer to AMPM Policy 320-W. The Contractor shall develop, and publish to its website, Therapeutic Foster Care (TFC) admission, continued stay, and discharge criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320-W. The Contractor shall submit the criteria for prior approval as specified in Attachment F3, Contractor Chart of Deliverables. Treatment Services: Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services include: 1. Behavioral Health Counseling and Therapy, 2. Assessment, Evaluation and Screening Services, and 3. Other Professional Services. The Contractor shall also provide behavioral health services as specified in Section D, Paragraph 11, Behavioral Health Service Delivery. (pp. 68-74, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Early and Periodic Screening, Diagnostic and Treatment Services: The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illnesses discovered by the screenings for members under age 21. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) includes, but is not limited to, ... behavioral health services, ... EPSDT also includes Diagnostic, Screening, preventive and rehabilitative services. The Contractor shall ensure that these members receive required health screenings and referrals as specified in AMPM Policy 430. (p. 76, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Emergency Services: The Contractor shall provide emergency services per the following [Section 1852(d)(2) of the Social Security Act, 42 CFR 457.1228, 42 CFR 438.114(b), 42 CFR 422.113(c)]: 1. 2. 3. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by A.A.C. R9-22 Article 1. Emergency medical (physical and behavioral health) services, including Crisis Intervention Services are covered without prior authorization. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health

emergencies [42 CFR 438.206(c)(1)(i)]. The Contractor shall monitor emergency service utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this Contract, a prudent layperson is an individual who possesses an average knowledge of health and medicine, 2. All medical services necessary to rule out an emergency condition, and 3. Emergency transportation. (p. 76, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Hospital: The Contractor shall provide hospital services as specified in Contract and policy. Inpatient services include semi-private accommodations for... behavioral health emergency/crisis services. (p. 76, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

11. BEHAVIORAL HEALTH SERVICE DELIVERY Behavioral health needs shall be assessed and services provided in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems. Refer to AMPM Policy 541. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the members and their family shall determine the types and intensity of services. Services should be provided in a manner that respects the member and family's cultural heritage and appropriately utilizes informal support in the member's community. The Contractor shall adhere to the following requirements with respect to delivery of behavioral health services. Regardless of the type, amount, duration, scope, service delivery method, and population served, the Contractor's behavioral health service delivery system shall incorporate the following elements: 1. The System Values and Guiding Principles as specified in Section D, Paragraph 1, Purpose, Applicability, and Introduction, 2. Service delivery by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider, 3. Providers, acting within the lawful scope of their practice, are not prohibited or otherwise restricted from communicating freely with members regarding their health care, medical needs and treatment options, even if needed services are not covered by the Contractor [Section 1932(b)(3)(A) of the Social Security Act, 42 CFR 457.1222, 42 CFR 438.102(a)(1)(i)(iv)]: a. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, [42 CFR 438.102 (a)(1)(i)], b. Information the member needs in order to decide among all relevant treatment options, c. The risks, benefits, and consequences of treatment or non-treatment, the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, [42 CFR 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(iv)], 4. Referral and Intake Processes as outlined in AMPM Policy 580, 5. Regular and ongoing training for providers and members to assist members with how to access services, including Non-Title XIX/XXI services. Contractors shall ensure providers coordinate care for members as appropriate to ensure services are delivered upon referral, 6. Conduct a behavioral health assessment and provide a service plan following a Health Home model as specified in AMPM Policy 320-O, 7. Coordination and provision of peer and family delivered support services, 8. Adherence to General and Informed Consent requirements as outlined in AMPM Policy 320Q, 9. Access to comprehensive care coordination across the continuum of healthcare and nonclinical healthcare-related needs and services, 10. Require covered services to be medically necessary and cost effective and to be provided by or coordinated by the primary care provider or Health Home except for annual well woman exams, behavioral health and children's dental services. The covered services shall be, and consistent with the terms of the demonstration, covered services must be provided by or coordinated with a primary care provider or Health Home, 11. Coordination and provision of quality health care services informed by evidence-based practice guidelines in a cost effective manner, 12. Coordination and provision of quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and implement a trauma-informed care approach, 13. Coordination and provision of preventative and health promotion services, including wellness services, 14. Organization, training, implementation, and documentation of provider involved trainings/implementation to increase outreach, identification, referrals and provision of services to under and uninsured individuals, 15. Coordination and provision of comprehensive care coordination and transitional care across settings; follow-up after crisis episodes, discharge from inpatient to other settings; participation in discharge planning; facilitating minimally disruptive transfers between systems of care, and outreach, engagement, re-engagement, and closure for behavioral health in as specified in AMPM Policy 1040, 16. Coordination and provision of chronic disease management support, including self management support, 17. Provision of covered services to members in accordance with all applicable Federal and State laws, regulations and policies, including those listed by reference in attachments and this Contract, 18. Coordination and provision of integrated clinical and non-clinical health-care related services, and 19. Implementation of health information technology to link services, facilitate communication among treating professionals, and between the health team and individual and family caregivers. The Contractor shall employ a phased-in implementation approach, as directed by AHCCCS to: 1. Utilize the American Society of Addiction Medicine (ASAM) Criteria (Third Edition, 2013) in substance use disorder assessments, service planning, and level of care placement, and 2. Implement standardized substance use disorder assessments as specified in the AMPM. The Contractor shall submit, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, a Case

Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child members. The Case Management Plan shall include performance outcomes, lessons learned, and strategies targeted for improvement. Following the initial submission, subsequent submissions shall include an evaluation of the Contractor's Case Management Plan from the previous year. (pp. 94-96, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Adult System of Care: For adult members, the Contractor shall adhere to Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, that were developed to promote recovery in the adult behavioral health system; system development efforts, programs, service provision, and stakeholder collaboration must be guided by these nine principles. The Contractor shall ensure use of: 1. Standardized validated screening instruments by PCPs: The Contractor shall implement validated screening tools for Primary Care Providers (PCPs) to utilize for all adults related to behavioral health needs, social determinants of health, and trauma, 2. Streamlined service referral mechanism for PCPs: The Contractor shall implement a streamlined mechanism for PCPs to refer adults who are screened at risk for a behavioral health need to the appropriate behavioral health provider for further assessment, if not served through an integrated care provider, 3. Provider Case management services based upon a member's acuity and service needs. The Contractor shall comply with the requirements for provider case management standards and caseload ratios at the provider level. The Contractor shall ensure that caseload ratios are maintained in accordance with caseload weighting guidelines as outlined by AHCCCS. The Contractor shall ensure that case management and other support and rehabilitation services are provided to their assigned members in accordance with guidelines as outlined by AHCCCS, 4. Psychosocial rehabilitation, 5. Centers of Excellence: Refer to Section D, Paragraph 72, Value-Based Purchasing, (p. 96, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Contractor Responsibilities: For all enrolled members, the Contractor is responsible for the following: Access to Behavioral Health Services: Members may self-refer to a behavioral health provider, or be referred by providers, schools, State agencies, or other parties. The Contractor shall be responsible for meeting the appointment standards found in Section D, Paragraph 32, Appointment Standards. (p. 99, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Community Service Agencies: The Contractor may contract with community service agencies for the delivery of covered behavioral health services. Refer to AMPM Policy 965. (p. 100, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Integrated Health Care Service Delivery: The Contractor shall increase and promote the availability of integrated, holistic care for members with chronic behavioral and physical health conditions that will help members achieve better overall health and an improved quality of life. The Contractor shall develop and promote care integration activities such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. The Contractor shall consider the behavioral health needs, in addition to the primary health care needs of members during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services. (p. 101, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Member Education: The Contractor shall be responsible for including information in the Member Handbook and other materials to inform members how to access covered behavioral health services. Materials shall include, but not be limited to, information about behavioral health conditions that may be treated by a Primary Care Provider (PCP) within their scope of practice. Refer to the AMPM Chapter 300 for covered behavioral health services. (p. 102, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Monitoring, Training, and Education: The Contractor is responsible for training staff and providers, in sufficient detail and frequency, to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding: 1. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, 2. The Arizona Vision-Twelve Principles for Children Behavioral Health Service Delivery, 3. The 10 Principles of Wraparound, 4. Covered behavioral health services and referrals, 5. How to access services, 6. Petitioning and court-ordered evaluation processes provided for in A.R.S. Title 36 (Ch. 5, Article 4), and 7. How to involve the member and their family in decision-making and service planning. The

Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Training for staff and providers may be provided through employee orientation, clinical in-services, and/or information sharing via newsletters, brochures, etc. (p. 102, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Outreach: The Contractor is responsible for the organization of provider level training and the development of informational materials to increase outreach, eligibility identification, referrals, and tracking of referral outcomes, including for under and uninsured individuals. Refer to AMPM Policy 1040 for provisions regarding Outreach, Engagement, and Reengagement for behavioral health services. (p. 103, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Primary Care Provider Medication Management Services: In addition to treating physical health conditions, the Contractor shall allow Primary Care Provider (PCPs) to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. For the antipsychotic class of medications, prior authorization may be required. For PCPs prescribing medications to treat Substance Use Disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider. The Contractor is responsible for these services both in the prospective and prior period coverage timeframes. (p. 105, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Referrals: The Contractor shall develop, monitor, and continually evaluate its processes for timely referral, assessment, service, and treatment planning for behavioral health services. The Contractor shall have identified staff members to ensure that requests for behavioral health services made by the member, family, guardian, or any health care professional are referred within one business day to ensure that the request for services results in the member receiving a referral to a behavioral health provider. Refer to Section D, Paragraph 32, Appointment Standards and ACOM Policy 417. A direct referral for a behavioral health assessment may be made by the member. A direct referral for a behavioral health assessment may be made by any health care professional. Refer to AMPM Policy 320-O for provisions regarding behavioral health assessment and treatment/service planning. For referrals received from a PCP requesting a member receive a psychiatric evaluation or medication management, the appointments with a behavioral health medical professional shall be provided according to the needs of the member and within AHCCCS appointment standards with appropriate interventions to prevent a member from experiencing a lapse in medically necessary psychotropic medications. Refer to AMPM Policy 520 for information regarding additional requirements for referrals resulting in Out of Service Area Placement for Members with SMI. Refer to Section D, Paragraph 31, Referral Management Procedures and Standards. (pp. 105-106, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

³ Maternity Services: The Contractor shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members... Refer to AMPM Policy 410. (p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

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

⁴ SECTION D: PROGRAM REQUIREMENTS 1. PURPOSE, APPLICABILITY AND INTRODUCTION PURPOSE AND APPLICABILITY The purpose of the Contract between AHCCCS and the Contractor is to implement and operate the AHCCCS Complete Care Program pursuant to A.R.S. §36-2901 et seq. The AHCCCS Complete Care Contractor (Contractor) shall be responsible for the provision of integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations: 1. Adults with General Mental Health/Substance Use (GMH/SU) needs,... (p. 45, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Peer and Family Support Specialists: The Contractor shall comply with all terms, conditions, and requirements in this Contract while embedding the following principles in the design and implementation of an integrated health care service delivery system: 1. Behavioral, physical, peer, and family support providers must share the same mission to place the member's whole-health needs above all else as the focal of point of care, 2. Utilize peer and family delivered support services/specialists and embed peer and family voice at all levels of the system. The Contractor shall submit information noting Peer/Recovery Support Specialist (PRSS) and Credentialed Parent/Family Support Specialist Involvement in Service Delivery as specified in Section F, Attachment F3: Contractor Chart of Deliverables, and 3. Maximize the use of existing behavioral and physical health infrastructure including peer and Family-Run Organizations. The Contractor shall provide access to peer and family support services for members to assist with understanding and coping with the stressors of a member's disability and how to effectively and efficiently utilize the service delivery system for covered benefits. The Contractor shall provide access to peer support services for members with Substance Use Disorders including but not limited to: Alcohol Misuse, Benzodiazepine Misuse and Dependence, and Opioid Use Disorders (OUDs). Where appropriate, Peer Support Specialists may navigate members to Medication Assisted Treatment (MAT) providers, increasing the member's participation and retention in MAT treatment and recovery support services. (pp. 57-58, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

⁵ C. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that providers adhere to the following maternity care requirements:... 3. Maternity care providers shall ensure that:... b. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling shall be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment... e. All pregnant members shall receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed... (p. 7, Effective September 01, 2021, [AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH](#))

⁶ C. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that providers adhere to the following maternity care requirements:... 3. Maternity care providers shall ensure that:... i. Members shall be referred for support services to the Special Supplemental Nutrition Program for WIC, as well as other community-based resources, in order to support healthy pregnancy outcomes... (p. 8, Effective September 01, 2021, [AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH](#))

⁷ Dental Services: The Contractor shall adhere to the Dental Uniform Prior Authorization List (List) and the Uniform Warranty List as specified in AMPM Policy 431. Requests for changes to the List must be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. For members under the age of 21: The Contractor shall provide all members under the age of 21 years with all medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor must develop processes to assign members to a dental home by one year of age and communicate that assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care as specified in AMPM Policy 431. The Contractor is required to meet specific utilization rates for members as specified in Section D, Paragraph 22, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified in writing when dental screenings are due, if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network. For members 21 years of age and older: Pursuant to A.A.C. R9-22-207,

for members who are 21 years of age and older, the Contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under State law either by a physician or by a dentist. These services would be considered physician services if furnished by a physician. Limited dental services are covered as specified in AMPM Policy 310-D1. Pursuant to A.R.S §36-2907(A) as amended by Arizona Senate Bill 1527 (2017), the Contractor shall provide adult members 21 years of age and older with emergency dental services, limited to a \$1,000 per member per contract year as specified in AMPM Policy 310-D1. (p. 75, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

⁸ 1. Comprehensive Case Management Including Coordination of Care Services Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member. Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's Provider Network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the member. A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor, and shall include: 1) Initial Health Assessment (IHA); 2) Individual Health Education Behavioral Assessment (IHEBA); 3) Identification of appropriate Provider and facilities (such as medical, rehabilitation, and support services) to meet Member care needs; 4) Direct communication between the Provider and Member/family; 5) Member and family education, including healthy lifestyle changes when warranted; and 6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies. B. Complex Case Management Services are provided by the Contractor, in collaboration with the Primary Care Provider, and shall include, at a minimum: 1) Basic Case Management Services 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team 3) Intense coordination of resources to ensure member regains optimal health or improved functionality 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the HIF/ MET, clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.... 3. Targeted Case Management Services Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services. If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM Provider that are Covered Services under the Contract. If Members under age 21 are not accepted for TCM services, Contractor shall ensure the Members' access to services are comparable to EPSDT TCM services per Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age. 4. Disease Management Program Contractor is responsible for initiating and maintaining a disease management program. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate. 5. Out-of-Network Case Management and Coordination of Care Contractor shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 18 below... 17. Women, Infants, and Children (WIC) Supplemental Nutrition Program A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's medical record. Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c). B. Contractor shall execute a MOU with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program. (no page #, Effective FY 17-18, Case Management and Care Coordination, Exhibit A, Attachment 11, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

See Cal. Code Regs. Tit. 22, § 51185 and § 51351, which describe Targeted Case Management Services and include pregnant women.

⁹8. Services for All Members... E. Mental Health and Substance Use Disorder Services 1) Contractor shall cover Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care Providers, in accordance with the Outpatient Mental Health Services requirements as defined in Exhibit E, Attachment 1, Definitions. Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Providers. In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs

prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below. 2) Contractor shall cover and pay for all Medically Necessary Covered Services for the Member, including the following services: a) Emergency room professional services as described in Title 22 CCR Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other specialty mental health Providers. b) Facility charges for emergency room visits which do not result in a psychiatric admission. c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition. d) Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title CCR Section 51323. e) All NEMT services, as provided for in Title 22 CCR Section 51323, required by Members to access Medi-Cal covered mental health and substance use disorder services. These services include outpatient opioid detoxification, tobacco cessation, and Alcohol Misuse Screening and Counseling (AMSC) services, and are subject to a written prescription by Contractor's mental health or substance use disorder Provider within Contractor's mental health and substance use disorder Provider Network. f) Medically Necessary Covered Services after Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by Title 9 CCR Section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to: i. The initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services. ii. Notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members. iii. When IMD services are provided to Members age 21 and under or age 65 and over, Contractor shall cover Skilled Nursing Facility (SNF) room and board. Contractor shall not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate. g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract. i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-Network psychiatrists for Members. ii. Contractor may require that covered prescriptions written by out-of-Network psychiatrists be filled by pharmacies in Contractor's Provider Network. iii. Reimbursement to pharmacies for those psychotherapeutic drugs listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated /Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program. h) Paragraphs c), e), and f) above shall not be construed to preclude Contractor from: (1) requiring that Covered Services be provided through Contractor's Provider Network, to the extent possible, or (2) applying utilization review controls for these services, including prior authorization, consistent with Contractor's obligation to provide Covered Services under this Contract. 3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services (services outside the scope of practice of Primary Care Providers) are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or to the county mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 6. Specialty Mental Health. 4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service Provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3, County Mental Health Plan Coordination. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹⁰ 7. Alcohol and Substance Use Disorder Treatment Services Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program. Contractor shall identify individuals requiring alcohol and or substance use disorder treatment services and arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within the Contractor's Service Area, the Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between the Primary Care Providers and the treatment programs. Contractor shall execute a MOU with the county department for alcohol and substance use disorder

treatment services. (no page #, Effective FY 17-18, Case Management and Coordination of Care, Exhibit A, Attachment 11, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

4. Outpatient Mental Health Care Services Providers... B. In order to determine whether Outpatient Mental Health Services and substance use disorder services are Medically Necessary, Contractor shall apply the criteria of Medical Necessity as stated in APL 17-016 and 17-018. C. Contractor shall cover Outpatient Mental Health Services and substance use disorder services that are within the scope of practice for licensed mental health care Providers as follows: 1) Individual/group mental health evaluation and treatment (psychotherapy); 2) Psychological testing when clinically indicated to evaluate a mental health condition; 3) Outpatient services for the purpose of monitoring drug therapy; 4) Psychiatric consultation; 5) Outpatient laboratory, supplies, and supplements; and 6) AMSC for alcohol use disorders. (no page #, Effective FY 17-18, Mental Health and Substance Abuse Disorder Benefit, Exhibit A, Attachment 20, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹¹ 7. Pregnant Woman... B. Risk Assessment Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include... nutritional... needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

17. Women, Infants, and Children (WIC) Supplemental Nutrition Program A. WIC services are not covered under this Contractor. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's medical record. Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c). B. Contractor shall execute a MOU with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program. (no page #, Effective FY 17-18, Case Management and Care Coordination, Exhibit A, Attachment 11, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹² 15. Dental Contractor shall cover and ensure that dental screenings/oral health assessments for all Members are included as a part of the IHA. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract. Contractor shall ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered Prescription Drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require prior authorization for medical services required in support of dental procedures. If the Contractor requires Prior Authorization for these services, Contractor shall develop and publish the procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall submit such procedures to DHCS for review and approval. (no page #, Effective FY 17-18, Case Management and Care Coordination, Exhibit A, Attachment 11, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹³ 9.4 Access to Care Standards 9.4.1. The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care: 9.4.1.1. Serve all primary care and care coordination needs;... (p. 63, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

10.2 Health Neighborhood... 10.2.4. The Contractor shall identify barriers to Provider participation in the Health Neighborhood, such as ineffective referral processes, high no-show rates of Members, and ineffective communication, and work to design and implement approaches to address these barriers to enable providers to appropriately care for more Medicaid Members. 10.2.4.1. The Contractor shall implement programs to address the identified barriers to Provider participation in the Health Neighborhood and to support the efficient use of specialty care resources. Programs may include, but are not limited to:... 10.2.4.1.2. Care Coordination, particularly coordinating travel and following up with Members that miss specialty care appointments. (p. 70, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

11. POPULATION MANAGEMENT AND CARE COORDINATION 11.1 The Contractor shall manage the health of all its Members. 11.1.1... The Contractor shall use the Population Management Framework to guide work in the areas of Care Coordination, condition management,... 11.2 Population Management... 11.2.2. The Contractor's population management activities shall include, but not limited to, the following... 11.2.2.5. Care Coordination for Members utilizing Medicaid services... 11.3 Care Coordination... The Contractor shall ensure Care Coordination is available to Members in alignment with the Contractor's Population Management Strategic Plan and the Department's Population Management Framework. The Contractor shall use its own resources and Department insights to ensure active Care Coordination for Complex Members... 11.3.3. The Contractor's Care Coordination activities shall comprise: 11.3.3.1 A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being. 11.3.3.2. Activities targeted to specific members who require more intense and extended assistance and includes appropriate interventions... 11.3.7. The Contractor shall ensure that Care Coordination: 11.3.7.1. Is accessible to Members 11.3.7.2. Is provided at the point of care whenever possible. 11.3.7.2. Is provided at the point of care whenever possible. 11.3.7.3. Addresses both short and long-term health needs. 11.3.7.4. Is culturally responsive. 11.3.7.5. Respects Member preferences. 11.3.7.6. Supports regular communication between care coordinators and the practitioners delivering services to Members. 11.3.7.7. Reduces duplication and promotes continuity by collaborating with the Member and the Member's care team to identify a lead care coordinator for Members receiving Care Coordination from multiple systems. 11.3.7.8. Address potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences 11.3.7.9. Is documented, for both medical and non-medical activities... See provision 11 for more information on care coordination. (pp. 74-77, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁴ 9.3 Specialty Behavioral Health Provider Network 9.3.1 The Contractor shall establish and maintain a statewide network of behavioral health providers that spans inpatient, outpatient, laboratory, and all other covered mental health and substance use disorder services.

9.4. Access to Care Standards 9.4.1 The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care:... 9.4.1.2. Serve all behavioral health needs;... (pp. 62-63, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.5 Covered Services 14.5.1. 14.5.1. The Contractor shall ensure access to care for all Members in need of Medically Necessary covered mental health and substance use disorder services in accordance with 10 CCR 2505- 10 8.076.1.8. The Capitated Behavioral Health Benefit does not include behavioral services covered in 1915(c) waivers for individuals with intellectual and developmental disabilities. Guidance for how the Contractor may consider evaluating and treating mental illness in individuals with developmental disabilities and individuals with traumatic brain injury is provided in Exhibit H. (p. 90, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁵ 10.2 Health Neighborhood... 10.2.7. The Contractor shall coordinate care with Colorado's Managed Service Organizations to ensure Member access to appropriate substance use disorder treatments. (p. 70, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

11.3 Care Coordination... 11.3.12. For Members with substance use disorders who require services not covered by Medicaid, the Contractor shall coordinate with the state's Managed Service Organizations. (p. 78, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.5 Covered Services... 14.5.1 The Contractor shall ensure access to care for all Members in need of Medically Necessary covered... substance use disorder services in accordance with 10 CCR 22505-10 8.076.1.8. (p. 90, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.8 Utilization Management... 14.8.8. If the Contractor determines that the Member does not meet standards of Medical Necessity for mental health and substance use disorder services, the Contractor shall inform the Member about how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules, and coordinate within their system and the Health Neighborhood to refer them to the appropriate providers, such as CCBs, SEPs, and Managed Service Organizations. (p. 101, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁶ 14.2.2.4. Wrap Around (Fee For Service) Benefits... 14.2.2.4.2... The Contractor shall also advise post-partum or breastfeeding or pregnant women of... state's specific special assistance program for substance abusing pregnant women... (p. 91, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁷ 14.2.2.4. Wrap Around (Fee For Service) Benefits... 14.2.2.4.2... The Contractor shall also advise post-partum or breastfeeding or pregnant women of the special supplemental food program (Women, Infants, and Children)... (p. 91, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁸ C.5.31 Care Coordination and Case Management... C.5.31.2. In accordance with 42 C.F.R. §438.208 and 42 C.F.R. §440.169, the Contractor shall: C.5.31.2.1 Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating services. The Contractor shall provide information to the Enrollee on how the Enrollee can contact his/her designated person or entity responsible for coordinating care; C.5.31.2.2 Coordinate the services the Contractor furnishes to the Enrollee: C.5.31.2.2.1 Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays; C.5.31.2.2.2 With the services the Enrollee receives from any other Contractor; C.5.31.2.2.3 With the services the Enrollee receives in FFS Medicaid; and C.5.31.2.2.4 With the services the Enrollee receives from community and social support providers. (pp. 156-157, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

See C.5.31 for more details.

¹⁹ Table A: Medicaid Covered Services Service: Mental Health and Inpatient Substance Use Disorder Treatment Benefit Limit: Covered as described in section C.5.28.10.1. (p. 85, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.28.10 Medicaid Behavioral Health Services C.5.28.10.1 The Contractor shall provide Behavioral Health Services, as applicable to the Contractor's scope of coverage, as defined in the State Plan and all applicable District of Columbia Municipal Regulations (DCMR) and waivers, which includes, but is not limited to services listed in Table B below. See Table B: Medicaid Behavioral Health Services on page 93. (pp. 92-94, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

Table A: Medicaid Covered Services Service: Mental Health and Inpatient Substance Use Disorder Treatment Benefit Limit: Covered as described in section C.5.28.10.1. (p. 156-157, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²⁰ Table B: Medicaid Behavioral Health Services Service: Pregnancy related services Contractor's Coverage Requirements: Pregnancy-related services described in 42 C.F.R. §§ 440.210(a)(2), and (3), including treatment for any mental condition that could complicate the pregnancy. (p. 93, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²¹ See "Mental health services" column for cross-reference of SUD services.

Table A: Medicaid Covered Services. Service: Substance Use Disorder screening and behavioral counseling. Benefit Limit: Covered as described in section C.5.28.10 (p. 85, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²² C.5.31.9.2 The Contractor shall refer pregnant and post-partum women and children up to age five (5) who have been or are at risk for nutritional deficiencies or have nutrition-related medical conditions to the Special Supplemental Food Program for Women, Infants and Children (WIC), and the Contractor shall furnish the WIC agency with the results of tests conducted to ascertain nutritional status. Contractor is responsible for conducting follow up activities to determine if referrals to WIC were successful. (p. 164, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²³ Table A: Medicaid Covered Services. Service: Dental Services. Benefit Limit: Covered as described in section C.5.28.11 (p. 85, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.28.11 Medicaid Dental Services C.5.28.11.1 The Contractor shall provide to the Medicaid Enrollees all dental services defined in the State Plan which shall include but is not limited to services listed in Table C below. See Table C: Medicaid Covered Dental Services for a full list of covered dental services and amount, duration and scope. (pp. 94-95, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²⁴ 3.6 CARE COORDINATION 3.6.1 General 3.6.1.1 The Contractor shall develop and implement an integrated care coordination program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize quality of care and member health outcomes. (p. 101, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.6.2.9 All-Member Level 3.6.2.9.1 Coordination of Services 3.6.2.9.1. The Contractor shall ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member, such as the member's PCP, other providers, a patient-centered medical home, or the Contractor's care coordination staff. Any person or entity responsible for coordinating the services accessed by the member will be required to participate in the State's care coordination oversight review process. The Contractor shall provide the member with information on how to contact their designated person or entity. 3.6.9.1.2 The Contractor shall coordinate services it furnishes to members: 3.6.2.9.1.2.1 Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; 3.6.2.9.1.2.2 With the services the member receives from the State's FFS program; and 3.6.2.9.1.2.3 With the services the member receives from community and social support providers. 3.6.2.9.1.2.4 The Contractor shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent they are applicable. 3.6.2.9.2 Appointment Assistance and Linkage to Services 3.6.2.9.2.1 For the Contractor's entire member population, the Contractor shall provide appointment assistance and linkage to Covered Services and non-Covered Services with the objective of facilitating member access to medically necessary services and identifying members who could benefit from wellness programs or services that address Health-Related Social Needs (these programs or services may be offered by the Contractor, providers or by other community organizations). 3.6.2.9.2.2 Members shall be able to access appointment assistance and linkage to Covered Services and non-Covered Services by calling the Contractor's member service information line. The Contractor's member services information line shall have the ability to assess the member's need for appointment assistance and linkage to Covered Services and non-Covered Services and, when necessary, warm transfer

the member's call to the Contractor's appointment assistance and linkage to services program staff (as described in Section 3.6.3.2.1.3 of this Contract, below). 3.6.2.9.3 Appointment Assistance and Linkage to Services Program Staff 3.6.2.9.3.1.1 The Contractor shall use field-based staff to provide appointment assistance and linkage to services. The Contractor shall maintain at least one full-time, field based staff in Delaware's New Castle County and one full-time, field-based staff in Kent or Sussex County who will serve both Kent and Sussex counties. If the Contractor's membership exceeds 75,000 members in New Castle County or a combination of Kent and Sussex counties, the Contractor shall hire a proportionate number of additional field-based staff for that county. 3.6.2.9.4 Access to Wellness and Community Resources 3.6.2.9.4.1.1 With the purpose of encouraging member access to needed preventive care, the Contractor shall perform active outreach to members who the Contractor has identified via EPSDT and/or HEDIS measures or other means have missed a preventive care visit. Outreach shall include an alert to the member's PCP and active assistance of the PCP's efforts to re-engage members. With member consent, outreach methods can also include phone calls, SMS text messages, emails, and/or mailers to members, however the primary objective shall be outreach and active coordination with PCPs. Digital outreach methods must be HIPAA and HITECH compliant. 3.6.2.9.4.1.2 With the objective of engaging members in wellness and healthy behaviors, as well as addressing members' Health-Related Social Needs, the Contractor shall maintain an up-to-date registry of all wellness, health education, disease management and self-management programs and activities, and community resources that address Health Related Social Needs that are available for members and that are accepting new participants. This registry shall be searchable by type of activity, location, whether the program is a Covered Service, and any additional eligibility criteria that a member must meet to participate in the program. The registry must include contact information for each program as well as the means of accessing the program. The Contractor shall make the registry available in a searchable format on its member and provider websites. The Contractor shall also make this information available in a searchable format to its member services information line, provider service line and pharmacy service line staff. The registry must be reviewed at least every six months for accuracy and to ensure all information is current. The Contractor shall cooperate with DMMA's efforts to develop a unified wellness and community resources registry for the State of Delaware. 3.6.2.9.4.2 With the objective of assisting participating providers in their efforts to offer wellness, disease management and health education programs for their patients, the Contractor shall offer training for participating providers on topics related to developing and implementing these types of programs. (p. 106, Effective 2020, Addendum 1, MCO MSA, Delaware)

See 3.6 for more details on the care coordination program/services, which provides detailed description of care coordination by level of need, assessments and identification/stratification of members, and coordination activities and services by level of need.

²⁵ 3.6 Care Coordination... 3.6.2 Member Assessment and Identification/Stratification... 3.6.2.2 Subject to State review and approval of the Contractor's methodology, the Contractor shall use predictive modeling utilizing claims data, pharmacy data, and laboratory results, and Health-Related Social Needs data, supplemented by information from providers, referrals, utilization management data, and/or health risk assessment results to stratify the member population into the following risk levels: 3.6.2.2.1 Level 1 – Members eligible to participate at this level shall be determined by predictive modeling to meet any of the following conditions: pregnancy... (p. 102, Effective 2020, Addendum 1, MCO MSA, Delaware)

In addition to the general provision described in this section, see 3.6.2.10 Level 1: Resource Coordination for more.

²⁶ 3.4 COVERED SERVICES 3.4.1 General 3.4.1.1. The Contractor shall cover... behavioral health... as specified in this Section 3.4. (p. 53, Effective 2020, Addendum 1, MCO MSA, Delaware)

²⁷ 3.4 COVERED SERVICES 3.4.2 DSHP Benefit Package... 3.4.2.2 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. Service: Substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), Medication Assisted Treatment (MAT) and licensed opioid treatment programs (p. 55, Effective 2020, Addendum 1, MCO MSA, Delaware)

²⁸ D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by "X" in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 3: Approved Expanded Benefits... Targeted Case Management (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

See Section E. Care Coordination/Case Management for general provisions, case management program description, freedom of choice, etc. (Refer to AHCA Contract No. FP0XX, Attachment II: Scope of Service – Core Provisions, Florida Managed Medical Assistance (MMA) Program, Updated February 2022)

²⁹ Section VI. Coverage and Authorization of Service... (7) Family Planning Services and Supplies... (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant. (p. 15, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

g. Additional Care Coordination/Case Management Requirements... e. Prenatal Care The Managed Care Plan shall: (1) Require care coordination through the gestational period according to the needs of the enrollee. (p. 34, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

5. Healthy Start Services a. The Managed Care Plan shall develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants. (p. 40, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

³⁰ C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 2A: Required MMA Services... (4) Behavioral Health Services (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

³¹ 6. Nutritional Assessment/Counseling a. The Managed Care Plan shall ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children. b. The Managed Care Plan shall determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance. c. The Managed Care Plan shall: (1) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes. (2) Offer a mid-level nutrition assessment. (3) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment. (4) Refer all enrollees under the age of five (5), and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075). (5) For subsequent WIC certifications, the Managed Care Plan shall ensure that providers coordinate with the local WIC office to provide the above referral data from the most recent well-child visit. (6) Each time the provider completes a WIC referral form, the Managed Care Plan shall ensure that the provider gives a copy of the form to the enrollee. (pp. 40-41, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

³² 1.0 SCOPE OF SERVICE 1.0.1 The Contractor will provide care management services to Georgia Families, Medicaid and PeachCare for Kids ® Members and Planning for Healthy Babies (P4HB) Participants. PeachCare for Kids ® is Georgia's Children's Health Insurance Program (CHIP), and the P4HB program is Georgia's Section 1115 family planning waiver program. A summary of the required responsibilities to be carried out by the Contractor include: 1.0.1.1 Provision of access to health care services, including but not limited to physical health service, behavioral health services, dental services and Care Coordination; (p. 2, no date, RFP #DCH0000100, Georgia Families Contract)

4.11 Utilization Management and Coordination and Continuity of Care Responsibilities... 4.11.8 Coordination and Continuity of Care Responsibilities 4.11.8.1 The Contractor is responsible for employing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination is a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely, and cost effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.... 4.11.8.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.... 4.11.8.7 Care Coordination 4.11.8.7.1 The Contractor shall provide Care Coordination services which shall: 4.11.8.7.1. 1 Be comprehensive: All services a Member receives are to be coordinated; 4.11.8.7.1.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and 4.11.8.7.1.3 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP. (pp. 148-153, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

4.11.10 Case Management 4.11.10.1 The Contractor's Case Management program shall emphasize prevention, Continuity of Care, and Coordination of Care and integration of care. The program shall link Members to services. 4.11.10.2 Case Management functions include, but are not limited to: 4.11.10.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO; 4.11.10.2.2 Assessment of a Member's risk factors such as an over- or underutilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities; 4.11.10.2.3 Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and measurable, with emphasis on Member education of disease or condition to facilitate shared decision making and selfmanagement; 4.11.10.2.4 Coordination of Care, as previously described; 4.11.10.2.5 Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's condition or lack of positive response to the plan of care; 4.11.10.2.6 Continuity of care which includes collaboration and communication with other Providers involved in the Member's transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care; 4.11.10.2.7 Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care; 4.11.10.2.8 Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction ; and 4.11.10.2.9 When appropriate, Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change. 4.11.10.3 Case Management functions for the IPC component of the P4HB Demonstration include: 4.11.10.3.1 Early identification of P4HB IPC Participants who have or may have special needs; 4.11.10.3.2 Assessment of a P4HB IPC Participant's risk factors; 4.11.10.3.3 Development of a plan of care; 4.11.10.3.4 Referrals and assistance to ensure timely access to Providers included and external to the Contractor's network; 4.11.10.3.5 Coordination of Care actively linking the P4HB IPC Participant to InNetwork and Out of Network Providers, physical and Behavioral Health Services, residential social and other support services where needed; 4.11.10.3.6 Resource Mothers Outreach; 4.11.10.3.7 Monitoring; 4.11.10.3.8 Continuity of care; 4.11.10.3.9 Follow up; and 4.11.10.3.10 Documentation 4.11.10.4 Details pertaining to Resource Mothers Outreach are incorporated in Attachment N to this Contract. The Contractor must utilize the Resource Mothers Training Manual specified by DCH as the training manual for the Resource Mothers Outreach. 4.11.10.5 The Contractor must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual. 4.11.10.6 Levels of Case Management for the GF Program include: 4.11.10.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated. 4.11.10.6.2 Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and transportation to the Member's appointments and referrals and verify that the referral site is available and appropriate for the Member's needs 4.11.10.6.3 Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in

Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems. 4.11.10.7 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays. 4.11.10.8 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB Case Management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members. (pp. 155-157, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³³ 1.0 SCOPE OF SERVICE 1.0.1 The Contractor will provide care management services to Georgia Families, Medicaid and PeachCare for Kids ® Members and Planning for Healthy Babies (P4HB) Participants. PeachCare for Kids ® is Georgia's Children's Health Insurance Program (CHIP), and the P4HB program is Georgia's Section 1115 family planning waiver program. A summary of the required responsibilities to be carried out by the Contractor include: 1.0.1.1 Provision of access to health care services, including but not limited to physical health service, behavioral health services, dental services and Care Coordination; (p. 2, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³⁴ Resource Mother Outreach: Service under the P4HB program made available to women who receive Medicaid benefits and give birth to a VLBW baby. The Resource Mother Outreach section offers support to mothers and provides them with information on parenting, nutrition, and healthy lifestyles. Details pertaining to Resource Mothers Outreach are incorporated in Attachment N to this Contract. (p. 48, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³⁵ 1.0 SCOPE OF SERVICE 1.0.1 The Contractor will provide care management services to Georgia Families, Medicaid and PeachCare for Kids ® Members and Planning for Healthy Babies (P4HB) Participants. PeachCare for Kids ® is Georgia's Children's Health Insurance Program (CHIP), and the P4HB program is Georgia's Section 1115 family planning waiver program. A summary of the required responsibilities to be carried out by the Contractor include: 1.0.1.1 Provision of access to health care services, including but not limited to physical health service, behavioral health services, dental services and Care Coordination; (p. 2, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³⁶ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services:... 4) Perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program. (p. 157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁷ 4.4 Coverage Provisions for Behavioral Health... 2. Standard Behavioral Health Services for Adults and Children a. The Health Plan shall be responsible for providing standard behavioral health services to all Members, both adults and children. The Health Plan is not responsible for standard behavioral health services for the Members that are receiving their behavioral health services from the CCS program as described in §4.4(B). The Health Plan shall provide behavioral health services to persons who have been involuntarily committed for evaluation and treatment under the provisions of HRS Chapter 334 when Medical Necessity is established by the Health Plan's utilization review procedures. Even if court ordered diagnostic, treatment, or rehabilitative services are not determined to meet Medical Necessity criteria, the costs of continuing care under court order shall be borne by the Health Plan. b. A Member's access to behavioral health services shall be no more restrictive than for accessing medical services (§4.4.A.9). The Health Plan shall make available triage lines or screening systems, and allow the use of telemedicine, e- visits, and/or other evolving and innovative technological solutions, when applicable. The Health Plan shall not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to the Members, whether or not the benefits are furnished by the same Health Plan. c. The Health Plan is not obligated to provide behavioral health services to those adults who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of HRS §706-607, or individuals who are committed to the Hawaii Youth Correctional Facility. d. The psychiatric evaluation and treatment of the Members who have been criminally committed to ambulatory mental healthcare settings, including those with legal encumbrances to DOH, shall be the clinical responsibility of the appropriate state agency. The Health Plan shall remain responsible for providing medical services to these criminally committed Members. In addition, the Health

Plan may be billed for standard behavioral health services provided to these Members. e. The Health Plan shall provide the behavioral health services in accordance with the prescribed parameters and limitations. The Health Plan shall comply with all state and federal laws pertaining to the provision of such services. (pp. 130-132, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁸ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services:... Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports;... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services: 1) Access to appropriate levels of care based on... behavioral,... need... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁹ 7. SUD Treatment a. The Health Plan shall provide coverage for both inpatient and outpatient SUD treatment when Medical Necessity is established. A Member's access to SUD treatment shall be no more restrictive than for accessing medical services. SUD treatment shall be provided in a treatment setting accredited according to the standards established by the ADAD. b. The Health Plan shall maintain a robust provider network that includes treatment providers that are closely aligned with the currently existing community-based providers that are accredited and monitored by ADAD to the extent possible. c. The availability and accessibility of inpatient and outpatient substance use treatment for pregnant and parenting women and their children. d. The Health Plan shall contract with SUD treatment providers that are closely aligned with the currently existing community-based providers that are accredited and monitored by ADAD to the extent possible. e. Certified Substance Abuse Counselors (CSACs) shall be certified by ADAD. f. The Health Plan shall provide coverage to its Members for all medication the FDA has approved for specific SUDs. The Health Plan may develop its own payment methodologies in accordance with §7.2.D for FDA-approved medications. Methadone, Opioid Medication, and Other Medication to Treat SUD – The Health Plan shall support practice utilization of medication-assisted treatment for substance use conditions across the continuum of services from primary care to specialty behavioral health services as described in §4.4.A.1.a.2. The Health Plan shall provide coverage for Methadone/Levomethadyl acetate services for the Members for acute opiate detoxification as well as maintenance. (pp. 133-134, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁴⁰ See general provisions under "SUD services" column, in part.

15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services:... Screening, diagnosis, and treatment for pregnancy-related conditions, to include... access to... substance use treatment or supports... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁴¹ 4.2 Coverage Provisions for Preventive Services... C. C. Nutrition Counseling 1. This service is provided by a licensed dietitian. This preventive health service includes nutrition counseling for diabetes, obesity, and other metabolic conditions, and when Medical Necessity is established for other medical conditions. Nutrition counseling requires a physician's order and shall be part of a treatment program to mitigate the effects of a medical condition. (p. 125, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁴² C. Coordination with Other State Programs In addition to the health coordination requirements in §3.7, the Health Plan is also responsible for coordination with other governmental programs. Data use agreements will be required for any disclosure of Medicaid data. This section describes other agencies' services and responsibilities, as well as the requirements of the Health Plan. 1. DOH – Women, Infants, and Children (WIC) The Health Plan shall coordinate the referral with Member consent of potentially eligible women, infants, and children to the WIC Supplemental

Nutrition Program and the provision of health data required by the WIC program, within the timeframe required by WIC, from their providers. The Health Plan shall cover the cost of specialty formula when Medical Necessity is established. (p. 113, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy and up to sixty (60) days post-partum when Medical Necessity is established. b. The following services are covered under pregnancy-related services:... 7) Lactation support for at least six months; 8) Breast pump, purchased or rented for at least six months; 9) Educational classes on... breastfeeding... (pp. 155-157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁴³ 4.5 Coverage Provisions for Primary and Acute Care Services A. 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 §4.1. The Health Plan shall comply with all state and federal laws pertaining to the provision of such services... 4. Dental Services to Treat Medical Conditions a. The Health Plan shall provide dental services to treat medical conditions when Medical Necessity is established. The Health Plan shall also be responsible for providing referrals, follow-ups, coordination, and provision of appropriate medical services related to dental needs when Medical Necessity is established. b. The Health Plan shall provide coverage for any dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center). This includes medical services provided to adults and children that are required as part of a dental treatment and certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists, and general surgeons), as defined in the Health Plan Manual. c. Specifically, the Health Plan shall be responsible for: 1) Providing referral, follow-up, coordination, and provision of appropriate services, including but not limited to, emergency room treatment, hospital stays, ancillary inpatient services, operating room services, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple and compound), oral surgery to repair traumatic wounds, surgical supplies, blood transfusion services, ambulatory surgical center services, x-rays, laboratory services, drugs, physician examinations, consultations, and second opinions; 2) Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist. Sedation services administered by an oral and maxillofacial surgeon, or other qualified dental anesthetist, in a private office or hospital-based outpatient clinic for services that are not medically related shall be the responsibility of the dental program contractor; 3) Providing dental services performed by a dentist or physician that are needed due to a medical emergency, for example, car accident, where the services provided are primarily medical; and 4) Providing dental services in relation to oral or facial trauma, oral pathology, including but not limited to infections of oral origin, cyst and tumor management, and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting. d. The Health Plan shall work closely and coordinate with DHS or its agent to assist the Members in finding a dentist, making appointments, and coordinating transportation and translation services. e. The Health Plan is not responsible for services that are provided in private dental offices, government-sponsored or subsidized dental clinics, and hospital-based outpatient dental clinics. f. In cases of medical disputes regarding coverage, the Health Plan's Medical Director shall consult with DHS' Medical Director to assist in defining and clarifying the respective responsibilities. DHS may make the final decisions if the issues are unclear or the dispute continues. (pp. 142-143, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁴⁴ 9. Care Coordination 9.1 General The Contractor shall provide care coordination that complies with 42 C.F.R. § 438.208 and includes, at minimum, the following components: (i) performance of an initial health risk screening; (ii) placement of members in a care coordination program based on assessed level of risk; (iii) performance of a comprehensive health risk assessment for members identified as having a special health care need; (iv) care plan development; and (v) reassessment. The Contractor shall implement a care coordination program in compliance with the requirements of this section. Care coordination programs shall also have a demonstrated record of: (i) improving quality outcomes; (ii) coordinating care across the healthcare delivery system; (iii) increasing member compliance with recommended treatment protocols; (iv) increasing member understanding of their healthcare conditions and prescribed treatment; (v) empowering members; (vi) coordinating care with other Contractors and or Agencies; and (vii) providing flexible person-centered care. The requirements in this section apply to non-LTSS services; see Section 4 for LTSS assessment, care plan and community-based case management requirements. For members receiving LTSS who are identified as eligible for services under the Contractor's care coordination program, as described in this section, the Contractor shall implement strategies to ensure the integration of LTSS case management and Contractor care coordination program services. (p. 135, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

⁴⁵ 3.2.8 Behavioral Health Services The Contractor shall deliver behavioral health services, which includes mental health and substance use disorder treatment and support services, as part of a recovery-oriented care system that welcomes and engages members in their personal recovery efforts. The Contractor shall develop and implement strategies approved by the Agency to build community capacity for behavioral health and L TSS. Contractor delivery and reimbursement of behavioral health services shall be aligned with the philosophy outlined in 3.2.8. I. (p. 47, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

⁴⁶ See "Mental health services" column.

⁴⁷ 3.2.8.14 Pregnant Women that have a Substance Use Disorder Women who are pregnant and have a substance use disorder shall be a priority population to serve. The Contractor shall support and integrate IDPH-funded Women and Children services provided to pregnant and parenting women. (pp. 52-53, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

b. Appointment Times: The Contractor shall require that network providers have procedures for the scheduling of member appointments in accordance with the following requirements:... vi. Substance Use Disorder & Pregnancy: Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment. (p. 213, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

⁴⁸ 8.7 Health Education and Initiatives The Contractor shall develop programs and participate in activities to enhance the general health and well-being of members. The Contractor shall develop a strategy to participate in and interface with the Healthiest State Initiative. Examples of health education, disease prevention and outreach programs and activities include, but not limited to, the following: 8.7.1 Example Programs... 8.7.1.5 Nutrition counseling;... (p. 124, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

Nutrition counseling; Max 40 units allowed for 12 month period. (p. 233, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

⁴⁹ Table D2: Iowa Wellness Plan Benefits Coverage List... Service Category: Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & inpatient maternity - Nutritional (p. 230 Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

⁵⁰ 5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management 5.12.2 Provision of Care Management. Contractor shall provide Care Management to all Enrollees that accept or request it, through a Care Coordinator who participates in an Interdisciplinary Care Team (ICT). Care Management includes assessment of the Enrollee's clinical risks and needs, medication management, and health education on complex clinical conditions, as appropriate to the individual needs and preferences of the Enrollee.

5.12.2.1 If Contractor enters into any contract with any entity that also administers the determination of need (DON) or prescreening required under HCBS Waivers, Contractor shall immediately provide the name of that Provider to the Department. 5.12.2.2 Contractor shall coordinate services with the services the Enrollee receives from community and social support providers. 5.12.2.3 Contractor shall have the capacity to perform the full range of Care Management prior to implementation, and the State will monitor Contractor's performance throughout the term of the Contract. 5.12.2.4 Contractor shall implement procedures to coordinate services provided between settings of care, including timely discharge planning for hospital and institutional stays. Contractor shall also provide Case management assistance to hospitals in securing timely transfer of patients from non-Network hospitals to contracted facilities. 5.12.2.5 For Enrollees residing in a Nursing Facility, Contractor shall ensure that Care Management services required by this Contract are provided. Nursing Facility Care Coordinators may provide Care Management services that supplement Contractor's Care Management services. 5.12.3. Care Coordinators. Each Enrollee who receives Care Management will be assigned a Care Coordinator. Contractor must provide Enrollee information on how to contact the Enrollee's designated person or entity primarily responsible for coordinating services. 5.12.3.1 *Qualifications*. Care Coordinators who serve High-Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, or DHS-DRS Persons with Disabilities HCBS Waiver must meet the applicable qualifications set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate qualifications to address the needs of Enrollees. 5.12.3.2 *Training requirements*. Care Coordinators who serve High-Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees. 5.13 Assessments and Care Planning. 5.13.1. Identifying need for Care Management. Contractor's goals, benchmarks, and strategies for managing the care of Enrollees in its traditional Disease Management Programs shall be incorporated in, and included as part of, Contractor's Care Management program. Contractor shall use population- and individual-based tools and real-time Enrollee data to identify an Enrollee's risk level. These tools and data shall include the following: 5.13.1.1 *Health-risk screening*. Contractor will develop and maintain a health-risk screening tool, which includes Behavioral Health risk, and will provide that tool to the Department. Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health. Contractor will use the results to guide the administration of more in-depth health assessments. Contractor may administer a health-risk assessment in place of the health-risk screening, provided it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCP of the enrollment of any new Enrollee who has not completed a health-risk screening within the time period set forth above and whom Contractor has been unable to contact. Contractor shall conduct outreach to their Enrollees and to schedule visits. 5.13.1.2 *Predictive modeling*. Contractor shall utilize claims and CCCD to risk stratify the population and to identify high-risk conditions requiring immediate Care Management. 5.13.1.3 *Surveillance data*. Contractor shall identify Enrollees through Referrals, transition information, service authorizations, alerts, Grievance system, memos, results of the DON, or other assessment tools adopted by the State, and from families, caregivers, Providers, community organizations, and Contractor personnel. 5.13.1.4 Stratification. Based upon an analysis of the information gathered through the process in this section, Contractor shall stratify all Enrollees to determine the appropriate level of intervention by its Care Management program. Enrollees shall be assigned to one (1) of three (3) levels: Level 1 (Low, includes low- or no-risk Enrollees to whom Contractor provides, at a minimum, prevention and wellness messaging and condition-specific education materials.), Level 2 (Moderate, includes moderate-risk Enrollees for whom Contractor provides problem-solving interventions.), and Level 3 (High, includes high-risk Enrollees for whom Contractor provides intensive Care Management for reasons such as addressing acute and chronic health needs, behavioral health needs, or addressing lack of social support. All Special Needs Children are categorized as Level 3.) 5.13.2 Health-Risk Assessment. Contractor shall use its best efforts to complete a for any Enrollee whose health-risk screening indicates a need for further assessment. For the purpose of this section 5.13.2, the Department will define best efforts on an annual basis. This section 5.13.2 applies to the following populations: 5.13.2.1 All Level 3 (high-risk) Enrollees. The assessment will be conducted, in-person or over the phone, and an IPoC will be developed within ninety (90) days after enrollment. Enrollees receiving HCBS Waiver Services or residing in NFs as of their Effective Enrollment Date with Contractor. The health-risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date. 5.13.2.2 Enrollees receiving HCBS Waiver services or residing in NFs as of the Effective Enrollment Date, who were enrolled in another MCO, but are transitioning to Contractor's Health Plan. The health-risk assessment relating to those Covered Services must be face-to-face and completed within the first ninety (90) days after the Effective Enrollment Date. 5.13.2.3 Enrollees transitioning to NFs. The health-risk assessment relating to those Covered Services must be face-to-face and completed within the first ninety (90) days after

the Effective Enrollment Date. 5.13.2.4 Enrollees deemed newly eligible for HCBS Waiver Services. The health-risk assessment must be face-to-face and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS waiver services. 5.13.3. Outreach. Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high-risk or moderate-risk. For the purpose of this section, the Department will define best efforts on an annual basis. Where appropriate, Contractor shall use community-based organizations to locate and engage such Enrollees. 5.13.4. Enrollee engagement and education. Contractor shall use a multifaceted approach to locate, engage, and educate Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee information. Contractor shall solicit input from Enrollees and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living. 5.13.5. Self-directed care. Contractor will encourage Providers to support Enrollees in directing their own care and developing an IPoC. (pp. 88-91, Effective 2018, State of IL Model Contract)

⁵¹ 5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees... (p. 88, Effective 2018, State of IL Model Contract)

1.1.1. These regulations require that Contractor have an ongoing, fully implemented QA program for health services that: ...1.1.1.17 describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for health education; and oversight of Provider requirements to coordinate care and provide health education topics (e.g., childhood immunizations, well-child visits, prenatal care, obesity, heart smart activities, mental health and substance use resources). (p. 224, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

1.1.2. Contractor shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management, Disease Management). This written description must meet federal and State requirements, as outlined below. (p. 226, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

3.1.3.13.3 specific areas to be addressed by Contractor in collaboration with network practitioners and Enrollees regarding the provision of prenatal care include but are not limited to the following items...3.1.3.13.3.5 visits close to the third (3rd) trimester should include... transition of maternal healthcare after the postpartum visit. Contractor shall have all protocols in place to facilitate appropriate continuity of care after the current pregnancy. (p. 311, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: 3.1.3.13.5.3 Contractor must continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother with seamless referrals, if Medically Necessary, to avoid interruption of care; 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease; and 3.1.3.13.5.5 Contractor shall provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery. (pp. 312-313, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

⁵² 4.15.2. Upon request by the Department, or at the times set forth in section 4.15.2.1, Contractor shall provide to the Department documentation that sets forth Contractor's physical, professional, and network capacity. The documentation must demonstrate that Contractor offers an appropriate range of preventive services, primary care, Behavioral Health, and specialty services that is adequate for the anticipated number of Enrollees, and that Contractor maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees. (p. 59, Effective 2018, State of IL Model Contract)

5.8.1.1.2 *Behavioral Health Provider access.* Contractor shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee’s residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee’s residence. (p. 81, Effective 2018, State of IL Model Contract)

1.1.3.1 Clinical areas to be monitored. At a minimum, the following areas shall be monitored for Behavioral Health: 1.1.3.1.37 Behavioral Health network adequate to serve the Behavioral Health needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides. (p. 230, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

1.1.9. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.9 Behavioral Health (Mental Health and substance use) screening, assessment, and treatment, including medication management and PCP follow-up. (p. 238, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

⁵³ 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: ...3.1.3.13.3.2 screening for diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool (refer to the *Handbook for Providers of Healthy Kids Services* for a list of approved screening tools.... 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with... depression, alcohol, tobacco or other substance use///. (pp. 312-313, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

⁵⁴ 4.15.2. Upon request by the Department, or at the times set forth in section 4.15.2.1, Contractor shall provide to the Department documentation that sets forth Contractor’s physical, professional, and network capacity. The documentation must demonstrate that Contractor offers an appropriate range of preventive services, primary care, Behavioral Health, and specialty services that is adequate for the anticipated number of Enrollees, and that Contractor maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees. (p. 59, Effective 2018, State of IL Model Contract)

5.8.1.1.2 *Behavioral Health Provider access.* Contractor shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee’s residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee’s residence. (p. 81, Effective 2018, State of IL Model Contract)

1.1.3.1 Clinical areas to be monitored. At a minimum, the following areas shall be monitored for Behavioral Health: 1.1.3.1.37 Behavioral Health network adequate to serve the Behavioral Health needs of Enrollees, including mental health and substance abuse services sufficient to provide care within the community in which the Enrollee resides. (p. 230, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

1.1.9. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.9 Behavioral Health (Mental Health and substance use) screening, assessment, and treatment, including medication management and PCP follow-up. (p. 238, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

⁵⁵ 3.1.3.13.3 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: 3.1.3.13.3.1 risk detection by appropriate inquiry, testing and consultation if necessary, counseling and treatment if indicated for: various chronic medical conditions including ... alcohol, tobacco,

and substance use including prescription opioids and marijuana; and, to prevent when possible, potential of ... fetal alcohol syndrome.... Contractor must put in place and be able to demonstrate that various evidence based strategies and interventions (including 17 P and referral to substance use, alcohol and tobacco abstinence programs, when indicated) to reduce adverse maternal and birth outcomes are operational. (p. 310, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care. At a minimum, Contractor shall provide and document the following services: 3.1.3.13.5.4 Contractor shall assure that Enrollees are transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period, Contractor shall identify and closely follow Enrollees who delivered and who are at risk of or diagnosed with..., alcohol, tobacco or other substance use... (p. 312, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

⁵⁶ 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: 3.1.3.13.2Contractor 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. 3.1.3.13.3.5 visits close to the third (3rd) trimester should include...referral to parenting classes and WIC. 3.1.3.13.5.1 postpartum visits, in accordance with the Department's approved schedule, to assess and provide education on areas such as... breastfeeding/feeding practices, nutrition... and referral to parenting classes, maternity education tools, platforms and materials and WIC. (pp. 309-312, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

3.1.3.14 Well-woman exam: Contractor shall ensure provision of evidence-based annual well-woman care to female Enrollees, which will include preconception care, interconception care, and reproductive life planning. 3.1.3.14.2 Appropriate referrals should be made to support services including WIC,.... (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract)

3.1.4 Coordination with other service providers. Contractor shall encourage Network Providers and Subcontractors to cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include WIC programs.... (pp. 314-315, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

⁵⁷ 5.8.1 Network adequacy standards. Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. (p. 80, Effective 2018, State of IL Model Contract)

1.1.9. At a minimum, clinical practice guidelines and best practice standards of care shall be adopted by Contractor for the following conditions and services at a minimum, and not necessarily limited to: 1.1.9.13 dental services. (p. 238, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

⁵⁸ 6.7.3 Case Management for Members Receiving Behavioral Health Services. The Contractor shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the Contractor shall offer to provide case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers shall contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization, and shall schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge. Case managers should use the results of health needs screenings and more detailed comprehensive health assessments, including the medically frail health assessments, to identify members in need of case management services. Case managers shall also monitor members receiving behavioral health services who are new to the Contractor's plan to ensure that the member is expediently

linked to an appropriate behavioral health provider. The case manager shall monitor whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services. OMPP shall provide access to its web-based interface CoreMMIS to allow the Contractor to monitor MRO utilization, which is covered by Medicaid FFS. Case managers shall regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member. In addition, with the appropriate consent, case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers shall provide this notification within five (5) calendar days of the hospital admission or emergency treatment. Documentation of case management procedures, contacts, interventions and outcomes shall be made available to OMPP upon request. (pp. 35-36, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.8 Disease Management. The Contractor shall make a spectrum of disease management tools available to the population, including population-based interventions, care management and complex case management, as described below. All care and case management programs should identify psychosocial issues of the members that may contribute to poor health outcomes and provide appropriate support services for addressing such issues. ... Disease management consists of three levels of Contractor-member interaction, including population-based interventions, care management and complex case management. For the purpose of this Contract, the term care coordination will serve as a global reference for case management, care management, complex case management or any other term referencing the organization, synchronization and/or management of health care services for the benefit of the member. Similarly, the term care manager is used for ease to describe the staff person performing the functions of disease management, case management, care management, or complex case management when organizing, synchronizing and/or managing health care services for the benefit of the member. Members served in the Contractor's disease management, care management and complex case management services may require additional resources to meet their biopsychosocial needs. To meet these needs, the Contractor shall make every effort to assist members in navigating community resources and linking members with community-based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services. (pp. 80-81, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.8.2 Care Management. The Contractor's protocol for referring members to care management shall be reviewed by OMPP and shall be based on identification through the health needs screening, member request or when the claims history suggests need for intervention. In addition to population based disease management educational materials and reminders, these members should receive more intensive services. Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy non-compliance for chronic conditions and identification of special health care needs should be strongly considered for care management or complex case management. Care management services include direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services. The Contractor shall make every effort to contact members in care management telephonically. Materials should also be delivered through postal and electronic direct -to consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest shall receive materials no less than quarterly. The Contractor shall document the number of persons with conditions of interest, outbound telephone calls, telephone contacts, category of intervention, intervention delivered, mailings and website hits. Care management shall be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program is not a replacement for care management. 6.8.3 Complex Case Management. The Contractor's protocol for referring members to complex case management shall be reviewed by OMPP and shall be based on a member's designation as medically frail, identification through the health needs screening as having special care needs, a condition of interest named above, or a chronic or co-morbid disease utilization history and/or member request that indicates the need for real-time, proactive intervention. Persons with clinical medical training shall be required to develop the member's care plan. The Medical Director shall be available to consult with the clinicians on the care management team as needed to develop the care plans for high-risk cases. Care plans developed by the Contractor shall include clearly stated health care goals to address the medical, social, educational, and other services needed by the individual and defined milestones to document progress, clearly defined accountability and responsibility and timely, thorough review with appropriate corrections ("course changes") as indicated. The Contractor's case management services and care plan development shall involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy to help link the member with providers or programs capable of helping the member achieve the defined goals of the care plan. The member's health care providers shall be included in the development

and execution of member care plans. Care plans and case management shall take into account co-morbidities being jointly managed and executed, as separate care plans for each medical problem in the same member may fragment care and add to the potential of missing interactive factors. The Contractor shall contact members telephonically and in-person as indicated by their need. Care managers should engage in care conferences with the member's health care providers, as necessary. Members shall receive the same educational materials delivered to those persons receiving case management including direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Call Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services. Materials can be delivered through postal and electronic direct -to-consumer contacts, as well as webbased education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. The Contractor shall document the number of persons with conditions of interest, outbound telephone calls to providers and members, telephone contacts to members and providers, category of intervention, intervention delivered, mailings and website hits. Utilization statistics on hospitalizations, emergency services, primary care and specialty care should be documented and trended from baseline. The Contractor's care management services shall be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program shall not be considered a replacement for care management or complex case management. (pp. 82-83, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.2.3 Health Screening. The Contractor shall conduct a Health Needs Screen (HNS) for new members that enroll in the Contractor's plan. The HNS will be used to identify the member's physical and/or behavioral health care needs, special health care needs, as well as the need for disease management, case management and/or care management services set forth in Section 6.8. The HNS may be conducted in person, by phone, online or by mail. (p. 93, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.2 Member Incentive Programs. For example, the Contractor may offer member incentives for: ... * Complying with treatment in a disease management, care management or complex case management program. (p. 143, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.3 Utilization Management Program. ...Contractor will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor shall identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The Contractor shall also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group shall be referred to an appropriate level of care coordination. The Contractor may use the Right Choices Program (RCP), as described in Section 9.3.1 below, in identifying members to refer to case management or care management. (p. 146, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁵⁹ 9.2.3 Notification of Pregnancy (NOP) Incentives. OMPP has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., a NOP form) for pregnant members. ...The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in a prenatal case management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p. 144, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶⁰ 6.1 Covered Benefits and Services. HIP covered services include all services, including coverage criteria, limitations and procedures, identified in the HIP alternative benefit plans (ABP) approved by CMS and meeting the requirements as set forth in Section 1937 of the Social Security Act. ...HIP covers the ten essential health benefits, as detailed by the alternative benefit plans: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (iv) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x)

pediatric services. Except as otherwise stated in this Scope of Work, HIP covered services are subject to a \$2,500 annual deductible, to be paid with POWER Account funds. (p. 64, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.2 Self-referral Services. In accordance with state and federal requirements, HIP program include some benefits and services that are available to members on a self-referral basis. These self-referral services shall not require a referral from the member's PMP or authorization from the Contractor. ...Behavioral health services are self-referral if rendered by an in-network provider. Members may self-refer, within the Contractor's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within network are: Outpatient mental health clinics; Community mental health centers; Psychologists; Certified psychologists; Health services providers in psychology (HSPPs); Certified social workers; Certified clinical social workers; Psychiatric nurses; Independent practice school psychologists; Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center; and Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option). (p. 66, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.7 Behavioral Health. Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and 1915(i) services, are a covered benefit under the HIP program. The Contractor is responsible for managing and reimbursing all such services in accordance with the requirements in this section. In furnishing behavioral health benefits, including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Additions Equity Act (MHPAEA). This includes, but is not limited to: Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those otherwise specified in this Scope of Work. Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members, or contracting provider upon request. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits. The Contractor shall assure that behavioral health services are integrated with physical care services, and that behavioral health services are provided as part of the treatment continuum of care. The Contractor shall develop protocols to: Provide care that addresses the needs of HIP members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health; Provide a written plan and evidence of ongoing, increased communication between the PMP, the Contractor and the behavioral health care provider; and Coordinate management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

6.7.1 Behavioral Health Care Services The Contractor shall provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services as identified in Contract Exhibit 4. Contractors shall pay CMHCs at no less than the Medicare rate or 130% of Medicaid FFS rate for any covered non-MRO service that the CMHC provides to a HIP member. The Contractor shall provide behavioral health services through hospitals, offices, clinics, in homes, and other locations, as permitted under state and federal law. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members, shall be available to members, including partial hospitalization services as described in 405 IAC 5-20-8. Behavioral health services codes billed in a primary care setting shall be reviewed for medical necessity and, if appropriate, shall be paid by the Contractor. The Contractor shall allow members to self-refer to any behavioral health care provider in the Contractor's network without a referral from the PMP. Members may also self-refer to any IHCP-enrolled psychiatrist.

6.7.2 Behavioral Health Provider Network FSSA requires Contractors to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network shall include psychiatrists, psychologists, clinical social workers and other licensed behavioral health care providers. In addition, Contractors shall provide inpatient care for a full continuum of mental health and substance abuse diagnoses. See Section 8.2 for behavioral health network requirements. All services covered under the clinic option shall be delivered by licensed providers, such as psychiatrists and health services providers in psychology, Advanced Practice Nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling. The Contractor shall train its providers in identifying and treating members with behavioral health disorders, and shall train PMPs and specialists on when and how to refer members for behavioral health treatment. The Contractor shall also train providers in screening and treating individuals who have co-existing mental health and substance abuse disorders. The Contractor is responsible for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of its member population and are competent in respectfully and effectively interacting with individuals with varying racial, ethnic and linguistic differences. The Contractor shall provide to OMPP its written training plan, which shall include dates, methods (e.g., seminar, web conference, etc.) and

subject matter for training on integration and cultural competency. Members shall be able to receive timely access to medically necessary behavioral health services. The network shall meet the access requirements specified in Section 8.2.5. 6.7.3 Case Management for Members Receiving Behavioral Health Services The Contractor shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the Contractor shall offer to provide case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers shall contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization, and shall schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge. Case managers should use the results of health needs screenings and more detailed comprehensive health assessments, including the medically frail health assessments, to identify members in need of case management services. Case managers shall also monitor members receiving behavioral health services who are new to the Contractor's plan to ensure that the member is expediently linked to an appropriate behavioral health provider. The case manager shall monitor whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services. OMPP shall provide access to its web-based interface CoreMMIS to allow the Contractor to monitor MRO utilization, which is covered by Medicaid FFS. Case managers shall regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member. In addition, with the appropriate consent, case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers shall provide this notification within five (5) calendar days of the hospital admission or emergency treatment. Documentation of case management procedures, contacts, interventions and outcomes shall be made available to OMPP upon request. 6.7.4 Behavioral Health Care Coordination The Contractor shall ensure the coordination of physical and behavioral health care among all providers treating the member. The Contractor shall coordinate services for individuals with multiple diagnoses of mental illness, substance abuse and physical illness. The Contractor shall have policies and procedures in place to facilitate the reciprocal exchange of health information between physical and behavioral providers treating the member. The Contractor shall share member medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. The Contractor shall contractually mandate that its behavioral health care network providers notify the Contractor within five (5) calendar days of the member's inpatient visit and within five (5) days of a member's initial referral visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information. Disclosure of mental health records by the provider to the Contractor and to the member's physician is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records. The Contractor shall contractually require every network provider, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the Contractor and to the PMP or behavioral health provider, if applicable. Contractors shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained. For each member receiving behavioral health treatment, the Contractor will contractually require behavioral and physical health providers to document and reciprocally share the following information for that member: Primary and secondary diagnoses; Findings from assessments; Medication prescribed; Psychotherapy prescribed; and Any other relevant information. Contractors shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member. The Contractor shall implement mechanisms to ensure coordination among member's providers. With appropriate consent, the Contractor shall notify behavioral health providers and medical providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five (5) calendar days of the hospital inpatient admission or emergency treatment. The Contractor shall maintain a description of strategies proposed to receive hospital notification of inpatient admissions to facilitate meeting the requirement for example, through the use of incentive programs. The Contractor shall develop additional mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The Contractor shall require the behavioral health provider to share clinical information directly with the member's PMP. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Refer to section 6.13 for notification and continuity of care requirements for non-behavioral health admissions and emergency services. The Contractor must develop mechanisms for facilitating

communication between behavioral health and physical health providers to ensure the provision of integrated member care. The Contractor shall maintain mechanisms for ensuring physical and behavioral health integration and information sharing. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Documentation of integration policies and procedures and outcomes data shall be made available to OMPP upon request and at minimum on a semi-annual basis. Additionally, the State is exploring implementation of new initiatives for behavioral and physical health integration for Indiana Medicaid members. The Contractor shall participate in the planning and execution of State-driven integration at the direction of OMPP. Documentation of integration policies and procedures, contacts, behavioral health profile templates and outcomes data shall be made available to OMPP upon request. 6.7.5 Behavioral Health Continuity of Care The Contractor shall utilize behavioral health case managers to monitor the care of members receiving behavioral health services who are new to the Contractor or who are transitioning to another MCE or other treatment provider, to ensure that medical records, treatment plans and other pertinent medical information follows each transitioning member. The Contractor shall notify the receiving MCE or other provider of the member's previous behavioral health treatment, and shall offer to provide to the new provider the member's treatment plan, if available, and consultation with the member's previous treating provider. The Contractor and receiving MCE shall coordinate information regarding prior authorized services for members in transition. The Contractor shall require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment shall be provided within seven (7) calendar days from the date of the member's discharge. If a member misses an outpatient followup or continuing treatment, the Contractor shall ensure that a behavioral health care provider or the Contractor's behavioral health case manager contacts that member within three (3) business days of notification of the missed appointment. (pp. 75-80, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

8.2.5 Non-psychiatrist Behavioral Health Providers. In addition to the access requirements for psychiatrists as described in Section 8.2.3, the Contractor shall establish a network of behavioral health providers, addressing both mental health and addiction, as set forth in this Section 8.2.5. The Contractor is encouraged to contract with all Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs). If all CMHCs are not included in the provider network, the Contractor shall demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services as required in Sections 6.11.1 and 6.11.2. Further, as described in Section 6.7.4, the Contractor shall, at a minimum, establish referral agreements and liaisons with both contracted and noncontracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member. The Division of Mental Health and Addiction (DMHA) conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the Contractor provides for contracted CMHCs, the Contractors shall utilize the results of DMHA's review to inform contracting decisions, to monitor contracted CMHCs and to develop improvement plans with contracted CMHCs. In urban areas, the Contractor shall provide at least one (1) behavioral health provider within thirty (30) minutes or thirty (30) miles from the member's home. In rural areas, the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home. The availability of professionals will vary, but access problems may be especially acute in rural areas. The Contractor shall provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas. The Contractor also shall monitor utilization in rural and urban areas to assure equality of service access and availability. The Division of Mental Health and Addiction (DMHA) conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the Contractor provides for contracted CMHCs, the Contractors shall utilize the results of DMHA's review to inform contracting decisions, to monitor contracted CMHCs and to develop improvement plans with contracted CMHCs. In urban areas, the Contractor shall provide at least one (1) behavioral health provider within thirty (30) minutes or thirty (30) miles from the member's home. In rural areas, the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home. The availability of professionals will vary, but access problems may be especially acute in rural areas. The Contractor shall provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas. The Contractor also shall monitor utilization in rural and urban areas to assure equality of service access and availability. The following list represents behavioral health providers that shall be available in the Contractor's network: Outpatient mental health and addiction clinics; Community mental health centers; Psychologists; Certified psychologists; Health services providers in psychology (HSPPs); Certified social workers; Licensed clinical social workers; Psychiatric nurses; Independent practice school psychologists; Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center; Marital and family therapists; and Licensed mental health counselors. All services covered under the clinic option shall be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling. (pp. 121-122, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

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

⁶² 6.1 Covered Benefits and Services. HIP covered services include all services, including coverage criteria, limitations and procedures, identified in the HIP alternative benefit plans (ABP) approved by CMS and meeting the requirements as set forth in Section 1937 of the Social Security Act. ...HIP covers the ten essential health benefits, as detailed by the alternative benefit plans: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (iv) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x) pediatric services. Except as otherwise stated in this Scope of Work, HIP covered services are subject to a \$2,500 annual deductible, to be paid with POWER Account funds. (p. 64, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.4.7 SUPPORT Act Compliance. In accordance with the federal Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, the Contractor shall implement and maintain the following processes and standards by October 1, 2019: 1. Safety edits and claims review automated process for the State-approved maximum daily morphine limitation 2. Safety edits and claims review automated process for the State-approved maximum daily morphine equivalent for treatment of chronic pain 3. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines, or is concurrently prescribed opioids and antipsychotics 4. Program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children 5. Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies. (p. 71, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.7 Behavioral Health. Behavioral health services, with the exception of Medicaid Rehabilitation Option (MRO) and 1915(i) services, are a covered benefit under the HIP program. The Contractor is responsible for managing and reimbursing all such services in accordance with the requirements in this section. In furnishing behavioral health benefits, including any applicable utilization restrictions, the Contractor shall comply with the Mental Health Parity and Additions Equity Act (MHPAEA). This includes, but is not limited to: Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those otherwise specified in this Scope of Work. Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential members, or contracting provider upon request. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits. (p. 75, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.7.6 Institution for Mental Disease (IMD). Pending CMS approval, FSSA reserves the right to alter the coverage and length of stay restrictions in this section. The Contractor will cover short term stays in an Institution for Mental Diseases (IMD) for serious mental illness (SMI) and substance use disorder (SUD) under the State's §1115 SMI and SUD demonstration authorities. IHCP will follow federal guidance in accordance with 42 CFR 435.1010 as well as any additional criteria established by the State's §1115 waivers used to distinguish qualified IMD providers. The Contractor will cover short term inpatient stays for serious mental illness (SMI) in a qualified Institution for Mental Disease (IMD) for members aged 21 to 64 and is required to maintain an average length of stay not to exceed 30 days for all IMD stays for SMI. A maximum of 60 days can be approved, if medically necessary, for short term IMD stays for SMI. The Contractor will cover short term inpatient stays for substance use disorder (SUD) in a qualified Institution for Mental Diseases (IMD) for members aged 21 to 64 for up to 15 days in a calendar month as medically necessary for individuals with substance use disorder. If a member's IMD stay exceeds 15 days in a calendar month and the member is awaiting placement in a state operated facility (SOF) for treatment, the

member will be disenrolled from the plan and enrolled in fee for service. For stays exceeding 15 days in a calendar month in which the member is not awaiting placement in a SOF, the member will remain enrolled with the Contractor and the state shall recover the entire monthly capitation payment for the member. The Contractor will cover short term residential stays for substance use disorder (SUD) in a qualified Institution for Mental Diseases (IMD) for members aged 21 to 64 and is required to maintain an average length of stay not to exceed 30 days for all residential IMD stays for SUD. The Contractor shall actively track and coordinate the care of members receiving care in an IMD. Anticipating and planning for a member's successful discharge should begin immediately upon a member's entry into an IMD. Lists of qualified IMD providers under both §1115 waivers will be provided to the Contractor. The Contractor may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan. In accordance with 42 CFR 435.1010, an IMD is generally defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases." This may include a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services. The Contractor will be responsible for reviewing and understanding all specific State criteria to distinguish qualifying IMDs under both SMI and SUD §1115 demonstrations as well as all related State guidance. The Contractor must submit data related to IMD stays as outlined in the MCE Reporting Manual. The proposed services and settings will be reimbursable and subject to the requirements contained in 42 CFR part 438. (pp. 79-80 Amendment #14, Effective 2021, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.1 Provider Incentive Programs. Physician incentive plans shall comply with the following requirements: ...The Contractor will expand the provider incentive plans and align them with the following healthy incentive program focus areas: tobacco cessation, substance use disorder treatment, chronic disease management, and employment related incentives. (p. 142, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.2 Member Incentive Programs. For example, the Contractor may offer member incentives for: ... Participation in substance use disorder treatment; (p. 143, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶³ 6.17 Opioid Treatment Program (OTP). The Contractor shall provide coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups. OTP coverage will include those members as defined by OMPP and approved by CMS. The MCE will be responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix. Eligible members include... pregnant members. (p. 89, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.5 Tobacco Dependence Treatment Services For HIP State Plan benefits and any member eligible under any HIP category for HIP Maternity benefits (see Section 3.4), the Contractor shall cover, at minimum, tobacco dependence treatment services as set forth in 405 IAC 5-37. Treatment may include prescription of any combination of tobacco dependence products and counseling. Providers may prescribe one or more modalities of treatment. Providers shall include counseling in any combination of treatment. For HIP Plus and HIP Basic benefits, the Contractor shall cover the tobacco dependence benefits described in the Alternative Benefit Plan. See Exhibit 6 of this Contract for more information. (p. 72, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

4. Performance Measures and Incentive Payment Structure.... c. Incentive Payments – Bonuses. Percentage of maternity discharges in 2022, who make connection with the Indiana Tobacco Quitline. The following incentives are payable in the form of a bonus. The bonus payment will be calculated as set forth below. i. The Contractor is eligible to receive 50% of the percent of the

funds deposited in the birth outcomes bonus pool set forth in section B.2.b of the 2022 contract if 1.5% of their maternity discharges for 2022 are referred to the Indiana Tobacco Quitline and those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report. ii. The Contractor is eligible to receive 75% of the percent of the funds deposited in the birth outcomes bonus pool set forth in Section B.2.b of the 2022 contract if 3.0% of their maternity discharges for 2022 are referred to the Indiana Tobacco Quitline and those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report. iii. The Contractor is eligible to receive 100% of the percent of the funds deposited in the birth outcomes bonus pool set forth in section B.2.b of the 2022 contract if 5.0% of their maternity discharges for 2022 are referred to the Indiana Tobacco Quitline and those members make at least 1 contact with the Quitline as reported on the OMPP monthly Indiana Tobacco Quitline report. If MCE has 1,000 maternity discharges in 2022, they would need to have 15 connections with the Quitline for 50% of the bonus pool, 30 connections for 75% and 50 connections for 100%. (pp. 198-199, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶⁴ 6.8 Disease Management. Members served in the Contractor's disease management, care management and complex case management services may require additional resources to meet their biopsychosocial needs. To meet these needs, the Contractor shall make every effort to assist members in navigating community resources and linking members with community-based services such as...food pantries.... (p. 80, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.15 Enhanced Services. Enhanced services may include, but are not limited to, such items as: Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition...). (p. 88, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4 Member Information, Outreach and Education. ...The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with school-based health centers, community mental health centers, WIC clinics, county health departments and prenatal clinics to promote health and wellness within its membership. In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once, but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year) . The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll. The Contractor shall develop communication strategies that meet the requirements of this section, and provide innovative approaches to ensure member understanding of the HIP program. The Contractor shall, at minimum, provide program information to the member through required notices and other communications prescribed by the State. (p. 99, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶⁵ 1.0 Background. Members who consistently make required contributions to their POWER account will maintain access to the "HIP Plus" benefit plan that includes enhanced benefits such as dental, vision, and chiropractic manipulation coverage. (p. 12, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.2 Self-referral Services Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 9-7 (HIP) provides further detail regarding these benefits. ...Routine dental services may be provided by any in-network licensed dental provider who has entered into a provider agreement under IC 12-15-11. Dental services may be provided to members receiving services through HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits. (p. 65, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.2 Member Website. ...Such website information shall include, at minimum, the following: ...Information about how HIP State Plan and HIP Plus members may access dental services and how to access the Contractor's dental network. (pp. 103-104, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.4.4.2 Power Account Education. The Contractor shall explain the impact members' health seeking behavior will have on their ability to use a left-over POWER Account balance to reduce the next benefit period's required POWER Account contribution for participation in the HIP Plus benefit plan, which provides access to additional benefits, including vision and dental services. Pg 105
8.2.7 Dental Providers The Contractor shall ensure the availability of a dentist practicing in general or family dentistry within thirty (30) miles of the member's residence. Specialty dentists such as orthodontists and dental surgeons shall be available within sixty (60) miles of the member's residence. (p. 122, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶⁶ 6.1 Covered Benefits and Services. In addition, HIP will cover additional pregnancy-only benefits which will only be available for pregnant HIP members enrolled in either the HIP Plus or HIP Basic plans. The additional pregnancy-only benefits are specified in the applicable ABP and include such services as... dental. (p. 64, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.2 Self-referral Services Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 and 405 IAC 9-7 (HIP) provides further detail regarding these benefits. ...Routine dental services may be provided by any in-network licensed dental provider who has entered into a provider agreement under IC 12-15-11. Dental services may be provided to members receiving services through HIP State Plan, HIP Plus, or while receiving the additional HIP pregnancy-only benefits. (p. 65, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶⁷ Definitions and Acronyms. Case Management – A collaborative process of assessment, planning, facilitation, service coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs (behavioral health, physical health, and long-term services and supports) through communication and referral to available resources to ensure needs are met. Additionally, case management addresses Social Determinants of Health and Independence that include but are not limited to housing, domestic violence, and food assistance. (p. 1, no date, Attachment A: Definitions and Acronyms, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

3.0 SUD Services...3.3.5.2 Case Management: i. Case Management Services assist Members to become more self-sufficient through an array of services which assess, plan, implement, coordinate, monitor, and evaluate the options and services to meet a Member's needs, using communication and available resources to promote quality, cost effective outcomes. Case management services are provided in OP levels of care or as indicated by the State plan. (p. 2-13, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

4.0 Mental Health (MH) Services...Particular attention will be paid to evidence-based practices which are proven to reduce the need for hospitalization. Covered MH services include all services listed below, but are not limited to these services.... 4.7 Targeted Case Management (TCM). (p. 14, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.1. RFP BACKGROUND...The State expects the CONTRACTOR(S) to utilize the existing Service Coordination and Case Management structures at the local level to achieve desired Outcomes and to contract with local providers for Outcomes-based Service Coordination services whenever feasible. (p. 9-10, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW A. The CONTRACTOR(S) shall be responsible for Service Coordination and continuity and continuation of care by establishing a set of Member-centered, goal-oriented, culturally relevant, and logical steps to ensure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Case Management, disease management, discharge planning, and transition planning are elements of Service Coordination for Members across all Providers and settings. Service Coordination shall also assist Members with addressing Social Determinants of Health and Independence. B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: 1. Supports person-centered care. 2. Intervenes along a continuum of need from Preventive Care to addressing acute, complex, and

chronic needs. 3. Integrates Behavioral Health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs). 4. Improves health Outcomes for the entire population. 5. Addresses the Social Determinants of Health and Independence, including housing, adequate nutrition, adequate environmental conditions, transportation and other social determinants. 6. Increases access to community-based LTSS. 7. Allows for maximum access to community supports. 8. Supplements but does not supplant natural supports. 9. Provides for conflict-free Case Management, service delivery and assessment as directed by Federal and State law, as well as State policy (per 42 CFR § 431.301(c)(1)(vi) and 42 CFR § 441.730(b)). 10. A process for establishing the necessary permissions from the individual to coordinate care among different Providers, and establishing the required HIPAA-approved and 42 CFR § Part 2 compliant Business Associate Agreements (BAA) to address protected health information (PHI). 11. A process to assure referrals for medically necessary, specialty, secondary, and tertiary care and a person designated as primarily responsible for coordinating the health care services furnished to the Member. 12. A process to assure the provision of care in emergency situations, including an educational process to help assure that Members know where and how to obtain medically necessary care in emergency situations. D. The CONTRACTOR(S) Service Coordination model requires at a minimum that the following groups be enrolled in Service Coordination: 1. Individuals enrolled on a 1915(c) Waiver or on a Waiver waiting list. 2. Youth (birth up through age 21) with intensive Behavioral Health needs. 3. Youth who are in and out of home placement through the foster care system. 4. Individuals who are institutionalized in a NF, ICF/IDD or hospital, psychiatric residential treatment facility, psychiatric hospital, or other institution. 5. Adults with Behavioral Health needs. 6. Individuals with chronic and/or complex physical and/or mental health conditions. 7. Individuals participating in the Work Opportunities Reward Kansans (WORK) program or Other Employment Programs. 8. Other individuals who the CONTRACTOR(S) determines would benefit from Service Coordination. The CONTRACTOR(S) shall use at a minimum information regarding Social Determinants of Health and Independence, such as housing instability, food insecurity, and unemployment/under employment in identifying other individuals who would benefit from Service Coordination. The CONTRACTOR(S) may also use other tools, including proprietary algorithms, to identify additional Members for Service Coordination. The CONTRACTOR(S) shall submit the criteria used for determining other Members who will receive Service Coordination to the State for review and approval. E. The CONTRACTOR(S) shall provide a detailed description in its proposal of its model for Service Coordination and how its model meets the requirements described in Section 5.4. The CONTRACTOR(S) shall address at a minimum: 1. How it will engage Providers in the Service Coordination program and how the CONTRACTOR(S) will build working relationships with needed Providers and community organizations. 2. How it will engage Members to participate in the Service Coordination program, including any incentives it would propose utilizing, and why it believes those incentives will be effective. 3. CONTRACTOR(S)' experience in working with PCPs and Behavioral Health Providers to facilitate a high degree of coordination and communication of care across disciplines for the benefit of its Members How it will engage Members and their physical, HCBS, LTSS, and Behavioral Health Providers under the CONTRACT to ensure optimal coordination and communication, including a description of best practices in this area and how the CONTRACTOR(S) proposes to address any barriers to integration. 5. How it will focus its integration efforts to get the most value, and what anticipated improved health Outcomes for Members or improved compliance with established medical protocols it would expect based on its efforts to improve the integration of medical and Behavioral Health care. 6. What other Outcomes, in addition to health Outcomes, it would expect to improve and monitor. 7. What type of clinical support it will offer to Providers treating Behavioral Health conditions (including but not limited to depression, anxiety and addiction) in the Primary Care setting. 8. How it will promote and support Primary Care based Behavioral Health in pediatric and adult populations; what best practices and recommended protocols it will use to support the integration of medical and Behavioral Health care; and what materials and tools it will utilize in order to engage Members and Providers to improve integration. 9. How it will engage Members in order to obtain consent to share PHI across physical health, Behavioral Health, HCBS, and LTSS care Providers, when such consent is required, and its previous experience in obtaining Member consent, particularly as it relates to 42 CFR § Part 2 for SUD care. 10. How CONTRACTOR(S) will assist Members with addressing Social Determinants of Health and Independence. 11. Examples of innovative network designs or structures that it has tested or implemented, if any, to facilitate integration of medical and Behavioral Health care services, and any direct improvements that resulted. CONTRACTOR(S) will provide designs or structures to support the development of high-functioning interdisciplinary teams for high-risk members. 12. How CONTRACTOR(S) will improve health outcomes, reduce placements and reduce use of psychotropic medication for children in foster care. 13. How CONTRACTOR(S) will reduce use of psychotropic medication for nursing home residents. 14. How CONTRACTOR(S) will ensure that Medicare-funded healthcare services are coordinated and maximized for populations including HCBS Waiver populations, 15. How CONTRACTOR(S) will engage with and CONTRACT with local organizations to provide community services. 16. How CONTRACTOR(S) will ensure conflict of interest is mitigated when Subcontracting Community Service Coordination. (p. 31-35, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁶⁸ 4.0 Mental Health (MH) Services. The CONTRACTOR(S) will provide all medically necessary services to Members accessing care through the MH service system or as directed by any changes to the State plan or policy. All services will be provided in accordance with service definitions and operational limits as approved by the State. All service provided shall be practice-research based

or evidence-based and consistent with fidelity to a model. Examples in rehabilitation services include; Supported Employment, Integrated Dual Diagnosis Treatment, Strengths-based Community Psychiatric Support and Treatment (CPST), and Family Psycho-education. Outpatient examples include Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Positive Behavior Supports, and Shared Decision Making. The CONTRACTOR(S) will maintain current sites where these practices are already available and will add at least two new sites annually until these services are available statewide. Particular attention will be paid to evidence-based practices which are proven to reduce the need for hospitalization. Covered MH services include all services listed below, but are not limited to these services. 4.1 Initial Admission Evaluation and Assessment. 4.2 Outpatient Therapy services. 4.3 Medication Management and pharmacology services. 4.3.1 Medication-Assisted Treatment (MAT): 4.3.1.1 MAT combines the use of medications with counseling and behavioral therapies to treat substance use disorders such as alcohol use and opioid use disorders. 4.3.1.1.1 Opiate Abuse: i. Kansas is ranked 16th in the United States for opioid prescribing rates. KDHE reports that between 2013 and 2015, Kansas' prescription opioid overdose death rate increased by twenty-eight (28%) and heroin deaths increased by seventy-one (71%). In 2015 in Kansas, nine (9) out of ten (10) poisonings were due to prescription drugs, illicit drugs, and OTC medications. Pharmaceutical opioids remain the leading cause of drug poisoning deaths in Kansas. (pp. 13-15, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

2.2.6 Mental Health Outcomes Data The CONTRACTOR(S) (and/or their subcontractors) shall report all mental health outcomes data in compliance with the AIMS data collection requirements. The CONTRACTOR(S) shall also provide summary and detail reports on data completeness and accuracy, as defined in the AIMS manual. (p. 8, no date, ATTACHMENT J Encounter Data and Other Data Requirements. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW... B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives:...3. Integrates Behavioral Health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs). D. The CONTRACTOR(S) Service Coordination model requires at a minimum that the following groups be enrolled in Service Coordination:...2. Youth (birth up through age 21) with intensive Behavioral Health needs. ...5. Adults with Behavioral Health needs. 6. Individuals with chronic and/or complex physical and/or mental health conditions. (pp. 31-33, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.2. HEALTH SCREENING, HEALTH RISK ASSESSMENTS, AND NEEDS ASSESSMENTS. A. The CONTRACTOR(S) shall have processes in place to identify and address Behavioral Health, physical health, and LTSS needs of all Members. The CONTRACTOR(S) shall implement processes to assess, monitor, and evaluate services to all subpopulations and shall ensure appropriate referrals and follow up take place as a result of any screening or assessment activity. (p. 35, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.4.2. PERSON CENTERED SERVICE PLANNING. A. For all Members enrolled in HCBS waiver services, children in foster care and Members with Behavioral Health needs, the CONTRACTOR(S) shall ensure that Members are able to participate in a Person-Centered Service Planning process that is compliant with federal and state law and the State's PCSP policy. (p. 41, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.11. SPECIAL NEEDS POPULATIONS. ... C. Adults with Behavioral Health Needs: 1. The CONTRACTOR(S) must ensure protocols, policies, and processes are in place for service coordinators to appropriately address Member contacts related to Behavioral Health crisis needs. 2. Protocols must include, at a minimum, how the service coordinator will refer Members to Behavioral Health Services and timeframes for updates in the PCSP or Plan of Service that ensures the Member's health and safety needs are met. 3. The CONTRACTOR(S) must develop procedures for cross training and consultation for service coordinators and community-based Behavioral Health Providers in order to facilitate continuity of care and cost-effective use of resources. 4. The CONTRACTOR(S) shall develop policy and procedures for obtaining releases to share clinical information and providing health records to community-based Behavioral Health Providers as requested, consistent with State and Federal confidentiality requirements. 5. The CONTRACTOR(S) shall facilitate the sharing of information, including PCSPs or Plans of Service and transitional services between the service coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service Providers, and the PCP. 6. The

CONTRACTOR(S) shall assist individuals with accessing safe and sustainable housing and must either employ or contract for a housing specialist to help support these efforts. (pp. 55-56, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.5.7. BEHAVIORAL HEALTH PROVIDER NETWORK STANDARDS The CONTRACTOR(S) shall adhere to the following requirements: A. The CONTRACTOR(S) will retain and recruit a sufficient number of Behavioral Health Providers to maintain network adequacy as defined for the applicable urban, rural, and frontier counties in the service area. The CONTRACTOR(S) shall respond to any State requests or inquiries relative to the adequacy of its Behavioral Health Provider network. B. The availability of types of Behavioral Health programs will vary from area to area, but access problems may be especially acute in rural and frontier areas. The CONTRACTOR(S) shall establish a program of assertive outreach and telemedicine programming capabilities to all areas but especially to rural and frontier areas where Behavioral Health services may be less available than in more urban areas. The CONTRACTOR(S) shall monitor utilization in regions across the State to ensure access and availability of all Behavioral Health services in all regions. C. The CONTRACTOR(S) shall document, and make available upon request, waiting lists preventing Admission to treatment in the prescribed timeframes. ... E. For Members presenting for mental health services: 1. For emergency needs Members shall be referred to services immediately. 2. Members with urgent, non-emergency needs shall be assessed within seventy-two (72) hours of a request for services. 3. Members with non-urgent needs shall be assessed within fourteen (14) business days of the date the services are requested. 4. The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include: a. Crisis responsiveness which includes twenty (24) hours a day, seven (7) days a week, 365 days a year emergency treatment and first response, including, when appropriate, staff going to the Member for personal intervention and for any Member that staff become aware of experiencing a crisis or other emergency. b. Provision of or referral to psychiatric and other community services, when appropriate. c. Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services. d. Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services. e. Follow up with any Member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution. (pp. 78-80, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.7. CONTRACTOR(S) PROPOSALS FOR VALUE BASED MODELS AND PURCHASING STRATEGIES. ... A. Value Based Models and Purchasing Strategies: 3. Behavioral Health Services: The State seeks innovative Provider contracting strategies to address Behavioral Health service needs including Mental Health and Addiction Services. The alternative payment strategies shall be designed to reduce total cost of care, and address gaps and improvement in access to services, quality of Providers, incentives for "warm handoff" transitions from institutions to less-restrictive and less costly treatment programs in community-based programs and services, seamless follow-up care, and diversions from institutions, particularly ED diversion resulting in reduced inpatient Admissions. Service focus of the strategies shall include, but not limited to, effective Service Coordination with a particular focus on managing individuals behavioral and physical health needs, Peer Support, Supported Employment, Supportive Housing and other evidence-based practices. ... 5. Physical and Behavioral Health Integration Strategies: The State seeks innovative models for integration of physical and Behavioral Health services. A 2015 Government Accountability Office report (GAO-15-460) showed that nationally, over half of the Medicaid-only Members in the top 5% of expenditures had a mental health condition and one-fifth had a SUD. That report also observed that "Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens), the health care system is often too fragmented to effectively and efficiently serve them." A particular area of interest is how to better identify, treat, and transition Members to appropriate Behavioral Health services and Providers when presenting at the hospital with an emergent medical condition. In addition, proposals should consider approaches to promote use and collaboration among different Provider systems within the delivery system, such as FQHCs and Community Mental Health Centers (CMHCs). (pp. 105-106, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.9. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT 5.9.1. GENERAL REQUIREMENTS. ... H. The CONTRACTOR(S) shall develop and implement mechanisms to identify and address Behavioral Health service needs of Members. The CONTRACTOR(S) shall ensure the Member receives all identified State approved Behavioral Health services for any unmet service needs. (p. 117, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

6.1. RFP PURPOSE. The State of Kansas is issuing this RFP to obtain competitive responses from CONTRACTOR(S) to provide managed care for the Kansas Medicaid and CHIP programs. Services included in this RFP are physical health services, Behavioral Health services, and LTSS, including NF care and HCBS. These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and SUD services including existing 1915(c) HCBS Waiver programs for children with a SED and six other 1915(c) HCBS Waiver populations. Statewide contracts will be awarded to winning CONTRACTOR(S). (p. 234, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

6.2. CONTRACTOR(S) RESPONSIBILITIES. ...E. In accordance with 42 CFR § 438.905(a), CONTRACTOR(S) must comply with all Federal regulations and guidance pertaining to parity in mental health and substance use disorder benefits, including: 1. If the CONTRACTOR(S) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Members, the CONTRACTOR(S) may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits. 2. If the CONTRACTOR(S) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to Members, the CONTRACTOR(S) must either apply the aggregate lifetime or annual dollar limit to both the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. 3. If the CONTRACTOR(S) includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to Members through a contract with the state, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits. The CONTRACTOR(S) must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by the same CONTRACTOR). 5. If a Member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Member in every classification in which medical/surgical benefits are provided. 6. CONTRACTOR(S) may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, and prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification. 7. CONTRACTOR(S) may not impose non-quantitative treatment limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. 8. CONTRACTOR(S) must provide documentation and reporting to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in a format and frequency as specified by the State. (pp. 236-238, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁶⁹ 3.0 SUD Services. The CONTRACTOR(S) must provide at least as much access to Medically Necessary substance use disorder treatment services for Members as was provided under the current delivery system or as directed by any changes to the State plan or policy. The CONTRACTOR(S) shall use Kansas definition of medical necessity and the American Society of Addiction Medicine (ASAM) criteria as contained in the State Approved Assessment Tool when determining the need for SUD services. These criteria are no more restrictive than those of the State Title XIX program. The CONTRACTOR(S) may not set limits on the amount, scope, or duration of these services for Members that were not imposed in the previous delivery program. The CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as the Kansas definition of medical necessity, ASAM criteria as contained in the State Approved Assessment Tool, and best practice guidelines, provided that the services furnished can reasonably be expected to achieve their purpose. 3.1 Court Referred Treatment: i. The CONTRACTOR(S) shall work with the Provider network for placement for medically necessary, court-ordered or court-referred treatment of covered services of Members. The CONTRACTOR(S) shall work with the courts to examine the appropriateness of court-ordered placements while examining the potential of offering more efficient alternatives and shall develop specific alternatives for the courts to consider which shall be based on the Kansas definition of medical necessity and ASAM criteria as contained in the State Approved Assessment Tool. 3.2 Civil Commitments. i. Involuntary Commitments: The CONTRACTOR(S) shall work with State approved Providers for placement for medically necessary, civil commitments of covered services for Members as cited in K.S.A 8-1567. (p. 10, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

3.3 Please see the Kansas Medical Assistance Program Substance Use Disorder Provider Manual for covered SUD services. 3.3.1 Description of Services. 3.3.2 General Principles. 3.3.2.1 For all modalities of care, the duration of treatment should be determined by the Member's needs and his or her response to treatment. 3.3.2.3 More details on all modalities of care are available in the Licensing Standards for Kansas. 3.3.2.4 The CONTRACTOR(S) shall provide assurance that any Providers delivering services are licensed as required by applicable State laws. Currently State law also requires that any Provider of SUD treatment services in a facility setting be licensed by KDADS/BHS to provide SUD treatment services; that any Provider determining the medical necessity of such services according to the Kansas definition must be a Behavioral Sciences Regulatory Board (BSRB)-licensed practitioner practicing within their scope as defined by the BSRB. 3.3.3 Level I: Outpatient and Level II: Intensive Outpatient Treatment/Partial: i. Outpatient and Intensive Outpatient treatment consisting of non-residential treatment consisting of group, individual, and/or family counseling. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements. 3.3.4 Level III: Community-based Residential Treatment: 3.3.4.1 "3.1 Reintegration and 3.3/3.5 Intermediate Treatment" i. Reintegration and Intermediate treatment provide a regimen of structured services in a twenty-four (24) hour staffed (awake on all shifts) residential setting. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements. 3.3.4.2 "3.7 D Acute Community-based Detoxification Treatment" i. Acute detoxification treatment provides care to those individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services in a residential setting. In this modality of treatment, twenty-four (24) hour observation, monitoring and counseling services are available. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements. 3.3.5 Auxiliary Services. 3.3.5.1 Substance Use Assessment and Referral: i. Substance Use assessment and referral programs provide ongoing assessment and referral services for individuals presenting a current or past abuse pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a Member's current substance use behavior and social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, behavioral health related treatment or referral. The State approved assessment tool shall be used by SUD Providers. 3.3.5.2 Case Management: i. Case Management Services assist Members to become more self-sufficient through an array of services which assess, plan, implement, coordinate, monitor, and evaluate the options and services to meet a Member's needs, using communication and available resources to promote quality, cost effective outcomes. Case management services are provided in OP levels of care or as indicated by the State plan. 3.3.5.3 Peer Support: i. Peer mentoring (support) is provided by people who are in long-term recovery and have been trained in providing recovery support. The purpose of providing this service is to help build recovery capacity for persons new to recovery by connecting them to naturally occurring resources in the community, assist in reduction of barriers to fully engaging in recovery, and providing support in skill development for maintaining a recovery life style. 3.4 The CONTRACTOR(S) must develop a network of Providers, which is supported by written contracts, to ensure availability of the services listed above for both adults and youth. A full continuum of SUD services must be available statewide in accordance with accessibility standards in the RFP and resultant CONTRACT. (pp. 11-13, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

4.0 Mental Health (MH) Services. 4.3.1.1.2 SUD Treatment and MAT. i. The CONTRACTOR(S) shall ensure coordination of care for individuals with opioid use, alcohol dependence and other SUDs to include the provision of traditional treatment services concurrent with medication assisted treatment when medically indicated. The CONTRACTOR(S) shall improve and expand the network of MAT Providers for opioid use and other substance use disorders. The CONTRACTOR(S) shall educate enrollees and Providers on the prevention and treatment of opioid use, alcohol use and other SUD evidence-based MAT practices. (p. 14, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

2.3 Substance Use Disorder (SUD) Data System Requirements. The CONTRACTOR(S) shall work with the Kansas Client Placement Criteria (KCPC) or other SUD specific data system/data collection tool. This tool incorporates the ASAM criteria and must be used in making SUD service authorization decisions. The State will monitor both the CONTRACTOR(S)' application and documentation of the Kansas definition of medical necessity and the ASAM criteria as contained in the KCPC system through ongoing reviews including, but not limited to, external audits. The CONTRACTOR(S) confirms it will document all authorizations and any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than the request in the CONTRACTOR(S)' records and that documentation shall reference the Kansas medical necessity definition and ASAM criteria as contained in the KCPC system. The CONTRACTOR(S) information systems must be compatible, or will become compatible, with the KCPC system used by providers in Kansas. The CONTRACTOR(S) shall ensure that it as well as its subcontracted providers uses the required Kansas medical necessity definition, ASAM criteria as contained in the KCPC system for determination of level of service, even when prior

authorization from the CONTRACTOR(S) is not required. (p. 8, no date, Attachment J – Encounter Data and Other Data Requirements. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW. ... B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: ... 3. Integrates Behavioral Health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs). (p. 31, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.5.7. BEHAVIORAL HEALTH PROVIDER NETWORK STANDARDS The CONTRACTOR(S) shall adhere to the following requirements: ...D. For Members presenting for SUD services: 1. The CONTRACTOR(S) may limit the number of SUD Providers in the network open panel to those needed to provide adequate Provider network coverage and services. 2. For emergency needs, Members shall be referred to services immediately. 3. Members with urgent, non-emergency needs shall be assessed within twenty-four (24) hours of a request for services. Services shall be delivered within twenty-four (24) hours of the date and time of the assessment. 4. Members with non-urgent needs shall be assessed within fourteen (14) calendar days of the date the services are requested. 5. Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within twenty-four (24) hours of assessment. When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care. 6. Persons who inject drugs must receive an assessment and shall be admitted to treatment no later than fourteen (14) calendar days after making the request for assessment. If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment. (p. 79, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁷⁰ Performance Guarantees. SUD Access to Care Standard: CONTRACTOR(S) must comply with the contract provisions regarding priority access to care for pregnant women. At minimum, pregnant women are to be placed in the urgent category. Members are assessed within 24 hours of initial contact and services delivered within 48 hours of initial contact. CONTRACTOR(S) must demonstrate performance at 100%. (Data source: KCPC.) Fine: \$10,000 for each non-compliant finding/pregnant woman not assigned at minimum to urgent category, not assessed within 24 hours of initial contact, or not delivered services within 48 hours of initial contact. Validation of metric will be completed by KDADS chart review prior to damages being assessed to the CONTRACTOR(S). (p. 9, no date, Attachment G, Liquidated Damages. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

⁷¹ 5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW. ... B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: ...5. Addresses the Social Determinants of Health and Independence, including...adequate nutrition.... (p. 31, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁷² C. CONTRACTOR(S) shall coordinate with the Special Supplemental Food Program for Women, Infants and Children (WIC). The State shall assure that coordination exists between the WIC and CONTRACTOR(S). This coordination should include the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by Providers working within managed care plans to the WIC Program: 1. To be eligible for WIC benefits, a competent professional authority must diagnose a pregnant woman, a breast-feeding woman, a non-breast feeding postpartum woman, an infant or a child under age five (5) as being at nutritional risk. Suggested medical information for a WIC referral includes: nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, premature birth, infants of alcoholic mothers, developmentally disabled infants, drug addicted or HIV positive mothers, AIDS, allergy or intolerance that affects nutritional status, and anemia. 2. The WIC Program in the State of Kansas is coordinated through the State and local health departments. CONTRACTOR(S) is expected to subcontract or coordinate with the local health departments in their service areas. (p. 18, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

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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: ...2.35 Dental services for those populations currently eligible to receive them. (p. 10, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aetna Better Health of Kansas)

⁷⁴ 1.1 General Definitions. Care Coordination is a process that actively and effectively links an Enrollee, in a timely and integrated manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.... Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. Case Management is distinguished from Disease Management by its intensity and a holistic focus on all of an Enrollee's disease(s), condition(s), and related needs. (Page 14, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

28.2.6 Behavioral Health and Substance Use Disorders The Contractor shall maintain a comprehensive network of behavioral health and substance abuse providers to provide out-patient (including intensive home services), intensive out-patient, substance abuse residential, Case Management, mobile crisis, residential crisis stabilization, assertive community treatment, and peer support services... (Page 119, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

34.1 Program Overview... The Contractor shall implement a PHM Program that supports Enrollees across the care continuum, promoting healthy behaviors and self-management as well as providing Care Coordination and Complex Care Management as needed and supported by evidence-based medicine and national best practices. ... In alignment with NCQA's PHM Model, the Contractor shall implement a PHM Program that incorporates the below three risk levels, at a minimum, in the most cost-effective manner possible. B. Management of Chronic Conditions. The Contractor shall provide Care Coordination support to Enrollees who have been identified as having emerging risk factors and/or one (1) targeted chronic condition. The Contractor shall provide services to Enrollees that aim to reduce healthcare costs and improve quality of life for Enrollees who have a chronic condition through integrative care. Care Coordination should help Enrollees to address potential co-morbidities or other complications and help to avoid complications. (Page 152-153, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

41.6.4 SKY Implementation Plan. ... The SKY Contractor's shall submit an Implementation Plan to the Department by 1-1-2020. The proposed Implementation Plan must comply with all due dates established by the Department, specific requirements set forth in the Contract, and address at a minimum the following SKY Contractor activities: ...M. Submission of policies and procedures related to the ability to share Care Coordination and Case Management Information electronically with DCBS and DJJ staff. (Page 194, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

41.10.1 Care Plans A. The SKY Contractor shall use the results of all assessments and screenings to develop a Care Plan which identified the SKY Enrollee's Care Coordination needs for all newly enrolled SKY Enrollees within thirty (30) Calendar Days of Enrollment. The SKY Contractor must document the involvement of the SKY Enrollee's PCP, Dental Provider, Behavioral Health Providers, specialists or other providers, as well as foster parents, adoptive parents, and caregivers in the development of the Care Plan and provide evidence of such documentation to the Department, DCBS, and DJJ. (Page 195, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

41.10.2 Care Coordination Teams A. All SKY Enrollees will have access to Care Coordination services and an interdisciplinary Care Coordination Team. The Care Coordination Team will be led by a Care Coordinator and include clinical and non-clinical representatives to meet the individual needs of SKY Enrollees. B. The Care Coordination Team shall: 1. Coordinate with The

Department, DCBS and DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical SKY Enrollee information; 2. Provide information to and assist Providers, SKY Enrollees, Foster Parents, Adoptive Parents, Fictive Kin, Foster Care Caregivers, Parents, and DCBS and DJJ staff with Care Coordination services; 3. Ensure access to primary, dental and specialty care and support services, including assisting SKY Enrollee, Foster Parents, Adoptive Parents, Fictive Kin, Foster Care Caregivers, Parents, and DCBS and DJJ staff with locating Providers, and scheduling and obtaining appointments as necessary; 4. Expedite the scheduling of appointments for assessments and facilitating Providers' timely submittal of assessment results used to determine Residential Placements as requested by DCBS and DJJ. The SKY Contractor must give high priority to this function in its Care Coordination operations; 5. Compile assessment results used to determine Residential Placements as requested by DCBS and DJJ and submitting those results to the appropriate DCBS or DJJ staff within the timeframes identified by DCBS or DJJ or otherwise specified in the Contract; 6. Assist with coordinating NEMT services for SKY Enrollees as needed for Provider appointments and other services; 7. Arrange community supports for SKY Enrollees and arrange for referrals to community based resources as necessary; 8. Document efforts to obtain Provider appointments, arrange transportation, establish meaningful contact with the Members' PCP, Dental Provider, specialists and other Providers, and arrange for referrals to community based resources. Such documentation shall include details on any barriers or obstacles to arranging or obtaining these services; and 9. Collaborate with PCPs and specialists of prior MCOs to ensure continuity of care for SKY Enrollees with Special Health Care Needs receiving services authorized in a treatment plan by their prior MCO. C. The Care Coordinator will ensure the Care Coordination Team has the information it needs to make timely and appropriate authorizations and referrals to meet SKY Enrollee needs. This includes, but is not limited to, contacting prior MCOs and Providers for information the Care Coordination Team may need to work with current Providers to develop treatment plans. The Care Coordinator will ensure that approved Care Plans and authorizations are communicated timely to Providers, the Department, DCBS, and DJJ as required, by electronic or direct communications. The Care Coordinator will ensure that SKY Enrollees, Providers, Foster Parents, Adoptive Parents, Fictive Kin, Foster Care Caregivers, Parents, DCBS and DJJ have the most current information regarding community resources available to assist SKY Enrollees with meeting their needs and assist SKY Enrollees with connecting with these resources. D. The Care Coordinator is responsible for convening Assessment Team meetings, as needed, to support the needs of SKY Enrollees. E. A Care Coordination Team shall be assigned by the SKY Contractor to each SKY Enrollee within one (1) business day of Enrollment in the program. F. Based on information identified through required assessments, the SKY Contractor shall stratify SKY Enrollees according to their risk(s), costs and impactability. The level of intensity of Care Management services provided by Care Coordination Teams must be tailored in intensity to meet the needs of each individual SKY Enrollee. SKY Enrollees may receive the following level of Care Management services: 1. Care Management services; 2. Intensive Care Coordination services which shall include monthly contacts with the SKY Enrollee: a. One (1) face-to-face visit. b. One (1) weekly contact. c. One (1) meeting with the SKY Enrollee and Caregivers. d. One (1) Care Plan update. 3. Complex Care Coordination which may include those SKY Enrollees with previous inpatient Behavioral Health admissions and SKY Enrollees with Special Health Care Needs. Complex Care Coordination services shall include the following monthly contacts: a. Two (2) face-to-face visits. b. One (1) weekly contact. c. A minimum of two (2) hours per week of Care Coordination. d. One (1) meeting with the SKY Enrollee and Caregivers. e. One (1) Care Plan update. 4. SKY Enrollees identified as needing Complex Care Coordination services due to Behavioral Health needs must receive Care Coordination services provided by Coordinators who have been certified and trained in the delivery of High Fidelity Wraparound care. The SKY Contractor shall include a Nurse Case Manager to assist SKY Enrollees identified through the assessment as SKY Enrollees with Special Health Care Needs. (Page 196-197, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

41.10.4 Case Management No less than quarterly, the SKY Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the SKY Contractor's SKY membership. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and Specialty Care providers are enrolled in the SKY Contractor's Network. If the DCBS service plan identifies the need for case management or DCBS staff requests case management for a SKY Enrollee, the SKY Contractor's staff will work with Foster Parent and/or DCBS staff to develop a case management plan. The SKY Contractor's staff will consult with DCBS staff before the development of a new case management plan (on a newly identified health care issue) or modification of an existing case management plan. The designated SKY Contractor staff will sign each service plan made available by DCBS to indicate their agreement with the plan. If the DCBS and SKY Contractor staff cannot reach agreement on the service plan for a SKY Enrollee, information about that Enrollee's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated Department's representative. (Page 197-198, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

41.11.2 SKY Enrollee Information Packet and Enrollee Handbook. ...4. The SKY Enrollee Information Packet shall include but not be limited to the following: ...e. Information on how the SKY Enrollee can share special health care needs and specific services for which the Care Coordination Team may need to coordinate services; f. Information on the role of the Care Coordination Team and how to seek assistance in scheduling appointments, and accessing Care Coordination services. (Page 200, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services... BB. Specialized Case Management Services for Members with Complex Chronic Illnesses (Includes adult and child targeted case management)... DD. Targeted Case Management. (Page 264, 2021 Master Agreement for Medicaid MCO with SKY – All Regions Between The Commonwealth of Kentucky Cabinet for Health and Family Services (CHFS) and Aetna Better Health of KY Insurance Company)

⁷⁵ 19.3 Quality Assurance and Performance Improvement (QAPI) Program. The QAPI program shall at a minimum include:... E. Integration of Behavioral Health indicators into the QAPI program and a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Enrollees. (p. 72, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.2.6 Behavioral Health and Substance Use Disorders The Contractor shall maintain a comprehensive network of behavioral health and substance abuse providers to provide out-patient (including intensive home services), intensive out-patient, substance abuse residential, Case Management, mobile crisis, residential crisis stabilization, assertive community treatment, and peer support services, including: A. Psychiatrists, Psychologists, and Licensed Clinical Social Workers; B. Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, and Licensed Clinical Alcohol and Drug Counselors; C. Targeted Case Managers and Certified Family, Youth and Peer Support Providers; D. Behavioral Health Multi-Specialty Groups and Behavioral Health Services Organizations; E. Chemical Dependency Treatment Centers; F. Psychiatric Residential Treatment Facilities (PRTFs) and Residential Crisis Stabilization Units; G. Community Mental Health Centers (CMHCs); H. Multi-Therapy Agencies providing physical, speech and occupational therapies, which include Comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers; and I. Other independently licensed behavioral health professionals. (p. 119, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

30.9 Mental Health Parity The Contractor and its providers must comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Contractor and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. (pp. 135-136, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

33.0 BEHAVIORAL HEALTH SERVICES 33.1 Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) Responsibilities The Department works collaboratively with Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to ensure that Medicaid Enrollees receive quality Behavioral Health Services. The Contractor shall use evidence-based practices (EBPs) that meet the standards of national models in all behavior health services. The Contractor shall comply with standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) and 45 CFR 170 Subpart B in complying with the Commonwealth's behavioral health policies. 33.2 Requirements for Behavioral Health Services The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Enrollees with SMI and SED, including Enrollees with co-occurring developmental disabilities, substance use disorders and smoking cessation. The Contractor, in its design and operation of Behavioral Health Services, shall incorporate these core values for Medicaid Enrollees: A. Enrollees have the right to retain the fullest control possible over their behavior health treatment. Behavioral Health Services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare. B. The Contractor shall provide the most normative care in the least restrictive setting and serve Enrollees in the community to the greatest extent possible. C. The Contractor shall measure Enrollees' satisfaction with

the services they receive. D. The Contractor's Behavioral Health Services shall be trauma-informed, recovery and resiliency focused. 33.3 Covered Behavioral Health Services The Contractor shall ensure the provision of all Medically Necessary Behavioral Health Services for Enrollees. These services are described in Appendix I "Covered Services." All Behavioral Health Services shall be provided in conformance with the access standards established by the Department. When assessing Enrollees for Behavioral Health Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers shall document DSM diagnosis and assessment/outcome information in the Enrollee's Medical Record. 33.4 Behavioral Health Provider Network The Contractor shall provide access to Psychiatrists, Psychologists, and other Behavioral Health Service providers. Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of Behavioral Health Services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, and other independently licensed behavioral health professions. To the extent that non-psychiatrists and other providers of Behavioral Health Services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses. 33.5 Enrollee Access to Behavioral Health Services The Contractor shall ensure accessibility and availability of qualified providers to all Enrollees. The Contractor shall maintain an adequate network that provides continuum of care to ensure the Enrollee has access to care at the appropriate level. The Contractor shall ensure that upon decertifying an Enrollee at a certain level of care, there is access to Providers for continued care at a lower level, if such care is determined Medically Necessary. The Contractor shall coordinate and collaborate with Providers on discharge plans and criteria. The Contractor shall maintain an Enrollee education process to help Enrollees know where and how to obtain Behavioral Health Services. The Enrollee Manual shall contain information for Enrollees on how to direct their behavioral health care, as appropriate. The Contractor shall permit Enrollees to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Enrollee with information on accessible in-network Providers with relevant experience. 33.6 Behavioral Health Services Hotline The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) Days a year, toll-free throughout the Commonwealth. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face-to-face Emergency Services shall be available twenty-four (24) hours a day, seven (7) Days a week. The Behavioral Health Services Hotline shall not be answered by any automated means. The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. No incoming calls may receive a busy signal. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 Emergency Services. The Contractor shall operate one hotline to handle emergency and crisis calls. The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Enrollee. Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Enrollees, including the interpretive services required for effective communication. The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Contractor shall conduct ongoing quality assurance to ensure these standards are met. The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated. If the Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by the Department or its authorized agent(s) relating to such monitoring. The Contractor shall also contribute to a statewide emergency Behavioral Health hotline in an amount equal to their proportional share of Medicaid Enrollees per Contract year. 33.7 Coordination between the Behavioral Health Provider and the PCP The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department for approval. Such approval is subject to Section 4.4 "Approval of Department." The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions. The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs. Such approval is subject to Section 4.4 "Approval of Department." The Contractor shall require that Behavioral Health Service Providers refer Enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Enrollee's or the Enrollee's legal guardian's consent. Behavioral Health

Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals. The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of an Enrollees' behavioral health status to the PCP, with the Enrollee's or the Enrollee's legal guardian's consent. This requirement shall be specified in all Provider Manuals. 33.11 Program and Standards Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Enrollees use physical and behavioral health systems simultaneously. The Contractor shall: A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including Emergency Behavioral Health Services, (i.e., Suicide Prevention and community crisis stabilization); B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions; C. Identify a method to evaluate the continuity and coordination of care, including Enrollee approved communications between behavioral health care providers and Primary Care Providers; D. Protect the confidentiality of Enrollee information and records; and E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan. The Department shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. The Department shall closely monitor drug utilization patterns of psychopharmacological medications. The findings of these evaluations will be provided to the Contractor. 33.13 Coordination and Collaboration with Behavioral Health Providers The Contractor shall identify and develop community alternatives to inpatient hospitalization for those Enrollees who are currently receiving inpatient psychiatric facility services and could be discharged from the facility if an appropriate treatment alternative were made available in the community. In the event that the Contractor does not provide and cover an appropriate community alternative, the Contractor shall remain financially responsible for the continued inpatient care of these individuals until the Contractor ensures availability and access to an appropriate community provider. (pp. 147-152, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX D. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES... 81. Mental Health Statistics Improvement Project Adult Survey Findings Report. The Contractor shall annually implement the Mental Health Statistics Improvement Program (MHSIP) Adult Survey. The Contractor shall administer the 28-Item Mental Health Statistics Improvement Program (MHSIP) Adult Survey plus eight (8) additional items for the Social Connectedness and Functioning National Outcome Measures (for adult behavioral health members). The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The Contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any behavioral health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains: • Access • Quality and Appropriateness • Outcomes • Treatment Planning • General Satisfaction with Services ((p. 242, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services... C. Behavioral Health Services – Mental Health and Substance Abuse Disorders...E. Community Mental Health Center Services... P. Inpatient Mental Health Services... W. Outpatient Mental Health Services. (p. 264, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁷⁶ 20.4 Medical Necessity Criteria The Contractor shall have a comprehensive UM Program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. The Contractor shall comply with federal and state regulations when selecting Medical Necessity criteria. The Contractor shall adopt Interqual or MCG (Milliman) as the primary medical/surgical criteria for Medical Necessity except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. (p. 81, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

22.1 Required Functions. The Contractor's Enrollee Services function shall also be responsible for: ... P. Providing Enrollees with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse. (p. 88, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

27.5 Provider Orientation and Education. The Contractor shall ensure that Provider education includes: ... N. Responding to needs of Enrollees with SUD or behavioral health, developmental, intellectual and physical disabilities. (p. 110, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.2 Network Providers to Be Contracted. The Contractor shall contract with providers who are willing to meet the terms and conditions for participation established by the Contractor, including, but not limited to the following provider types: ... D. Behavioral health and substance abuse providers (p. 116, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.2.6 Behavioral Health and Substance Use Disorders The Contractor shall maintain a comprehensive network of behavioral health and substance abuse providers to provide out-patient (including intensive home services), intensive out-patient, substance abuse residential, Case Management, mobile crisis, residential crisis stabilization, assertive community treatment, and peer support services, including: A. Psychiatrists, Psychologists, and Licensed Clinical Social Workers; B. Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, and Licensed Clinical Alcohol and Drug Counselors; C. Targeted Case Managers and Certified Family, Youth and Peer Support Providers; D. Behavioral Health Multi-Specialty Groups and Behavioral Health Services Organizations; E. Chemical Dependency Treatment Centers; F. Psychiatric Residential Treatment Facilities (PRTFs) and Residential Crisis Stabilization Units; G. Community Mental Health Centers (CMHCs); H. Multi-Therapy Agencies providing physical, speech and occupational therapies, which include Comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers; and I. Other independently licensed behavioral health professionals. (p. 119, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

30.9 Mental Health Parity The Contractor and its providers must comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Contractor and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. (pp. 135-136, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

34.3 Population Health Management Program Tools. C. Enrollee Needs Assessments. The Enrollee Needs Assessment shall at a minimum assess the following: 1. Enrollee's immediate, current and past health care, mental health and SUD needs. (p. 155, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services... C. Behavioral Health Services – Mental Health and Substance Abuse Disorders... R. Medical Detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the individual has been addicted. (p. 264, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁷⁷ 22.1 Required Functions. The Contractor's Enrollee Services function shall also be responsible for: ... P. Providing Enrollees with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition...weight loss... (p. 88, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

34.5 Coordination with Women, Infants and Children (WIC) The Contractor shall comply with Section 1902(a)(11)(C) of the Social Security Act which requires coordination between Medicaid MCOs and WIC. This coordination includes the referral of potentially eligible women, infants and children to the WIC program and the provision of medical information by providers working within Medicaid managed Care Plans to the WIC program if requested by WIC agencies and if permitted by applicable law. Typical types of medical information requested by WIC agencies include information on nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of mothers with a SUD or other drug addiction, developmental disabilities or intellectual disabilities, AIDS, allergy or intolerance that affects nutritional status and anemia. (p. 157, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁷⁸ 22.1 Required Functions. The Contractor's Enrollee Services function shall also be responsible for: ...Q. Facilitating direct access to...primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists...all as further described in Appendix I "Covered Services" of this Contract. (p. 88, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.2.7 Dental Providers The Contractor shall enroll providers of dental services in accordance with 907 KAR 1:026. Page 119 30.2 Direct Access Services. 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: ... B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists (p. 133, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

32.2 Dental Services The Contractor shall provide preventive and primary care dental services for oral health conditions and illness in a timely manner on an emergent, Urgent Care or non-urgent care basis in accordance with 42 C.F.R. 438. Covered dental services shall be provided in accordance with 907 KAR 1:026. The Contractor shall establish written policies and procedures to ensure the timely provision of services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to fee-for-service Medicaid Enrollees. The Contractor shall assess the oral health of Enrollees and develop a plan for improving oral health in Enrollees, particularly in children and persons with special health care needs. The Contractor shall have ultimate responsibility for the provision of dental services and shall oversee and coordinate the delivery of or access to all Enrollee health information and other data relating to dental services, as requested by the Department. The Contractor will also provide for adherence to standards of care based on established clinical criteria and evidence based science. The Contractor shall determine the Medical Necessity criteria to be used in the provision of dental services which shall be submitted to the Department for approval in accordance with Section 4.4 "Approval of Department." (p. 145, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

41.1 Scope of Services The SKY Contractor will provide Covered Services, Population Health Management Program services, and Care Management Services to the SKY Enrollees. A summary of the required responsibilities to be carried out by the SKY Contractor include: ... E. Provision of a Dental Provider for SKY Enrollees. The Dental Provider is responsible for coordinating all dental care for SKY Enrollees; (p. 185, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification, Version #3)

41.11.2 SKY Enrollee Information Packet and Enrollee Handbook. ...B. The SKY Enrollee Handbook shall address the following topics: 2. Role of the PCP and Dental Provider... 5. How to select and change PCPs and Dental Providers (p. 200, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification, Version #3)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services... F. Dental Services, including Oral Surgery, Orthodontics and Prosthodontics (p. 264, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification, Version #3)

⁷⁹ 6.19.4. Individualized Treatment Plans and Care Plans All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager. (p. 86, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.24. Excluded Services. ... These services shall be paid for by LDH on a fee-for-service basis or other basis. Services include the following: ...6.24.1.7. Targeted Case Management Services. (p. 90, October December 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.28. Care Management 6.28.1. Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member. 6.28.2. The MCO shall be responsible for ensuring: 6.28.2.1. Member's health care needs

and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider 6.28.2.2. Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.3(g) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and 6.28.2.3. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services. 6.28.2.4. Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff. (p. 93, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.29.2. The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements: ... 6.29.2.5. Process for member referral for case management. (p. 94, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.30. Care Coordination, Continuity of Care, and Care Transition The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that an MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH. 6.30.1. The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population. 6.30.2. The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements: 6.30.2.1. Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) day time period; 6.30.2.2. Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs; 6.30.2.3. Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses; 6.30.2.4. Coordinate care between network PCPs and specialists, including specialized behavioral health providers; 6.30.2.5. Coordinate care for out-of-network services, including specialty care services; 6.30.2.6. Coordinate MCO provided services with services the member may receive from other health care providers; 6.30.2.7. Upon request, share with LDH or other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities; 6.30.2.8. Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards; 6.30.2.9. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws; 6.30.2.10. Maintain and operate a formalized hospital and/or institutional discharge planning program; 6.30.2.11. Coordinate hospital and/or institutional discharge planning that includes postdischarge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that: 6.30.2.11.1. Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to,

inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings). 6.30.2.11.2. Care managers follow-up with members with a behavioral health-related diagnosis within 72 hours following discharge. 6.30.2.11.3. Coordination with LDH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home. 6.30.2.11.4. Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan. 6.30.2.12. Document authorized referrals in its utilization management system; 6.30.2.13. Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less; 6.30.2.14. Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and 6.30.2.15. For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility. 6.30.3. The MCO shall not deny continuation of residential treatment (e.g., TGH or PRTF) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care. (pp. 94-97, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.39. Case Management 6.39.1. The MCO shall maintain a case management program through a process which provides appropriate and medically-related services, social services, and basic and specialized behavioral health services that are identified, planned, obtained and monitored for identified members who are in the special healthcare needs (SHCN) population and identified members who have high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to LDH for approval annually and thirty (30) days prior to implementation of any revision. 6.39.2. Case Management program functions shall include but not be limited to the following, all of which shall be addressed in the MCO's case management policies and procedures: 6.39.2.1. Identification criteria, process, and triggers for referral and admission into case management, including a process to offer voluntary participation in case management to members; 6.39.2.2. Identification criteria, process, and tracking mechanisms for members receiving services in or referred to a nursing facility; 6.39.2.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, reproductive aged women with a history of prior poor birth outcomes and high risk pregnant women; 6.39.2.4. Early identification, through active outreach, of members who have or may have special healthcare needs; 6.39.2.5. Assessment of a member's risk factors, current health status, current service utilization, gaps in care, and medication review initially and on an ongoing basis to ensure member health and safety; 6.39.2.6. Education regarding patient-centered medical home and referral to a medical home when appropriate; 6.39.2.7. Development of an individualized comprehensive plan of care, which is based on the results of the member's individual needs assessment. The plan of care shall be developed and implemented through a person-centered process in which the member has a primary role and which is based on the principles of self-determination and recovery. The plan of care shall include the following elements at a minimum; 6.39.2.7.1. Member demographics; 6.39.2.7.2. Identification of the member's treating providers and Interdisciplinary Team if applicable; 6.39.2.7.3. Member's past and present primary care and behavioral health concerns, relevant treatment history including gaps in care, significant medical history, and present health status; 6.39.2.7.4. Member's goals; 6.39.2.7.5. Identified strengths and needs; 6.39.2.7.6. Identified barriers to the care plan goals; 6.39.2.7.7. Documentation that freedom of choice of network providers were offered to the member and/or his/her caregiver; 6.39.2.7.8. Supports and services needed to meet the member's needs; 6.39.2.7.9. Resources and settings of care recommended to the member's providers, including responsible party and target date for completion; 6.39.2.7.10. Strategies to improve care coordination; 6.39.2.7.11. Strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication management. Each follow-up item includes an identified responsible party(ies); and 6.39.2.7.12. Plan for addressing crisis to prevent unnecessary hospitalization or institutionalization for members

with a behavioral health diagnosis who may experience crisis. The crisis plan shall identify resources and contact information. 6.39.2.8. Documentation of a schedule for following-up with the member's providers and convening plan of care reviews at intervals consistent with the identified member care needs and to ensure progress and safety; 6.39.2.9. A process for updating the plan of care based on the member's changing needs, progress, and outcomes; 6.39.2.10. Facilitation of a service authorization for those services identified in the plan of care; 6.39.2.11. Referrals and assistance to ensure timely access to providers; 6.39.2.12. Continuity of care for identified Special Health Care Needs populations including managing transitions between pediatric and adult health care providers; 6.39.2.13. Active linking of the member to providers and coordination with medical services, residential, social, community and other support services where needed; 6.39.2.13.1. For members who have DD eligibility, verification of the Statement of Approval and collaboration with Local Governing Entities (LGEs) and Support Coordination Agencies. 6.39.2.14. Identification of barriers to adequate healthcare and assisting with timely resolution; 6.39.2.15. A process for monitoring to identify early changes in the health status of members, ensuring members are receiving needed services and supports, and ensuring member safety and progress; 6.39.2.16. A process for providing high-touch, face-to-face engagement for high-risk members, including those who have complex care needs, are difficult to engage through telephonic care management, are residing in or transitioning from an institution, access care primarily through emergency services, or are frequently admitted to inpatient settings; 6.39.2.17. A process for continuity of care, including managing transitions between levels of care. Services shall be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to prevent institutionalization and assist the member with maintaining community placement; 6.39.2.18. A process for offering or arranging self-management training and health education to members and caregivers regarding conditions; 6.39.2.19. A process for conducting case management rounds for CSoC enrolled youth at least monthly with the CSoC Contractor; and 6.39.2.20. Follow-up and documentation. 6.39.3. Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19. A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services. 6.39.3.1. The MCO shall:

- Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately;
- Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment;
- Ensure members are referred to service providers in accordance with freedom of choice requirement;
- Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and
- Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.

6.40. Case Management Policies and Procedures The MCO shall submit Case Management Program policies and procedures to LDH for approval annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements: 6.40.1. A process to offer voluntary participation in the Case Management Program to eligible members; 6.40.2. Identification criteria, process, and triggers for referral and admission into the Case Management Program; 6.40.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: 6.40.3.1. Reproductive aged women with a history of prior poor birth outcomes; and 6.40.3.2. High risk pregnant women. 6.40.4. The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers; 6.40.5. A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning; 6.40.6. Procedures and criteria for making referrals to specialists and subspecialists 6.40.7. Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and 6.40.8. Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program. 6.41. Case Management Reporting Requirements The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum: 6.41.1. Number of members identified with potential special healthcare needs utilizing historical claims data; 6.41.2. Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider; 6.41.3. Number of members identified with potential special healthcare needs that self-refer; 6.41.4. Number of members with potential special healthcare needs identified by the MCO; 6.41.5. Number of members in the lock-in program; 6.41.6. Number of members identified with special healthcare needs by the PASRR Level II authority; 6.41.7. Number of members with assessments completed, and 6.41.8. Number of members

with assessments resulting in a referral for Case Management ((pp. 103-109, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸⁰ 6.13. Perinatal Services. ...6.13.2. The MCO shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated). (p. 81, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.39. Case Management. 6.39.2. Case Management program functions shall include but not be limited to the following, all of which shall be addressed in the MCO's case management policies and procedures: ... 6.39.2.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, reproductive aged women with a history of prior poor birth outcomes and high-risk pregnant women; 6.40. Case Management Policies and Procedures... The MCO shall submit Case Management Program policies and procedures to LDH for approval annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements: 6.40.3. Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: ... 6.40.3.2. High risk pregnant women. (p. 108, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸¹ 2.3.9. Mental Health Parity 2.3.9.1. The MCO shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. The MCO shall comply with all 42 CFR Part 438, Subpart K, specifically, 438.900, 905, 910, and 915 for all Medicaid managed care enrollees. (p. 4, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.4. Behavioral Health Services 6.4.1. For the purposes of this Contract, behavioral health services are divided into two levels: basic and specialized. 6.4.1.1. Basic behavioral health services shall include, but are not limited to, screening, prevention, early intervention, medication management, treatment and referral services provided in the primary care setting and as defined in the Medicaid State Plan. Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities. These services shall be covered by the MCO for members with both physical health and behavioral health coverage. 6.4.1.2. Specialized behavioral health services shall include, but are not limited to services specifically defined in the Medicaid State Plan. Specialized behavioral health services shall also include any other behavioral health service subsequently amended into the Medicaid state plan or waivers. Effective December 1, 2015, these services are covered by the MCO for all covered populations except for specialized behavioral health services covered by the Coordinated System of Care contractor for youth enrolled with the CSoC contractor as per 5.17. 6.4.2. The MCO shall screen members to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, the MCO shall authorize Medicaid State Plan services as appropriate. 6.4.3. Services shall be managed to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high quality services. 6.4.4. Specialized Behavioral Health Covered Services: •Psychiatrist (all ages) •Licensed Mental Health Professionals (LMHP) o Medical Psychologists o Licensed Psychologists o Licensed Clinical Social Workers (LCSW) o Licensed Professional Counselors (LPC) o Licensed Marriage and Family therapists (LMFT) o Licensed Addiction Counselors (LAC) o Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & mental Health, Family Psychiatric & Mental health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health) •Mental Health Rehabilitation Services o Community Psychiatric Support and Treatment (CPST) o Community Psychiatric Support and Treatment (CPST), specialized for high-risk populations. This includes: Multi-Systemic Therapy (MST) (under age 21) Functional Family Therapy (FFT) (under age 21) Homebuilders (under age 21) Assertive Community Treatment (limited to 18 years and older) o Psychosocial Rehabilitation (PSR) o Crisis Intervention o Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement. o Crisis Stabilization (under age 21) •Psychiatric Residential Treatment Facilities (under age 21) •Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services •Outpatient and Residential

Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care •Screening for services, including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. The MCO shall ensure (either using MCO care management protocols or by ensuring appropriate, proactive discharge planning by MCO contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared for discharge to a home and community-based setting. For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, the MCO shall ensure that screening for CSoc takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoc screening shows appropriateness, referral to CSoc up to 90 days prior to discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment. •Pending CMS approval for the coverage of Methadone to treat opiate addiction, the MCOs shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at the discretion of the MCOs. •Pending CMS approval of the 1115 SUD Demonstration waiver and associated State Plan Amendments for the implementation plan, coverage may include, but is not limited to adoption of additional services in the following categories: o Outpatient; o Intensive outpatient services; o Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); o Intensive levels of care in residential and inpatient settings; and o Medically supervised withdrawal management. (pp. 70-72, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.4.8. The MCO is responsible for the provision of screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health.") Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i)) (p. 74, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.36. Continuity for Behavioral Health Care 6.36.1. The PCP shall provide basic behavioral health services (as described previously in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services. 6.36.2. The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: •Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; •Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; •The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; •It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy. 6.36.3. In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. 6.36.4. The MCO shall comply with all post-stabilization care service requirements found at 42 CFR §422.113. 6.36.5. The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider. 6.36.6. The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care. 6.36.7. These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services. 6.36.8. The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures. 6.36.9. The MCO shall work to strongly support the integration of both physical and behavioral health services through: 6.36.9.1.1. Enhanced detection and treatment of behavioral health disorders in primary care settings; 6.36.9.1.2. Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders; 6.36.9.1.3. Assisting members without a diagnosed behavioral health

disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; 6.36.9.1.4. Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management. 6.36.9.1.5. Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. 6.36.9.1.6. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use. 6.36.9.1.7. Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate; 6.36.9.1.8. Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists; 6.36.9.1.9. Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services. 6.36.9.1.10. Documenting authorized referrals in the MCO's clinical management system; 6.36.9.1.11. Developing capacity for enhanced rates or incentives for integrated care by providers; 6.36.9.1.12. Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures; 6.36.9.1.13. Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and 6.36.9.1.14. Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication. (pp. 99-101, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.1.10. The MCO shall ensure parity in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3). (p. 114, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.3.7. Specialized Behavioral Health Providers 7.3.7.1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members. 7.3.7.2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members. (p. 116-117, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.10. Patient-Centered Medical Home (PCMH) 7.10.1. A Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. (p. 140, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸² 2.3.9. Mental Health Parity 2.3.9.1. The MCO shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. The MCO shall comply with all 42 CFR Part 438, Subpart K, specifically, 438.900, 905, 910, and 915 for all Medicaid managed care enrollees. (p. 4, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

2.4. 1115 Substance Use Disorder (SUD) Demonstration Waiver 2.4.1. In response to the national opioid epidemic and guidance issued from CMS, LDH is developing an implementation plan to address service adequacy within the substance use service array. LDH has applied for an 1115 demonstration waiver to address utilization of institutes for mental disease (IMD) for substance use residential facilities. 2.4.2. LDH may also pursue state plan amendments to expand the substance use service array to include additional American Society of Addiction Medicine (ASAM) criteria and/or levels of care, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. Once adopted, utilization management guidelines, reporting requirements, and provider manual updates will be addressed in addition to any necessary contract amendment language. 2.4.3. The MCO shall adhere to network adequacy requirements

established by the state in its implementation plan and provide network development and adequacy plans upon request. 6.3.6. Behavioral Health Specific Pharmacy Policies and Procedures The MCO shall develop LDH approved policies and procedures that meet or exceed the following requirements: 6.3.6.1. The MCO or its subcontractor(s) shall contract with the psychiatric facilities and residential substance use facilities so that the plans are notified upon patient admission and upon patient planned discharge from the psychiatric facility or residential substance use facilities. Prior to discharge the MCO shall be informed of the recipient's discharge medications. The MCO will then be responsible to override or allow all behavioral health discharge medications to be dispensed by overriding prior authorization restrictions for a ninety (90) day period. This includes, but is not limited to, naloxone, Suboxone, and long-acting injectable anti-psychotics. 6.3.6.2. If the MCO is not notified prior to the discharge and the member presents at the pharmacy with a medication issued at the time of discharge, the MCO will provide a prior authorization override for a ninety (90) day period from the date of discharge as long as the member presents the prescription within ninety (90) days of being discharged from a psychiatric and/or residential substance use facility. 6.3.6.3. The MCO shall have a specific Suboxone, Subutex and methadone management program and approach, which shall be approved by LDH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State Opioid Treatment Authority/LDH. The MCO shall submit the policy for LDH approval no later than January 1, 2016. (p. 67, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.19. Services for Special Populations 6.19.1. Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. Individuals with special health care needs include: 6.19.1.1. Individuals with co-occurring mental health and substance use disorders; 6.19.1.2. Individuals with intravenous drug use...6.19.1.4. Individuals with substance use disorders who have dependent children (p. 85, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.1.10. The MCO shall ensure parity in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3). (p. 114, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸³ 6.11. Prenatal Care Services. ...6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth. (pp. 79-80, Effective December 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.19. Services for Special Populations 6.19.1. Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. Individuals with special health care needs include: ... 6.19.1.3. Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome. (p. 85, Effective December 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸⁴ 12.25. Web and Mobile-Based Member Applications. 12.25.1. No later than February 1, 2019, the MCO shall provide a web - or mobile – based member/patient portal that includes the following information and features: ...12.25.1.2. Social services information and resources, such as housing supports, food programs, etc. (p. 232, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸⁵ 6.11.4. The MCO shall ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and

choosing a PCP to provide subsequent pediatric care to the child once the child is added to the MCO as well as appropriate referrals to the WIC program for nutritional assistance. (A sample WIC Referral Form may be found at this link) (p. 80, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.13.2. The MCO shall provide case management services to women postpartum who were identified as high risk during the pregnancy or who have had an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks. Case management services shall include referral to safety net services for inter-pregnancy care and breastfeeding support (if indicated). (p. 81, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.21. Women, Infants, and Children (WIC) Program Referral The MCO shall be responsible for ensuring that coordination exists between the WIC Program and MCO providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The LDH Office of Public Health administers the WIC Program. A sample referral/release of information form is found using this link. (p. 87, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸⁶ 6.0 CORE BENEFITS AND SERVICES. 6.1. General Provisions... 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: * Surgical Dental Services... Emergency Dental Services. (p. 59, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.5. Laboratory and Radiological Services... 6.5.2. For excluded services such as dental, the MCO is responsible for laboratory or radiological services that may be required to treat an emergency or provide surgical services. (p. 75, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.24. Excluded Services. ...6.24.1.1. Dental services with the exception of varnish provided in a primary care setting, surgical dental services, and emergency dental services. (p. 90, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁸⁷ Section 2.5 Care Delivery, Care Coordination, and Care Management In addition to Enrollees' other rights, the Contractor shall ensure that all Enrollees experience care that is integrated across providers (including Network Providers), that is Member-centered, and that connects Enrollees to the right care in the right settings, as described in this Section and as further specified by EOHHS... B. Care Needs Screening and Appropriate Follow-Up The Contractor shall ensure that Enrollees receive screenings to identify their health and functional needs as follows: 1. The Contractor shall develop, implement, and maintain procedures for completing, an initial Care Needs Screening for each Enrollee, and shall make best efforts to complete such screening within 90 days of the Enrollee's Effective Date of Enrollment, including making subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful;... 3. The Contractor shall otherwise evaluate Enrollees' needs through means other than the Care Needs Screenings. Such means shall include but not be limited to regular analysis of available claims, Encounter Data, and clinical data on Enrollees' diagnoses and patterns of care;... 4. The Contractor shall ensure that Enrollees receive Medically Necessary and appropriate care and follow-up based on their identified needs through any assessment or screening, including but not limited to those performed pursuant to this Section... 5. To prevent duplication of activities relating to identifying and assessing an Enrollee's needs, share any such identification and assessment of needs conducted by the Contractor with EOHHS, as requested and in a form and format specified by EOHHS... C. Care Coordination, Transitional Care Management, and Clinical Advice and Support Line The Contractor shall ensure that care for all Enrollees is coordinated. The Contractor shall, at a minimum, as described in this Section and further specified by EOHHS, perform care coordination activities for Enrollees; have a Transitional Care Management program to coordinate Enrollees' care during transitions such as hospital discharges; and maintain a Clinical Advice and Support Line to provide Enrollees access to information and assistance that supports coordinated care...D. Assessment and Member-Centered Care Planning The Contractor shall ensure that certain Enrollees, as described in this Section and further specified by EOHHS, are comprehensively assessed and receive a documented Care Plan that is informed by such assessment. Such assessment and documented Care Plan shall be member-centered and shall inform Enrollees' care, including but not limited to any Care Management activities, as described in this Section and further specified by EOHHS... E. Case Management The Contractor shall provide Care Management activities to appropriate Enrollees as

described in this Section and further specified by EOHHS. 1. The Contractor shall proactively identify Enrollees who may benefit from Care Management activities based on the results of the evaluation as described in this Section...2. The Contractor shall provide each such identified Enrollee with Care Management... 3. Care Management Program Compliance Review To support evaluation of the Contractor's Care Management programs, the Contractor shall collaborate with EOHHS to develop specifications for a clinical data set and report. The Contractor shall analyze the data set and submit the results to EOHHS for review in a form, format, and frequency specified by EOHHS. The Contractor shall revise the clinical data set and report as directed by EOHHS;... (pp. 66-92, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁸⁸ See pp. 13-27, Appendix C, Exhibit 3, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract for a list of covered behavioral health services.

5. PCP Coordination with Behavioral Health Providers The Contractor shall implement a plan to facilitate communication and coordination of Enrollee mental health, substance use disorders, and medical care between the Behavioral Health Provider, and the Enrollee's PCP. The plan shall, at a minimum, include policies and procedures that meet the following requirements: a. Instruct Behavioral Health Providers on how to obtain the Enrollee's PCP name and telephone number; b. Require the Enrollee's PCP and Behavioral Health Provider to request written consent from the Enrollee to release information to coordinate care regarding mental health or substance use disorders services, or both, and Primary Care. Such consent shall conform to the requirements set forth in 42 CFR 2.00 et seq., when applicable. The Contractor shall require the PCP and the Behavioral Health Provider to document all instances in which consent was not given and, if possible, the reason why; c. Ensure that the PCP and the Behavioral Health Provider communicate and coordinate the Enrollee's care; and d. Ensure that the PCP has access to Behavioral Health service resources including CBHI, substance use disorder services, community support program services, and emergency service program services. (p. 63, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

B. Care Needs Screening and Appropriate Follow-Up. ... 2. The Contractor's Care Needs Screening shall: ...f. As further directed by EOHHS, evaluate Enrollees' needs for Behavioral Health-related services, including unmet needs and including Enrollees' appropriateness for assignment to BH CPs as further specified by EOHHS. Contractor's Care Needs Screening shall evaluate characteristics such as but not limited to: 1) The Enrollee's current use of BH Services, if any, including substance use disorder treatment services; 2) The presence of mental health diagnoses or conditions, if any; 3) The presence of any substance use disorders, if any; and 4) The Enrollee's affiliation with any state agency that provides BH-related care management or other activities, including the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS); ...g. Ensure that all Enrollees with significant BH needs, as further defined by EOHHS, receive appropriate services to address their care needs, as follows: 1) The Contractor shall: a) Ensure all such Enrollees receive appropriate services and referrals to address their care needs, which may include for certain Enrollees referral to a BH CP, as described in Section 2.5.D; b) Work with Contractor's BH CPs to assist such Enrollees with in accessing appropriate services, including but not limited to providing navigation and referral, as described in Section 2.5.F; c) Ensure that providers utilize a Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for Enrollees with potential substance use disorder treatment needs as further directed by EOHHS; d) Record in each such Enrollee's medical record appropriate information on the Enrollee's access to care, including but not limited to information on whether each Enrollee has a Comprehensive Assessment, a Care Plan, a Care Coordinator or Clinical Care Manager assigned to their care, and sufficient access to ongoing support and treatment that meets the Enrollee's care needs; e) Report to EOHHS on such information and on Contractor's success in connecting such Enrollees to appropriate levels of care, in aggregate form or as further directed by EOHHS; and f) Ensure that each such Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, as applicable; 2) Such services shall include but not be limited to services such as: a) Behavioral health services including inpatient, diversionary, and outpatient care; b) Substance use disorder treatment; c) Peer Supports, recovery coaches, and self-help groups; d) For Enrollees under the age of 21, services under the Children's Behavioral Health Initiative; e) Community Support Program (CSP) services, including but not limited to CSP services for the chronically homeless; and f) Services provided by other state agencies, including but not limited to DMH, DDS, DCF, and DYS; h. The Contractor shall ensure that certain Enrollees receive BH clinical assessment and treatment planning as described in Section 2.8.D; (pp. 70-72, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

E. Behavioral Health Services: Authorization Policies and Procedures The Contractor shall: 1. Review and update annually, at a minimum, the Behavioral Health Clinical Criteria definitions and program specifications for each MCO Covered Service. The Contractor shall submit any modifications to these documents to EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with its clinical staff or medical consultants outside of the Contractor's organization, or both, who are familiar with standards and practices of mental health and substance use treatment in Massachusetts; 2. Review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies and procedures (p. 125, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

2. Behavioral Health Providers The Contractor shall enter into and oversee Provider Contracts with Network Providers who provide Behavioral Health Services as follows: a. The Contractor shall ensure that such Provider Contracts shall require that clinicians, including psychiatrists, psychiatric residents, psychiatric nurse mental-health clinical specialists, psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of a licensed clinician, who provide Behavioral Health Services to Enrollees under the age of 21 in certain levels of care, including Diagnostic Evaluation for Outpatient Therapy (individual Counseling, Group Counseling, and Couples/Family Counseling), In-Home Therapy, Inpatient Psychiatric Services, and Community Based Acute Treatment Services: 1) Participate in CANS training sponsored by EOHHS; 2) Become certified in the use of the CANS Tool and recertified every two years; 3) Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for an Enrollee under the age of 21, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment; 4) Use the CANS Tool as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services; and 5) Subject to consent by the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT system the information gathered using the CANS Tool and the determination whether or not the assessed Enrollee is suffering from a Serious Emotional Disturbance (SED). (pp. 151-152, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

B. Primary Care Provider (PCP) Network... 4. The Contractor shall provide education and training at least annually for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify Behavioral Health Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate. (p. 173, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁸⁹ See pp. 13-27, Appendix C, Exhibit 3, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract for a list of covered substance use disorder benefits.

5. PCP Coordination with Behavioral Health Providers The Contractor shall implement a plan to facilitate communication and coordination of Enrollee mental health, substance use disorders, and medical care between the Behavioral Health Provider, and the Enrollee's PCP. The plan shall, at a minimum, include policies and procedures that meet the following requirements: a. Instruct Behavioral Health Providers on how to obtain the Enrollee's PCP name and telephone number; b. Require the Enrollee's PCP and Behavioral Health Provider to request written consent from the Enrollee to release information to coordinate care regarding mental health or substance use disorders services, or both, and Primary Care. Such consent shall conform to the requirements set forth in 42 CFR 2.00 et seq., when applicable. The Contractor shall require the PCP and the Behavioral Health Provider to document all instances in which consent was not given and, if possible, the reason why; c. Ensure that the PCP and the Behavioral Health Provider communicate and coordinate the Enrollee's care; and d. Ensure that the PCP has access to Behavioral Health service resources including CBHI, substance use disorder services, community support program services, and emergency service program services. (p. 63, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

B. Care Needs Screening and Appropriate Follow-Up. ... 2. The Contractor's Care Needs Screening shall: ...f. As further directed by EOHHS, evaluate Enrollees' needs for Behavioral Health-related services, including unmet needs and including Enrollees' appropriateness for assignment to BH CPs as further specified by EOHHS. Contractor's Care Needs Screening shall evaluate characteristics such as but not limited to: 1) The Enrollee's current use of BH Services, if any, including substance use disorder treatment services; 2) The presence of mental health diagnoses or

conditions, if any; 3) The presence of any substance use disorders, if any; and 4) The Enrollee's affiliation with any state agency that provides BH-related care management or other activities, including the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS); ...g. Ensure that all Enrollees with significant BH needs, as further defined by EOHHS, receive appropriate services to address their care needs, as follows: 1) The Contractor shall: a) Ensure all such Enrollees receive appropriate services and referrals to address their care needs, which may include for certain Enrollees referral to a BH CP, as described in Section 2.5.D; b) Work with Contractor's BH CPs to assist such Enrollees with in accessing appropriate services, including but not limited to providing navigation and referral, as described in Section 2.5.F; c) Ensure that providers utilize a Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for Enrollees with potential substance use disorder treatment needs as further directed by EOHHS. (p. 71, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract) B. Primary Care Provider (PCP) Network... 4. The Contractor shall provide education and training at least annually for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify Behavioral Health Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate. (p. 173, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁹⁰ F. Enrollee Outreach, Orientation, and Education The Contractor shall: ...2. The Contractor must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall: ... Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in Section 2.5. Condition and disease specific information must be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to: ... 9) Pregnant individuals with substance use disorders (pp. 64-65, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Service: Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1) – 24- hour short term intensive case management and psycho-educational residential programming with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization prior to placement in a residential or community based program. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care... Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Withdrawal management services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs... Clinical Support Services for Substance Use Disorders (Level 3.5) – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care... Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24hour residential environment that provides a structured and comprehensive rehabilitative environment that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Residential programs licensed and approved to serve pregnant and post-partum women provide assessment and management of gynecological and/or obstetric and other prenatal needs, as well as treatment plans addressing parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions... Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour residential environment for families in which a parent has a substance use disorder and either is pregnant, has custody of at least one child or has a physical reunification plan with at least one child within 30 days of admission. Scheduled, goal-oriented rehabilitative services intended to support parents

and children are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal and parenting skills necessary to lead an alcohol and/or drug-free lifestyle and support family reunification and stability. Enrollees receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities... Structured Outpatient Addiction Program (SOAP) - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring. (pp. 12-27, Appendix C, Exhibit 3, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

⁹¹ B. Care Needs Screening and Appropriate Follow-Up. 2. The Contractor's Care Needs Screening shall: ... h. As further directed by EOHHS, evaluate Enrollees' health-related social needs, including whether the Enrollee would benefit from receiving community services to address health-related social needs. Such services shall include but not be limited to: ... 4) Physical activity and nutrition (p. 79, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Covered Services.Medical Nutritional Therapy – nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are furnished by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited mid-level providers (e.g., registered nurses, physician assistants, and nurse practitioners). (p. 5, Appendix C, Exhibit 1, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

⁹² Section 2.5 Care Delivery, Care Coordination, and Care Management. The Contractor shall... 9. Develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS: ... 4) Nutrition counseling, with targeted outreach for pregnant women, older Enrollees, and Enrollees with Special Health Care Needs (p. 68, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

J. Provider Education The Contractor shall establish ongoing Provider education, including but not limited to, the following issues: ...c. Issues concerning women, including but not limited to, the following: 1) Pre-conception health concerns, including folic acid administration...; nutrition; p. (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

MCH Covered Services ...Breast Pumps – to expectant and new mothers as specifically prescribed by their attending physician, consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014, including but not limited to double electric breast pumps one per birth or as medically necessary. (p. 1, Appendix C, Exhibit 1, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

⁹³ MCO Covered Services: Ambulatory Surgery/Outpatient Hospital Care... dental services... Dental - Emergency related dental services as described under Emergency Services in Appendix C, Exhibit 1 and oral surgery performed in an outpatient setting, as described in Ambulatory Surgery/Outpatient Hospital Care in Appendix C, Exhibit 1, which is Medically Necessary to treat a medical condition... Orthotics – braces (non dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. See Subchapter 6 of the Orthotics Manual. (p. 1, 3, 5, Appendix C, Exhibit 1, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

⁹⁴ G. Coordination of Care 1. To coordinate care and deliver quality health care to the MCO's Enrollees by providing all necessary information to the Medicaid Program, its authorized agents, the Administrative Services Organizations with which the Department contracts and to any other entity as directed by the Department, in accordance with applicable federal and state confidentiality laws and regulations. 2. For Enrollees with behavioral health conditions, coordination of care should include but not be limited to: a. Participation in monthly collective MCO medical directors'

meetings and one-on-one MCO meetings with the ASO for care coordination, b. Cooperation with the Department's high utilizer pilot program, c. Assistance with the development and coordination of appropriate treatment plans for Enrollees, d. Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, e. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and f. Provider education for Enrollee identification and referrals to the ASO or core service agencies for behavioral health services, 3. To implement procedures to deliver care to and coordinate services for all Enrollees. These procedures must do the following: a. Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee (e.g., a primary care provider); b. Provide the Enrollee with information on how to contact their designated person or entity; c. Coordinate the services the MCO furnishes to the Enrollee: i. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; ii. With the services the Enrollee receives from any other MCO; iii. With the services the Enrollee receives in FFS Medicaid; and iv. With the services the Enrollee receives from community and social support providers. d. Make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment for all new Enrollees, including subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful; e. Share with the Department or other MCOs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of services or benefits; f. Use CRISP to identify new Enrollees and their potential risk categories and to coordinate with other MCOs as appropriate for transition of care activities; g. Ensure that each provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards; and h. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. (pp. 12-13, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

C. General Requirements for Special Needs Populations. ... (4) The MCO shall demonstrate the use of a primary care system of care delivery which includes a comprehensive plan of care for an enrollee who is a member of a special needs population and which uses a coordinated and continuous case management approach, involving the enrollee and, as appropriate, the enrollee's family, guardian, or caregiver, in all aspects of care, including primary, acute, tertiary, and home care. (p. 120, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁹⁵ MATERNAL OPIOID MISUSE (MOM) MODEL AGREEMENT...B. In the Transition Period (January 2022 – June 2022) and Implementation Period (July 2022 – December 2022) of Model Year 3 of the MOM model, the MCO agrees to: ... ii. Coordinate care, engage participants and provide referrals for community and other support services to complement the current set of Medicaid-covered services to meet MOM model participants' comprehensive needs, including screening and referral for health-related social needs, measurement of patient activation and to satisfy at least one of the following model components per month: 1. Comprehensive care management; 2. Care coordination; 3. Health promotion; 4. Individual and family support; and 5. Referral to community/support services. (pp. 79-80, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁹⁶ .26 Benefits — Primary Mental Health Services. An MCO shall provide to its enrollees medically necessary primary mental health services, including appropriate referrals for service to the Department's behavioral health ASO as described in COMAR 10.09.59. (p. 221, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁹⁷ MATERNAL OPIOID MISUSE (MOM) MODEL AGREEMENT...B. In the Transition Period (January 2022 – June 2022) and Implementation Period (July 2022 – December 2022) of Model Year 3 of the MOM model, the MCO agrees to: ...Ensure MOM model participants access at least one physical or behavioral health care services billable to Medicaid, including: 1. Physical health care: Maternity care and relevant primary care services, including medication for opioid use disorder (MOUD); and 2. Behavioral health care: Mental health and other appropriate substance use disorder services beyond MOUD. ii. Coordinate care, engage participants and provide referrals for community and other support services to complement the current set of Medicaid-covered services to meet MOM model participants' comprehensive needs, including screening and referral for health-related social needs, measurement of patient activation and to satisfy at least one of the following

model components per month: 1. Comprehensive care management; 2. Care coordination; 3. Health promotion; 4. Individual and family support; and 5. Referral to community/support services. (pp. 79-80, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁹⁸ MATERNAL OPIOID MISUSE (MOM) MODEL AGREEMENT...B. In the Transition Period (January 2022 – June 2022) and Implementation Period (July 2022 – December 2022) of Model Year 3 of the MOM model, the MCO agrees to: 1. Confirm that they comply with Medicaid Program integrity rules at 42 CFR Part 455. 2. Participate in CMMI- and Department-led MOM model activities, such as monthly meetings, collaboratives, and technical exchanges. 3. If active in designated MOM model target jurisdictions: a. Proactively identify and serve as a referral hub for potential MOM model participants and confirm eligibility prior to intake. b. Receive the per member, per month reimbursement of \$208 in accordance with Section A(6), to provide the following services, at a minimum, on a monthly basis to MOM model participants: i. Ensure MOM model participants access at least one physical or behavioral health care services billable to Medicaid, including: 1. Physical health care: Maternity care and relevant primary care services, including medication for opioid use disorder (MOUD); and 2. Behavioral health care: Mental health and other appropriate substance use disorder services beyond MOUD. ii. Coordinate care, engage participants and provide referrals for community and other support services to complement the current set of Medicaid-covered services to meet MOM model participants' comprehensive needs, including screening and referral for health-related social needs, measurement of patient activation and to satisfy at least one of the following model components per month: 1. Comprehensive care management; 2. Care coordination; 3. Health promotion; 4. Individual and family support; and 5. Referral to community/support services. (pp. 79-80, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.08 Special Needs Populations — Pregnant and Postpartum Women. E. An MCO shall refer pregnant and postpartum women with a substance use disorder to the behavioral health ASO for substance use treatment within 24 hours of request. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (3) Enriched maternity services, including: ... (c) Substance abuse treatment, as provided in Regulation .10 of this chapter. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁹⁹ .08 Special Needs Populations — Pregnant and Postpartum Women. ... F. An MCO shall refer pregnant and postpartum women, infants, and children younger than 5 years old to the WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Program, and shall provide to WIC necessary medical information to determine WIC nutritional eligibility. H. An MCO shall provide risk-related medical and nonmedical preventive treatment services, including nutrition counseling by licensed nutritionists or dietitians and smoking cessation education and treatment for pregnant and postpartum women. (p. 126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. (3) Enriched maternity services, including: ... (b) Basic nutritional education.... (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)... (e) High-risk nutrition counseling services for nutritionally high-risk pregnant women. (p. 128, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

¹⁰⁰ III. Payment Reform... B. Patient-Centered Medical Homes... 2. Contractor must contract with providers in their network to provide care management and care coordination services to their members with contracts effective January 1, 2020. (p. 29, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

V. Access and Availability of Providers and Services. Q. Care Coordination Contractor must ensure that the Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designates as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity. 1. Contractor must implement procedures to deliver care to and coordinate services for all Medicaid Health Plans (MHP), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP) Enrollees. These procedures must meet state requirements and Contractor must coordinated services the Contractor furnishes to the Enrollee a. Between settings of care,

including appropriate discharge planning for short-term and long term hospital and institutional stays. b. With the services the Enrollee receives from any other MHP, PIHP or PAHP. c. With the services the enrollee receives in FFS Medicaid d. With the services the enrollee receives from community and social support providers 2. Contractor must make a best effort to conduct an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment of all new Enrollees. Contractor must make subsequent attempts to conduct an initial screening of each Enrollee's needs if the initial attempt to contact the Enrollee is unsuccessful. 3. Contractor must share with the state or other MHPs, PIHPs and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities. 4. Contractor must ensure that each provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards. 5. Contractor must use and disclose individually identifiable health information, such as medical or dental records and any other health or enrollment information that identifies a particular Enrollee, in accordance with confidentiality requirements in 45 CFR parts 160 and 164. (pp. 46-47, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

D. Providing Care Management Services and Other Targeted Interventions 1. Care Management Services a. Contractor must create risk stratification to identify Enrollees by population or sub-population who qualify for intensive care management service, moderate intensity care management services and low intensity care management services. b. Contractor must offer a robust care management program that meets NCQA and/or URAC accreditation standards to Enrollees who qualify for those services, and other subpopulations as designated by MDHHS, including but not limited to disabled populations, high-risk pregnancies, and chronic condition-specific populations. c. Contractor must, to the extent possible, coordinate with other care managers and supports coordinators. d. Contractor must refer Enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments. e. Annually, the Contractor must report to MDHHS the percentage of Enrollees that are eligible for and receiving each care management service level. f. Contractor must report to MDHHS, at intervals designated by MDHHS, on the effectiveness of its care management initiatives implemented. g. CSHCS Enrollee i. Contractor must assess the need for a care manager and a family-centered care plan developed in conjunction with the family and care team ii. Contractor must collaborate with the family and established primary and specialty care Providers to assure access to the most appropriate Provider for the Enrollee. iii. Contractor must have separate, specific PA procedures for CSHCS Enrollees. (1) In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, Contractor must accept prior authorizations in place when the CSHCS Enrollee is enrolled with the Contractor's plan. If the prior authorization is with a non-network ancillary provider, Contractor must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization. (2) Upon expiration of the prior authorization, the Contractor may utilize the Contractor's prior authorization procedures and network ancillary services. iv. Contractor must accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but may utilize the Contractor's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of such equipment. h. Persons with Special Health Care Needs (PSHCN) Contractor is required to do the following for members identified by MDHHS as Persons with Special Health Care Needs (PSHCN): i. Conduct an assessment in order to identify any special conditions that require ongoing case management services for the Enrollee. ii. Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs. iii. For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the Enrollee. (pp. 75-76, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰¹ D. Providing Care Management Services and Other Targeted Interventions. 1. Care Management Services a. Contractor must create risk stratification to identify Enrollees by population or sub-population who qualify for intensive care management service, moderate intensity care management services and low intensity care management services. b. Contractor must offer a robust care management program that meets NCQA and/or URAC accreditation standards to Enrollees who qualify for those services, and other subpopulations as designated by MDHHS, including but not limited to... high-risk pregnancies.... (p. 75, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰² B. Services Covered Under Contract. ... Covered Services provided to Enrollees under this Contract include, but are not limited to, the following:...c. Outpatient mental health services consistent with Appendix 7. (p. 48, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

M. Mental Health Outpatient Benefit 1. Contractor must provide outpatient mental health consistent with Appendix 7 and Medicaid Policy. 2. Contractor may provide services through contracts with Community Mental Health Services Programs (CMHSPs), Prepaid Inpatient Health Plans (PIHPs), or contracts with other appropriate Network Providers. (Page 62 4. Integration of Behavioral Health and Physical Health Services. a. Contractor must collaborate with PIHPs serving its Enrollees to improve integration of behavioral health and physical health services by meeting the following requirements: 1. Facilitate the placement of primary care clinicians in community mental health centers (CMHC) to enable Enrollees to receive both primary care services and behavioral health services at the location where they are most comfortable and incorporate principles of shared decision-making. 2. Facilitate placement of behavioral health clinicians in primary care settings and providing training on treating patients in a holistic manner, using a single treatment plan that addresses both physical and mental health needs and taking into account unmet needs such as substance abuse treatment; and also helping the individual access his/her natural community supports based on his/her strengths and preferences; 3. Develop and implement initiatives to improve communication and collaboration between Contractor's Provider Network and PIHP's contracted CMHSPs and other behavioral health providers. (p. 68, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰³ VII. Coordination for Services Covered Outside this Contract The Contractor must provide information to the Enrollee regarding the availability of these services and coordinate care as appropriate. ...7. Substance use disorder services through accredited Providers including: a. Assessment b. Detoxification (see Appendix 8) c. Intensive outpatient counseling and other outpatient services d. Methadone treatment and other substance use disorder treatment (p. 65, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

C. Health Promotion and Disease Prevention 1. General. a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding: oral health, alcohol and substance use, tobacco use, healthy eating/physical activity, stress, and immunization status. (p. 73, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

3. Health Risk Assessments a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding: oral health, alcohol and substance use, tobacco use, healthy eating/physical activity, stress, and immunization status. (p. 73, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

2. Member Handbook... i. 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:... xxxi. Signs of substance use problems, available substance use disorder services and accessing substance use disorder services (p. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰⁴ 2. Member Handbook. i. 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: ... xxxvi. WIC Supplemental Food and Nutrition Program. (p. 96, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰⁵ B. Services Covered Under This Contract. ... 2. Additional Services Covered for Healthy Michigan Plan Enrollees The Covered Services provided to HMP Enrollees under this Contract include all those listed above and the following services:...b. Dental services for all HMP beneficiaries...s (p. 49, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

VII. Coordination for Services Covered Outside this Contract The Contractor must provide information to the Enrollee regarding the availability of these services and coordinate care as appropriate. A. General 1. Dental services for all Enrollees (except HMP and non-HMP pregnant beneficiaries. (p. 64, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

C. Health Promotion and Disease Prevention 1. General. a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding: oral health.... (p. 73, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

3. Health Risk Assessments a. Contractor recognizes MDHHS's commitment to assessing health risk status among Enrollees and facilitating the adoption of healthy behaviors, specifically regarding: oral health... (p. 73, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

H. Medical and Oral Health Coordination and Integration 1. Contractor recognizes the importance of coordinating and integrating oral and medical health Services to effectively address and improve Enrollee overall health status. 2. Contractor must work with MDHHS to develop initiatives to better coordinate and integrate services covered by the Contractor, dental vendors, and dental Providers serving Contractor's Enrollees. 3. Contractor must collaborate with, PCPs, community partners, dental Providers, dental vendors and MDHHS in the treatment and care of Enrollees. 4. Contractor must promote oral and medical health service collaboration among its Network Providers. 5. Contractor must engage in activities that work to increase awareness about the impact of oral health on Enrollee chronic disease outcomes and improve communication and Collaboration among dental Providers, community partners and medical professionals. 6. Contractor must engage in activities that will educate and build awareness of the benefits of integrated care to its medical Providers and dental Providers as applicable. 7. Contractor must build relationships with community partners that will engage in integrated care and promote good oral health practices. 8. Contractor must encourage its network PCPs to become trained to administer oral health screenings and fluoride varnish Services for patients between zero and three years of age. 9. Contractor reimburses network PCPs for Covered Services, including oral health screenings and fluoride varnish application for Enrollees zero to three years of age. (p. 80-81, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁰⁶ O. Dental Service Enrollment for non-HMP Pregnant Beneficiaries 1. MDHHS will pay Contractor an enhanced Maternity Case Rate for all non-HMP Enrollees including CSHCS beneficiaries for the provision of dental services. 2. Pregnant beneficiaries enrolled in Healthy Kids Dental (HKD) will continue to receive services through HKD and are excluded. 3. Contractor must administer covered dental services through the Contractor's managed care structure. 4. Pregnant non-HMP Enrollees are eligible to access covered dental services. 5. Contractor must provide dental services for pregnant non-HMP Enrollees when: a. MDHHS indicates Enrollee access to dental services via the pregnancy due date listed in the HIPAA-compliant enrollment files. b. Contractor becomes aware of Enrollee's pregnancy via Enrollee's claims data or Enrollee notification to Contractor. i. If Contractor becomes aware of Enrollee's pregnancy prior to MDHHS notification, Contractor must notify MDHHS of Enrollee's pregnancy utilizing the appropriate MDHHS notification form. 6. Contractor must notify its dental vendor of Enrollee's eligibility for covered dental services. 7. Coverage for managed care dental service begins on the first day of the same month that the Contractor becomes aware of the Enrollee's pregnancy as specified in section IV.O.5 of this contract. 8. Coverage for managed care dental services ends on the last day of the third calendar month, after the end of beneficiary's pregnancy. Contractor must calculate the coverage period using the calculation in this section (IV.O) (p. 34, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

H. Pregnant Women.... 4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

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

¹⁰⁷ 6.1.4 Care Management Services. The MCO shall be responsible for the Care Management of all Enrollees. The MCO's Care Management system must be designed to coordinate the provision of primary care and all other Covered Services to its Enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery including between settings of care, the provision of culturally appropriate care, and fiscal and professional accountability. The MCO shall maintain documentation sufficient to support its Care Management responsibilities as listed in section 11.5.1(5). [42 CFR §438.208] At a minimum, the MCO's Care Management system must incorporate the following elements: 6.1.4.1 Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment for acute and long-term services, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's Enrollees. 6.1.4.2 A strategy to ensure that all Enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. 6.1.4.3 A method for coordinating the medical needs of an Enrollee with his or her social service needs. This may involve working with Local Agency social service staff or with the various community resources in the county... 6.1.4.4 Procedures and criteria for making referrals to specialists and sub-specialists. 6.1.4.5 Capacity to implement, when indicated, Care Management functions such as: 1) individual needs assessment, including screening for special needs (for example, mental health and/or substance use disorder problems, developmental disability, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); 2) individual treatment plan development; 3) establishment of treatment objectives; 4) treatment follow-up; 5) monitoring of outcomes; or 6) revision of treatment plans for acute and long-term care. The MCO shall coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings. 6.1.4.6 Procedures for coordinating care for American Indian Enrollees. 6.1.4.7 Procedures for coordinating with an individual education program (IEP), an individualized family service plan (IFSP) or Individual Community Support Plan (ICSP) services and supports. 6.1.4.8 Procedures for coordinating with care coordination and services provided by children's mental health collaboratives, family services collaboratives, adult county mental health initiatives, and Behavioral Health Homes. 6.1.4.9 Hospital In-reach Community-based Service Coordination (IRSC). The MCO will cover in-reach community-based service coordination that is performed through a hospital emergency department for an Enrollee who has frequented a hospital emergency department for services three or more times in the previous four consecutive months... 6.1.4.10 Officer-involved, community-based care coordination pursuant to Minnesota Statutes, §256B.0625, subd. 56a, is not covered under this Contract. The MCO must cooperate with case managers for Enrollees who are receiving officer-involved, community-based care coordination. (pp. 90-91, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹⁰⁸ 6.1.35.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹⁰⁹ 6.1.30 Mental Health Services in General. Mental health services shall be provided by qualified mental health professionals. In approving and providing mental health services, the MCO shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, §62Q.53 or described in section 2.91... (p. 108, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹⁰ 6.1.5 Child and Teen Checkups....(4) Diagnostic services include up to three (3) maternal depression screenings that occur during a pediatric visit for a child under age one (1). The STATE recommends the initial maternal screening within the first month after delivery, with a subsequent screen suggested at the four-month visit (pp. 92-93, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹¹ 6.1.49 Substance Use Disorder (SUD) Treatment Services. The MCO is responsible for the continuum of SUD services identified in Minnesota Statutes, §254B.05, subd. 5, (b), excluding room and board. Notwithstanding section 6.15.2, SUD treatment services shall be provided in accordance with Minnesota Statutes, §§245G.22, subd. 1 and 254B. Enrollees may select the Provider of their choice within the MCO's Network up to the highest level of care recommended. Transportation to Providers is described in section 6.1.28.3 above and limited by section 6.1.29.2... 6.1.49.3 The following services are covered: (1) Outpatient treatment services; (2) Comprehensive Assessment for SUD services; (3) SUD treatment coordination services. SUD treatment coordination for SUD services is only for facilitation of referrals indicated in the SUD treatment plan and does not include coordination for medical services, except those identified in the SUD treatment plan; (4) Peer recovery support services provided according to Minnesota Statutes, §245G.07, subd. 2, (8); (5) Medication-assisted therapy services; (6) High, medium, and low intensity residential treatment services; (7) Hospital-based treatment services; (8) Adolescent treatment programs licensed as outpatient treatment programs or as residential treatment programs; and (9) SUD assessments that are otherwise covered by Medical Assistance as direct face-to-face services may be provided via Telehealth, effective July 1, 2021, or upon federal approval and notice by the STATE. [Minnesota Statutes, §254A.19, subd. 5] (p. 128, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹² 6.1.35.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹³ 6.1 MEDICAL ASSISTANCE (PMAP) COVERED SERVICES.....6.1.12 Dental Services....6.1.12.4 In addition to the services specified in 6.1.12.2 and 6.1.12.3, the following services for adults are covered: (1) House calls or extended care facility calls for on-site delivery of covered services; (2) Behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used; (3) Oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and (4) Prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year. (5) The MCO may not require Service Authorization for the services in 6.1.12.4(1) through (3) above. [Minnesota Statutes, §256B.0625, subd. 9, (f)] 6.1.12.5 Services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in Minnesota Statutes, §§150A.105 and 150A.106 are covered. 6.1.12.6 If a dental provider is providing services to an Enrollee based on a treatment plan that requires more than one visit, the MCO or its Subcontractor must not require the completion of the treatment plan as a condition of payment to the dental provider for services performed as part of the treatment plan. The MCO or Subcontractor must reimburse the dental provider for all services performed regardless of whether the treatment plan is completed, as long as the Enrollee was covered under the MCO at the time the service was performed. Nothing in this section may be construed to prevent the MCO or its Subcontractor from paying for dental services using a bundled method. (pp. 90-95, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹⁴ 6.1.12.1 Medical Assistance covers dental services for children and pregnant women that are Medically Necessary. The following guidelines also apply: (1) Posterior fillings are paid at the amalgam rate; (2) Application of sealants once every five years per permanent molar for children only; and (3) Application of fluoride varnish once every six months; and (4) Orthodontia is eligible for coverage for children only, and in limited circumstances described in Minnesota Rules, Part 9505.0270, subp. 2a, item F. (p. 93, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹⁵ . c. Local Community Care Coordination Program (LCCCP) The health plan shall develop a Local Community Care Coordination Program (LCCCP) to be implemented no later than May 1, 2017. Such program may use any delivery model that focuses on providing care management, care coordination, and disease management through local healthcare providers; however such model shall be prior approved by the state agency. Models may include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), primary care case management (PCCM), subcapitated entities, a combination thereof, or other similar models consistent with the principles and requirements listed below. Providers within these applicable models may include, but are not limited to, primary care physicians/specialties/groups, CMHCs, FQHCs, behavioral health providers/groups, or other provider types or groups that coordinate and manage the care of members. The health plan shall submit to the state agency for prior review and written approval the health plan's LCCCP application and program model. The health plan shall also describe its own internal care management program to which members not enrolled, eligible, or opting into one of the other models would default. The state agency will work with the health plan to achieve an appropriate and approvable LCCCP model to be approved and implemented as soon as feasible but no later than May 1, 2017. The health plan's failure to obtain approval from the state agency on its LCCCP application and program model and to implement the program by May 1, 2017 may result in the withheld funds (described elsewhere herein) not being returned in their entirety to the health plan. (pp. 16-17, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management: 2.11.1 Member Care Management: The health plan shall provide Member Care Management Services to selected members. Member Care Management is an umbrella term that encompasses services such as, but not limited to: Comprehensive care management applying clinical knowledge to the member's condition; Care coordination; Health promotion services; Comprehensive transitional care; Individual and family support activities; Disease management; and Referrals to community and social supports. a. Member Care Management Services (previously referred to as case management but herein after referred to as care management) encompasses services required under the current contract and replaces the term case management: The health plan shall provide care management to selected members. The health plan's care management service shall focus on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes. The health plan may use a Section 2703 designated health home provider or the LCCCP provider to perform care management functions if the health home and LCCCP provider are members of the health plan network. In this event, the health plan shall have processes in place to monitor service delivery. Physical health and behavioral health care management shall be integrated to the greatest extent possible. The health plan shall have a team of mixed specialists working together to provide the best level of integrated care management to all MO HealthNet members using an approach that includes both consistent interpersonal integration as well as integrated care management systems. The health plan shall submit a detailed plan of how the health plan shall support staff integration through activities including but not limited to case conferences. This plan shall include detail regarding physical health and behavioral health care management personnel integration. If physical health and behavioral health care management personnel are not colocated, the health plan shall ensure that the integration between physical health care management personnel and behavioral health care management personnel does not differ from the integration between care management personnel in the same field. This detailed plan must be met by the second year of the contract. The state agency will evaluate the health plan's care management and disease management programs during the readiness review and annually throughout the term of the contract. The tool for review of the health plan's care management and disease management programs will be provided immediately following the state agency's notification to the health plan to proceed with contract services. The care management review will include monitoring of the integration between physical health and behavioral health care management personnel... The health plan shall perform an assessment for care management within thirty (30) calendar days of enrollment for new members who present with a diagnosis listed below and who are not enrolled in the State health home program. The health plan shall perform an assessment for care management within thirty (30) calendar days of diagnosis for existing members who receive a new diagnosis listed below and who are not enrolled in the State health home program... e. Care Plans: 1) For all eligible members, the health plan shall use the initial assessment to identify the issues necessary to formulate the care plan... (pp. 68-78, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹¹⁶ 2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management: 2.11.1 Member Care Management: The health plan shall provide Member Care Management Services to selected members. Member Care Management is an umbrella term that encompasses services such as, but not limited to:... d. General Eligibility and Assessment 1) The

health plan shall screen all pregnant members for care management needs and offer care management to all pregnant members. The health plan shall offer care management within fifteen (15) business days of date effective with the health plan of newly eligible members or within fifteen (15) business days of notice of pregnancy for currently eligible members. The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs and must be completed within fifteen (15) business days from the date effective with the health plan for newly eligible members or within fifteen (15) business days of notice of pregnancy for currently eligible members... e. Care Plans... 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women: A risk appraisal form must be a part of the member's record. The health plan may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd. Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in care management; Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment; Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21); Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in care management; Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation; Assistance in making transportation arrangements for prenatal care, delivery, and postpartum care; Referrals to prenatal or childbirth education where available; Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment; Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed; Assistance in identifying and selecting a medical care provider for both the mother and the child; Identification of feeding method for the child; Notifications to current health care providers when care management services are discontinued; Referrals for family planning services if requested; and Directions to start taking folic acid vitamin before the next pregnancy. (pp. 71, 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹¹⁷ 2.4.8 Behavioral Health Providers: Behavioral Health encompasses mental health and substance use disorder treatment. To ensure a broad range of treatment options are available, the health plan shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults. a. The health plan shall include in the health plan provider network, the majority of Community Mental Health Centers (CMHC) within each county where the health plan has covered lives. If there is not a CMHC in that county, the health plan must contract with a CMHC within thirty (30) miles of a county where the health plan has covered lives. If there is not a CMHC within thirty (30) miles of that county, the health plan must contract with a CMHC in the Department of Mental Health (DMH) CMHC catchment area for any county where the health plan has covered lives. A map of the DMH CMHC catchment areas may be found at <http://dmh.mo.gov/mentalillness/helpinfo/adminagents.html>. To the maximum extent possible, the health plan shall include all CMHCs in its network. A listing of CMHCs is provided in Exhibit C and in Federally Qualified Health Clinics, Rural Health Clinics, Community Mental Health Centers, Safety Net Hospitals, Family Planning and STD Providers located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-scheduletemplates/>). The health plan shall have protocols for coordinating care between the primary care providers and the CMHC providers. The protocols shall indicate the expected response time for consults between the primary care providers and the CMHC. (p. 28, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

c. Behavioral health services: Behavioral health services encompass mental health and substance use disorder treatment. For children covered under MO HealthNet Managed Care within Category of Aid 4 and with dual diagnoses (physical and behavioral related), the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and behavioral health. These admissions are subject to the prior authorization and concurrent review process identified by the health plan. The health plan shall not be responsible for all other behavioral health services for children within Category of Aid 4. For all other members, the health plan shall provide all medically necessary behavioral health services included in the comprehensive benefit package. The state agency, in conjunction with the Department of Mental Health, has developed community-based services with an emphasis on the least restrictive setting. The health plan shall consider, when appropriate, using such services in lieu of using an out-of-home placement setting for members. Services which the health plan shall provide shall include, but not be limited to: · Inpatient hospitalization, when provided by an acute hospital, or private or state psychiatric hospital. (pp. 48-49, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

2.7.11 Short-Term Inpatient Stays in an Institution for Mental Diseases (IMD): In accordance with 42 CFR 438.6(e), the health plan may offer an inpatient stay in an IMD, as an in lieu of setting, of no more than 15 days within the month for covered inpatient psychiatric or substance use disorder services to members between ages 21-64. In accordance with 42 CFR 438.3(e)(2)(ii)-(iii), the health plan may not require a member to receive inpatient psychiatric or substance use disorder services in an IMD and the health plan is not required to use the IMD as an in lieu of setting. For purposes of rate setting, the state agency will consider member utilization of covered inpatient psychiatric or substance use disorder services in an IMD when developing the respective component of the capitation rate; however, IMD utilization will be priced at the cost of the same services through providers included in the Medicaid State plan. No FFP will be claimed for the month in which the member's stay in an IMD exceeds fifteen (15) calendar days. (p. 60, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹¹⁸ 2.7 Comprehensive Benefit Package:... 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/>):... c. Behavioral health services: Behavioral health services encompass mental health and substance use disorder treatment. (pp. 48-49, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹¹⁹ 2.11 Member Care Management, Disease Management, and Hospital Care Transition (HCT) Management: 2.11.1 Member Care Management: The health plan shall provide Member Care Management Services to selected members... e. Care Plans:... 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:... Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. (p. 75, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹²⁰ 2.10.8 Public Health Programs: Services offered by the Department of Health and Senior Services and local public health agencies and the method... 2) The health plan shall require its in-network providers to document and refer eligible members for WIC services. As part of the initial assessment of members, and as a part of the initial evaluation of newly pregnant women, the in-network providers shall provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program. (Local WIC provider locations, contact information, and hours of operations can be found on the Department of Health and Senior Services WIC web page at: <http://health.mo.gov/living/families/wic/>.) (p. 65, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

2.11.1 Member Care Management:... e. Care Plans:...3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:... Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in care management;... Directions to start taking folic acid vitamin before the next pregnancy. (pp. 75-76, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹²¹ 2.7 Comprehensive Benefit Package... 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/>):... f. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. (p. 51, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹²² 2.7 Comprehensive Benefit Package:... 2.7.7 Additional Services: In addition to the services listed in the comprehensive benefit package herein, the health plan shall provide the following services to children under twenty-one (21) years of age and pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98. The state agency reserves the right to modify the additional services listed below at any time, via a contract amendment. To the extent the additional services listed below are modified during the term of the contract, the capitation rates will be reviewed and

adjusted if necessary and the contract amendment will advise of the new capitation rates... b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan... (p. 58, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹²³ A. Care Management Responsibilities The Contractor is responsible for Care Management – a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management includes but is not limited to Continuity of Care, Transition of Care, and Discharge Planning. The Contractor shall develop and implement a Care Management system to ensure and promote timely access and delivery of health care and services required by Members, continuity of Members' care, and coordination and integration of Members' care, including physical and Behavioral Health/Substance Use Disorder Services, especially for those members with chronic and severe medical and behavioral conditions. Within ninety (90) calendar days of contract award, the Contractor shall provide its overall approach to Care Management to the Division for review and approval. The Contractor shall revise its approach as requested by the Division, and will submit any subsequent updates to the Division for approval....2. Care Management Services Member information shall be maintained by the Contractor and accessible twenty-four (24) hours per day seven (7) days per week by members of the Care Management Team. The Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services: a. Assignment to a Care Management team: The Contractor must assign a point of contact for each Member. The Contractor shall assign Members in the high risk and medium risk categories to a specific Care Management team member; b. Access to a Member services call center; c. Assistance with care coordination and access to primary care, inpatient services, Behavioral Health/Substance Use Disorder Services, preventive and specialty care, as needed; d. Coordination of discharge planning and follow-up to care post inpatient discharge; e. Coordination of discharge planning and follow-up to care post discharge from a PRTF; f. Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; Developing, planning and assisting Members with information about community-based, free care initiatives and support groups; g. Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement; h. When requested by individuals, identifying participating Providers, facilitating access and assisting with appointment scheduling when necessary; i. Providing information about the availability of services and access to those services; j. Working with Members, Providers, and other Contractors to ensure continuity of care; and k. Monitoring and following up with Members and Providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate. (pp. 117-120, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

The Contractor shall provide Members assigned to the high risk level all the services included in the low risk and medium risk levels and the following services, at a minimum: a. As appropriate, form inter-disciplinary treatment teams to assist with development and implementation of individual medical treatment plans; b. Provide list of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.; c. Identify Providers with special accommodations (e.g., sedation dentistry); d. Educate staff about barriers Members experience in making and keeping appointments; e. Facilitate group visits to encourage self-management of various physical, substance use disorder, and behavioral health conditions/diagnoses such as pregnancy, diabetes and tobacco use; and f. Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP. (p. 122, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹²⁴ 3. Perinatal High Risk Management/Infant Services System The Contractor shall coordinate with the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will provide case management services to those Members, and the Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. Should the Members have additional needs; the Contractor will provide additional case management and coordinate with the MSDH case managers to create an individual medical treatment plan for the Members. Members shall have freedom of choice regarding PHRM/ISS services provided by MSDH or the Contractor. Should the Member choose PHRM/ISS services through the MSDH, the Contractor will conduct health care assessments for pregnant women and offer the women the option of case management by either the Contractor or the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will coordinate with MSDH to confirm

the case manager will support all of the Members' health care needs. The Contractor will coordinate with the MSDH, as specified by the Division. (p. 122, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

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

¹²⁵ E. Behavioral Health/Substance Use Disorder The Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in the MississippiCAN Program in accordance with 42 C.F.R. § 438.3 and the Mental Health Parity and Addiction Equity Act (MHPAEA). The Contractor shall comply with all requirements related to Care Management, access and availability with respect to Behavioral Health/Substance Use Disorder Services. All Behavioral Health/Substance Use Disorder Services covered by the Division for enrolled populations that are medically necessary must be covered. The Contractor's provision of Behavioral Health/Substance Use Disorder services shall fully comply with the requirements set forth in 42 C.F.R. §§ 438.900 through 438.930. All Contract requirements herein shall apply to the provision of Behavioral Health/Substance Use Disorder Services unless specified. Division policy regarding Behavioral Health/Substance Use Disorder Services is referenced in the Mississippi Administrative Code, Title 23, Part 206, but other sections of the code may also reference Behavioral Health/Substance Use Disorder Services. (pp. 55-56, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹²⁶ 5. Transition of Care Contractor Requirements. . . For members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care provider and any provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder through the postpartum period. (pp. 125-126, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹²⁷ E. Behavioral Health/Substance Use Disorder The Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in the MississippiCAN Program in accordance with 42 C.F.R. § 438.3 and the Mental Health Parity and Addiction Equity Act (MHPAEA). The Contractor shall comply with all requirements related to Care Management, access and availability with respect to Behavioral Health/Substance Use Disorder Services. All Behavioral Health/Substance Use Disorder Services covered by the Division for enrolled populations that are medically necessary must be covered. The Contractor's provision of Behavioral Health/Substance Use Disorder services shall fully comply with the requirements set forth in 42 C.F.R. §§ 438.900 through 438.930. All Contract requirements herein shall apply to the provision of Behavioral Health/Substance Use Disorder Services unless specified. Division policy regarding Behavioral Health/Substance Use Disorder Services is referenced in the Mississippi Administrative Code, Title 23, Part 206, but other sections of the code may also reference Behavioral Health/Substance Use Disorder Services. (pp. 55-56, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹²⁸ 5. Transition of Care Contractor Requirements. . . For members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care provider and any provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder through the postpartum period. (pp. 125-126, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹²⁹ The Contractor shall provide Members assigned to the high risk level all the services included in the low risk and medium risk levels and the following services, at a minimum:... b. Provide list of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.; (p. 122, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

6. Care Management The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. The Contractor will develop and implement a Care Management system to ensure and promote:... e. Coordination with appropriate resources to reduce socioeconomic disparities, including... nutrition programs. (p. 151, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹³⁰ 2. Care Management Services Member information shall be maintained by the Contractor and accessible twenty- four (24) hours per day seven (7) days per week by members of the Care Management Team. The Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services:... f. Coordination with other health and social programs such as... the Special Supplemental Food Program for Women, Infants, and Children (WIC)... (p. 120, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹³¹ The Member Handbook must include at a minimum the following information:...8. Member Services:... A description of all available covered services, including... dental... (pp. 72-73, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹³² 10.3 Coordination and Continuity of Care ... (A) MCO shall ensure access to a coordinated, comprehensive, and continuous array of needed services through coordination with other appropriate entities. ... 10.3.2 Primary Care (A) MCO shall implement procedures to deliver Primary Care to and coordinate Health Care Services for all Enrollees. The procedures shall ensure that each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the Health Care Services furnished to the Enrollee. (pp. 94-95, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

¹³³ 4.3 Mental Health and Substance Use Disorder Benefits MCO must provide Mental Health or Substance Use Disorder Benefits to Enrollees in every classification (inpatient, outpatient, emergency care, or prescription drugs) in which Medical/Surgical Benefits are provided as in accordance with applicable laws and regulations including 42 CFR § 438.910(b)(2) and 45 CFR § 146.136(c)(2)(ii). (p. 40, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

¹³⁴ 4.3 Mental Health and Substance Use Disorder Benefits MCO must provide Mental Health or Substance Use Disorder Benefits to Enrollees in every classification (inpatient, outpatient, emergency care, or prescription drugs) in which Medical/Surgical Benefits are provided as in accordance with applicable laws and regulations including 42 CFR § 438.910(b)(2) and 45 CFR § 146.136(c)(2)(ii). (p. 40, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

¹³⁵ C. Section IV.L.1.I – Care Management I. MCOs are required to provide care management to all members. Care management should include, but is not limited to, a set of processes that arrange, deliver, monitor, and evaluate benefit of medical and social services provided to a member. Care management planning must include resources that help identify the care management needs of a member through the following: Homeless identification form; Self-identification forms provided to the patient in the member benefit packet; HRS; MCO specific health risk assessment; Medical records; Predictive analytic tools which are technology-based patient stratification tools that help identify high-risk and rising risk members; Historical claims data; Provider referrals; State-wide HIE; State-registries; PDMP i. Ongoing engagement with the member through care management as described in Section IV.L. Care Management. ii. The MCO must respond to MLTC requests for supporting documentation to support periodic audits. Care management plans are: Ongoing and modified as needed, to meet the changing needs of the patient Comprehensive;

Evidence-based; Care coordination with multi-disciplinary care teams, which at a minimum includes clinical and behavioral health services, psychosocial needs, referrals and care transition management. Appropriate interventions that will reduce health risks and decrease the cost of care.

D. Section IV.L.1.m – Case Management 1. Any Heritage Health Adult (HHA) expansion group member may be reviewed by MLTC for medical complexity during any time of the member's enrollment, and as a result the MCO will provide MLTC any requested clinical documentation necessary to review patient for medical complexity and MCO care or case management of that member. 2. Case management planning must include resources that help identify the case management needs of a member through the following: a. Homeless self-identification form b. Self-identification forms provided to the member in the member benefit packet c. HRS d. MCO specific health risk assessment e. Medical records f. Predictive analytic tools which are technology-based patient stratification tools that help identify high-risk and rising risk members g. Historical claims data h. Provider referrals i. State-wide HIE j. State-registries k. PDMP 3. Case management activities that must be performed include: a. The MCO must assist members who self-identify as medically complex either in conversation with the MCO staff or through self-identification form in the member benefit packet. b. The MCO must administer Health Risk Screenings which includes, but is not limited to, the MLTC defined and required HRS questions. i. This also includes obtaining documentation collected by the member related to the medically complex condition(s). ii. MCO must perform the required MCO action(s) based on the member responses to the HRS. c. Performing periodic evaluation of the member's historical claims data, including diagnosis information that is current and verified, within a 12 month look back as defined in the medically complex guidance policy. d. Ongoing engagement with the member through care and case management as described in Section IV.L. Care Management. e. Enroll the HHA member that is determined to be medically complex in active care/case management as described in Section IV.L. Care Management f. The MCO must provide case management to medically complex members according to the specifications included in the Medically Complex Guidance policy. (pp. 1-3, Effective 2021, Amendment #21, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

¹³⁶ Notification of Pregnancy (NOP) Incentive. Early Submission of NOPs allow for earlier member screening and enrollment into Care Management services. NTC will encourage providers and office staff to submit NOPs as early as possible during the member's pregnancy. (p. 1255, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

Nebraska Total Care's Care Management Program NTC will design and implement a CM program to monitor and coordinate care for members identified as having special health care needs such as...high-risk pregnancy (p. 1400, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

Our Start Smart for Baby Perinatal and NICU Management program emphasizes early identification and stratification of pregnant members, and education and CM interventions to improve birth outcomes for all pregnant members. The program serves as the umbrella for all our perinatal management efforts. Start Smart staff assist members...to access prenatal and post-partum care, provide education on their healthcare needs, address social needs and concerns, and connect members to appropriate specialists and non-covered services, such as specialty behavioral health and SUD services and dental services, and community resources (p. 1408, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

¹³⁷ Covered Services and Benefits ...Behavioral health services... (pp. 122-124, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

¹³⁸ Our Start Smart for Baby Perinatal and NICU Management program emphasizes early identification and stratification of pregnant members, and education and CM interventions to improve birth outcomes for all pregnant members. The program serves as the umbrella for all our perinatal management efforts. Start Smart staff assist members...to access prenatal and post-partum care, provide education on their healthcare needs, address social needs and concerns, and connect members to appropriate specialists and non-covered services, such as specialty behavioral health and SUD services and dental services, and community resources (p. 1408, no date, Nebraska Total Care Inc. Medicaid Managed Care RFP)

6. Special Considerations for Pregnant Members...The MCO must screen members for the DHHS Division of Behavioral Health Women's Set Aside program and make referrals to the Division of Behavioral Health (DBH) as appropriate (p. 2427, no date, Nebraska Total Care Inc. Medicaid Managed Care Contract RFP)

¹³⁹ Our Start Smart for Baby Perinatal and NICU Management program emphasizes early identification and stratification of pregnant members, and education and CM interventions to improve birth outcomes for all pregnant members. The program serves as the umbrella for all our perinatal management efforts. Start Smart staff assist members...to access prenatal and post-partum care, provide education on their healthcare needs, address social needs and concerns, and connect members to appropriate specialists and non-covered services, such as speciality behavioral health and SUD services and dental services, and community resources (p. 1408, no date, Nebraska Total Care Inc. Medicaid Managed Care RFP)

Our Perinatal SUD Management program will provide education and resource linkage, and connect pregnant members with SUD to intensive outpatient and partial hospitalization programs... (p. 1408, no date, Nebraska Total Care Inc. Medicaid Managed Care RFP).

¹⁴⁰ Covered Services and Benefits... Nutrition services (pp. 122-123, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

¹⁴¹ 6. Special Considerations for Pregnant Members...Appropriate referrals must also be made to the WIC program for nutritional access and other needed community resources (p. 2427, no date, Nebraska Medicaid Managed Care Contract RFP).

¹⁴² Our Start Smart for Baby Perinatal and NICU Management program emphasizes early identification and stratification of pregnant members, and education and CM interventions to improve birth outcomes for all pregnant members. The program serves as the umbrella for all our perinatal management efforts. Start Smart staff assist members...to access prenatal and post-partum care, provide education on their healthcare needs, address social needs and concerns, and connect members to appropriate specialists and non-covered services, such as specialty behavioral health and SUD services and dental services, and community resources (p. 1408, no date, Nebraska Total Care Inc. Medicaid Managed Care Contract RFP)

¹⁴³ 4.10.1.3 The MCO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level. 4.10.1.4 The MCO shall either provide these services directly or shall Subcontract with Local Care Management Networks entities as described in Section 4.10.8 (Local Care Management) to perform Care Coordination and Care Management functions. 4.10.1.5 [Amendment #2:1 Care Coordination means the interaction with established local community-based Providers of care including Local Care Management Networks to address the physical, mental and psychosocial needs of the Member. 4.10.1.6 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's physical, mental. Substance Use Disorder status and needed social supports that shall enable the Member in achieving the best health outcomes....4.10.1.8 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, behavioral health Providers, and social service resources; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care. (pp. 190-191, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum: 4.10.6.4.1 Coordination of physical, mental health. Substance Use Disorder and social services; 4.10.6.4.2 Quarterly medication reconciliation; 4.10.6.4.3 Monthly telephonic contact with the Member; 4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants; 4.10.6.4.5 Referral follow-up monthly; 4.10.6.4.6 Peer support; 4.10.6.4.7 Support for unmet resource needs; 4.10.6.4.8 Training on disease self-management, as relevant; and 4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management). 4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to, the Member, caretaker(s), PCP, behavioral health Provider(s), specialist(s), HCBS case managers, school personnel as needed, nutritionist(s), and/or pharmacist(s). 4.10.6.6 The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. 4.10.6.7 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective health care including how the Care

Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports. 4.10.6.8 The MCO shall develop a care plan, within 30 calendar days of the completed Comprehensive Assessment, for each high-risk/high need Member identified through a Comprehensive Assessment who is in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)] 4.10.6.9 The MCO's care plan shall be regularly updated and incorporate input from the local community based care team participants and the Member. The care plan shall be comprehensively updated: 4.10.6.9.1 At least quarterly; 4.10.6.9.2 When a Member's circumstances or needs change significantly; 4.10.6.9.3 At the Member's request; 4.10.6.9.4 When a re-assessment occurs; and 4.10.6.9.5 Upon DHHS's request. 4.10.6.10 The care plan format shall be submitted to DHHS for review as part of the Readiness Review process and annually thereafter. 4.10.6.11 The MCO shall track the Member's progress through routine care team conferences, the frequency to be determined by the MCO based on the Member's level of need. 4.10.6.12 The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the care team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring. 4.10.6.13 Policies and procedures for discharge shall include a Member notification process. 4.10.6.14 For high-risk/high-needs Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)] 4.10.6.15 The MCO shall ensure that each Provider furnishing services to Members maintains and shares a Member health record in accordance with professional standards. [42 CFR 438.208(b)(5)] (pp. 201-202, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁴ 2.1.99 Priority Population 2.1.99.1 "Priority Population" means a population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults and Children with Special Health Care Needs, including, but not limited to... pregnant women with Substance Use Disorder; (p. 30, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁵ 1.2 Overview of Covered Services 4.1.2.1 The MCO shall cover the physical health, behavioral health...benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.11 (Behavioral Health)...(p. 79, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.11.1.5 The MCO shall be responsible for providing a full continuum of...Behavioral Health Services; ensuring continuity and coordination between covered physical health and Behavioral Health Services; and requiring collaboration between physical health and behavioral health Providers. (p. 214, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

11.1.9 Promotion of Integrated Care 4.11.1.9.1 The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible. (p. 215, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.11.1.14 Referrals 4.11.1.14.1 The MCO shall ensure through its Health Risk Assessment Screening (described in Section 4.10.2) and its Risk Scoring and Stratification methodology that Members with a potential need for Behavioral Health Services, particularly Priority Population Members as described in Section 4.10.3 (Priority Populations), are appropriately and timely referred to behavioral health Providers if co-located care is not available. 4.11.1.14.2 This shall include education about Behavioral Health Services, including the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s). (p. 220, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁶ MCO Covered Services: Substance Use Disorder Services (Per He-W 513) - including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver (p. 83, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.1.8.11 The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening: 4.1.8.11.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders; (p. 92, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.4.4 Welcome Call 4.4.4.4.1 The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO... 4.4.4.4.2.2. Arrange for a wellness visit with the Member's PGP (either previously identified or selected by the Member from a list of available POPs), which shall include: 4.4.4.4.2.2.2 Screening for... Substance Use Disorder (p. 132, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.7.5.19 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission. (p. 169, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.2 Health Risk Assessment Screening... 4.10.2.13 The evidence-based Health Risk Assessment Screening tool shall Identify, at minimum, the following information about Members:... 4.10.2.13.5 Behavioral health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services); (p. 193, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.2.14 Wellness Visits... 4.10.2.14.2 The wellness visit shall include appropriate assessments for the purpose of developing a health wellness and care plan:... 4.10.2.14.2.3. Substance Use Disorder. (p. 194, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁷ 4.10.3 Priority Populations 4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:... 4.10.3.1.5 Individuals with high unmet resources needs meaning MCM Members who are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 {Coordination and Integration with Social Services and Community Care}; 4.10.3.1.5.3. Pregnant women with Substance Use Disorders; (p. 195, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.7.5.23 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall: 4.7.5.23.1 Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member; 4.7.5.23.2 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week: Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs. 4.7.5.24 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation (pp. 169-170, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁸ 4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to... nutritionist(s) (p. 201, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.10.6 The MCO shall develop relationships that actively link Members with other State, local, and community programs that may provide or assist with related health and social services to Members including, but not limited to:... 4.10.10.6.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children... nutrition assistance programs (p. 213, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.1.3.5 In Lieu Of Services... 4.1.3.5.3 DHHS has authorized medical nutrition, diabetes self-management... as In Lieu Of Services. (p. 84, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁴⁹ 4.6.5 CARE MANAGEMENT The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. A. Care Management Standards. Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will: · Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status. · Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change. · Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.... B. Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components: · Identification of Enrollees who need Care Management; · Comprehensive Needs Assessment; · Care Plan development; · Implementation of Care Plan; · Analysis of the effectiveness and appropriateness of Care Plan; · Modification of Care Plan based on the analysis; and · Monitor Outcomes. (pp. 99-100, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵⁰ R. Mental Health and Substance Use Disorder (SUD) Benefits 1. For all SUD services, the Contractor may contact State's IME to inquire about available and medically appropriate community resources. 2. Effective October 1, 2018, the Contractor shall be responsible for the provision of all additional behavioral health services included in the alignment of DDD and FIDE-SNP behavioral health benefits with those of Members eligible for MLTSS, as well as the provision of all in-patient hospital services for the entire managed care population (as identified in Section 4.1.2A.27 and A.31 and elsewhere in the Contract and State guidance). This will allow the Contractor adequate opportunity until September 30, 2018 for the purposes of Provider contracting, Member education, incorporating Stakeholder input, and for the State to complete its extended readiness review of the Contractor prior to the Contractor's assumption of responsibility for providing these services. (p. 7, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

4.4.5 COORDINATION WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES The State shall retain a separate Mental Health/Substance Use Disorder system for the coordination and monitoring of most mental health/substance use disorder conditions. The Contractor shall furnish MH/SUD services to DDD clients and MLTSS Members as specified in Article 4.4. However, as described below, the Contractor shall retain responsibility for MH/SUD screening, referrals, prescription drugs, and for treatment of the conditions identified in Article 4.1.2B. (p. 61, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵¹ F. Centering. The Contractor shall provide pregnant female Members the option of attending "Centering" group prenatal care at a site accredited by the Centering Healthcare Institute. The center shall utilize the Centering Pregnancy model and incorporate the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each visit. The program consists of ten (10) prenatal visits, each 90 minutes - two hours long, where Providers engage in health assessments and group education/discussion that covers topics including but not limited to... stress management... Sessions are held in a group setting consisting of 2-20 women. (p. 31, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵² R. Mental Health and Substance Use Disorder (SUD) Benefits 1. For all SUD services, the Contractor may contact State's IME to inquire about available and medically appropriate community resources. 2. Effective October 1, 2018, the Contractor shall be responsible for the provision of all additional behavioral health services included in the alignment of DDD and FIDE-SNP behavioral health benefits with those of Members eligible for MLTSS, as well as the provision of all in-patient hospital services for the entire managed care population (as identified in Section 4.1.2A.27 and A.31 and elsewhere in the Contract and State guidance). This will allow the Contractor adequate opportunity until September 30, 2018 for the purposes of Provider contracting, Member education, incorporating Stakeholder input, and for the State to complete its extended readiness review of the Contractor prior to the Contractor's assumption of responsibility for providing these services. (p.7, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵³ Health promotion topics shall include, but are not limited to, the following:... C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs)... Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish), Diabetes Self-Management Program (DSMP), Medical Nutritional Therapy (MNT), Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). (p. 50, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

N. Home Delivered Nutrition The provision of nutritionally adequate meals which assure, at a minimum, one-third of the Dietary Reference Intakes (DRI) to older persons in their places of residence. Home Delivered Nutrition services shall meet or exceed the following standards: 1. Persons eligible for home delivered meals are those individuals age eighteen (18) and older: • Who are homebound; refer to Article 1 Definitions; • Incapacitated due to accident, illness, or frailty; • Unable to prepare meals because of lack of facilities, inability to shop or cook for self, unable to prepare meals safely, or lack knowledge and skills to prepare meals; • Lacking support from family, friends, neighbors, PCA or other caregivers to consistently provide daily meal preparation and preference. • Receives PCA services less than five (5) hours a day and the aide's hours are all allocated to IADL and ADL needs besides meal preparation. • If individual requires nutritional assistance or meal preparation; it must be identified in the Plan of Care. o The Plan of Care will address who is cooking and preparing meals, individual's meal preferences, and access to home delivered meals if there is no formal or informal support to consistently provide daily meal preparation and preferences. 2. Each meal must contain at least one-third of the current Dietary Reference Intakes (DRI), as established by the Food and Nutrition Board, National Research Council, National Academy of Sciences. 3. The Provider of Home Delivered meals must certify and document the meals as meeting DRI standards by a qualified nutritionist. 4. Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal per day based on the enrollees assessed needs and/or meal preference. 5. An in home assessment is required, to determine if a weekly or biweekly delivery of refrigerated or frozen meals is suitable for the participant. Specifically: • The client indicates a preference for refrigerated /frozen meal; • The client must demonstrate the ability to properly store bulk delivered refrigerated or frozen meals; this includes the capacity or means to physically move and store the meals; • The client must have the needed appliance to safely prepare the frozen meals and must demonstrate their ability in using the appliance safely; 6. Arrangements shall be made for safety protocols through services such as personal emergency response systems (PERS) or friendly volunteer outreach for participants who choose weekly or biweekly delivery who live alone and are identified as having risk factors through the risk assessment and risk management agreement processes. 7. When feasible and appropriate, programs should make arrangements for the availability of meals to older persons during weather-related emergencies. Examples of suitable emergency meals include: shelf stable meals, cold meal or delivery of an extra meal that can be refrigerated and heated the following day. 8. An individual delivering daily meals must bring to the attention of appropriate

officials, conditions or circumstances that place the older person or household in imminent danger. 9. The home delivered meal provider must be in compliance with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." (pp. 43-44, Article 9, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Provider Specifications: · All Home Delivered Nutrition providers must ensure that the meals meet one-third (1/3) RDI requirements and all food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." Additionally, the State Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action when conditions warrant. · Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal per day based on the enrollees assessed needs. Examples of Potential Providers: · Area Agency on Aging (AAA) Title III Nutrition Providers · Local or national providers of refrigerated/frozen home delivered meals (p. 841, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵⁴ REFERRAL/NUTRITION ASSESSMENT FOR WOMEN (p. 674, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Health promotion topics shall include, but are not limited to, the following:... C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). (p. 50, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

K. WIC Program Requirements/Issues. The Contractor shall require its providers to refer potentially eligible women (pregnant, breast-feeding and postpartum), infants, and children up to age five, to established community Women, Infants and Children (WIC) programs. The referral shall include the information needed by WIC programs in order to provide appropriate services. The required information to be included with the referral is found on the sample forms in Section B.4.8 of the Appendices, the New Jersey WIC program medical referral form, and must be completed with the current (within sixty (60) days) height, weight, hemoglobin, or hematocrit, and any identified medical/nutritional problems for the initial WIC referral and for all subsequent certifications. (p. 120, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

F. Centering. The Contractor shall provide pregnant female Members the option of attending "Centering" group prenatal care at a site accredited by the Centering Healthcare Institute. The center shall utilize the Centering Pregnancy model and incorporate the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each visit. The program consists of ten (10) prenatal visits, each 90 minutes - two hours long, where Providers engage in health assessments and group education/discussion that covers topics including but not limited to, nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care. Sessions are held in a group setting consisting of 2-20 women. (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵⁵ G. Dental Services. Reimbursement for dental services in progress that require multiple visits to complete and are provided to eligible NJFC members who have a change in enrollment between NJFC Fee for Service non-managed care program (NJFC FFS) and a NJFC MCO or between NJFC MCOs shall be allowed. These dental services will include those services that require more than one visit to complete and will include but are not limited to crowns (cast, porcelain fused to metal and ceramic), cast post and core, endodontic treatment and fixed and removable prosthetics. Payment is based on service being approved and provided or started during a period of eligibility. Reimbursement will be made by the MCO or FFS of program of changed

enrollment. Information for orthodontic services under these circumstances is located in section B.4.1. Benefit Package. When orthodontic services are paid at a case rate, treatment shall continue within the time period covered by the payment.... (pp. 3-4, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

D. Dental access - On an annual basis, the Contractor shall ensure that all members with dental benefits are notified of the participating dental providers in their geographic area. With regard to children of EPSDT age, the Contractor shall ensure that information on oral health, the importance of a dental visit by 12 months of age, early childhood caries prevention, good oral health habits, dental safety and treatment of dental emergencies are also routinely communicated. (p. 6, Article 3, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

The Contractor shall develop specific policies and procedures for the provision of dental services to Enrollees with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. At a minimum, the policies and procedures shall address: ...4. Provisions for visits to a Enrollee's place of residence, long term care facility, skilled nursing facility or medical day care facility when medically necessary and where available. The contractor must monitor on an annual basis the standard of dental care rendered and ensure that needed referrals for dental treatment that cannot be provided by a mobile dental practice occur. Dental services may be provided in these settings through the following modalities. (pp. 66-67, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁵⁶ 4.5.10 Care Coordination 4.5.10.1 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement. 4.5.10.2 Section 7.2.9 of this Agreement details which care coordination services will be deemed medical expenses and which will be deemed administrative expenses in determining the CONTRACTOR's Medical Expense Ratio. (pp. 89-90, no date, New Mexico Amended Version Sample RFP)

¹⁵⁷ 4.3.5 Care Coordination Level 2 and Level 3. For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:... 4.4.3.5.5 Is identified as having a high risk pregnancy; 4.4.3.5.5.1 Pregnant members 18 years of age and younger (p. 50, no date, New Mexico Amended Version Sample RFP)

4.4.6 Requirements for Care Coordination Level 2 4.4.6.1 Based on the Comprehensive Needs Assessment, the CONTRACTOR shall assign care coordination level 2, at a minimum, to Members with one of the following:... 4.4.6.1.7 High risk pregnancy including pregnant members who are eighteen (18) years and younger...4.4.6.3 Care coordinators for Members in care coordination level 2 shall provide and/or arrange for the following care coordination services: 4.4.6.3.1 Development and implementation of a CCP; 4.4.6.3.2 Monitoring of the CCP to determine if the CCP is meeting the Member's identified needs; 4.4.6.3.3 Assessment of need for assignment to a Health Home; 4.4.6.3.4 Targeted Health Education, including disease management, based on the Member's individual diagnosis (as determined by the Comprehensive Needs Assessment); 4.4.6.3.5 Annual Comprehensive Needs Assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed; 4.4.6.3.6 Semi-annual in-person and in-home visits with the Member; 4.4.6.3.7 Two telephonic contacts shall occur as follows: (1) 60-90 Calendar Days, and (2) 240-270 Calendar Days, from the most recent CNA (pp. 53-54, no date, New Mexico Amended Version Sample RFP)

4.8.15.3.1 Families First Program: The DOH Families First program provides case management functions to Prenatal and Pediatric members. 4.8.15.3.1.1 Prenatal members are typically seen four times during the pregnancy/postpartum and the postpartum visit is conducted in the Member's home with the member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit. (p. 120, no date, New Mexico Amended Version Sample RFP)

4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize

participation....4.13.4.5.2 Targeted Case Management: These services include activities such as conducting a comprehensive history and assessment (in place of CNA), developing an individualized care plan, providing referrals and scheduling treatment services, linking members to necessary community resources, monitoring, and follow-up activities. (pp. 160-161, no date, New Mexico Amended Version Sample RFP)

¹⁵⁸ Non-Community Benefit Services Included Under Centennial Care... Behavioral Health Professional Services: outpatient behavioral health and substance abuse services (p. 298, no date, New Mexico Amended Version Sample RFP)

¹⁵⁹ 4.3.5 Care Coordination Level 2 and Level 3. For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:... 4.4.3.5.5 Is identified as having a high risk pregnancy; 4.4.3.5.5.1 Pregnant members 18 years of age and younger (p. 50, no date, New Mexico Amended Version Sample RFP)

4.4.5 Comprehensive Needs Assessment for Care Coordination Level 2 and Level 3 ...4.4.5.5 At a minimum, the CNA shall: 4.4.5.5.1 Assess physical and Behavioral Health needs including but not limited to: current diagnosis; history of significant physical and Behavioral Health events including hospitalizations; medications; allergies; providers; Durable Medical Equipment (DME); substance abuse screen (CAGE); family history; cognitive ability; health-related lifestyle (smoking, food intake, sleep patterns, continence); ...4.4.5.5.2.2 Identify any primary caregiver training needs and resources available for training such as the Savvy Caregiver Program, CPR, First Aid, Mental Health First Aid, etc. 4.4.5.5.3 Include a risk assessment using a tool and protocol approved by HSD and develop, as applicable, a risk agreement that shall be signed by the Member or his or her Representative and that shall include identified risks to the Member the consequences of such risks, strategies to mitigate the identified risks, and the Member's decision regarding his or her acceptance of risk; ... 4.4.5.5.6 Identify possible suicidal and/or homicidal thinking and/or planning; (pp. 51-52, no date, New Mexico Amended Version Sample RFP).

4.13.4.5 Activities that may be conducted as part of the visits include, but are not limited to: 4.13.4.5.1 Screening: HV services include best practice guidelines and standards for screening services. These include screenings for pregnant mothers to help identify services or resource supports needed to prevent, assess and treat maternal problems such as high-risk pregnancy, depression, trauma, intimate partner violence, and mental health and substance use disorders and may also include home and family relationship assessment. (p. 161, no date, New Mexico Amended Version Sample RFP)

¹⁶⁰ Non-Community Benefit Services Included Under Centennial Care... Behavioral Health Professional Services: outpatient behavioral health and substance abuse services (p. 298, no date, New Mexico Amended Version Sample RFP)

¹⁶¹ 4.3.5 Care Coordination Level 2 and Level 3. For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:... 4.4.3.5.5 Is identified as having a high risk pregnancy; 4.4.3.5.5.1 Pregnant members 18 years of age and younger (p. 50, New Mexico Amended Version Sample RFP, 2022).

4.4.5 Comprehensive Needs Assessment for Care Coordination Level 2 and Level 3 ...4.4.5.5 At a minimum, the CNA shall: 4.4.5.5.1 Assess physical and Behavioral Health needs including but not limited to:...substance abuse screen (CAGE); (pp. 51-52, no date, New Mexico Amended Version Sample RFP)

4.13.4.5 Activities that may be conducted as part of the visits include, but are not limited to: 4.13.4.5.1 Screening: HV services include best practice guidelines and standards for screening services. These include screenings for pregnant mothers to help identify services or resource supports needed to prevent, assess and treat maternal problems such as... substance use disorders.... (p. 161, no date, New Mexico Amended Version Sample RFP)

4.8.5.2 The PCP shall refer a Member for Behavioral Services based on the following indicators:... 4.8.5.2.15 A prenatal visit indicates substance abuse problems; (pp. 110-111, no date, New Mexico Amended Version Sample RFP)

¹⁶² Non-Community Benefit Services Included Under Centennial Care... Nutritional Services (p. 299, New Mexico Amended Version Sample RFP, 2022).

Self-Directed Community Benefit Services Included Under Centennial Care...Nutritional Counseling (p. 300).

Adult Benefit Plan Services Included Under Centennial Care... Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity (p. 315).

SDCB Service Description... Nutritional supplements... Billing Code... T1999 (p. 329).

4.8.15 Shared Responsibility Between the CONTRACTOR and Public Health Offices ...4.8.15.1.5 Referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants, and Children (WIC); 4.8.15.1.6 Health Education services for individuals and families with a particular focus on injury prevention including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition, and substance use (pp. 119-120).

4.4.9.6.11 Other services that will be provided to the Member, including Covered physical and Behavioral Health Services that will be provided by the CONTRACTOR to help the Member maintain or improve his or her physical or Behavioral Health status or functional abilities and maximize independence, as well as other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, and any non-Covered Services including services provided by other community resources, including plans to link the Member to financial assistance programs including but not limited to housing, utilities and food as needed; (p. 59).

¹⁶³ 4.3.5 Care Coordination Level 2 and Level 3. For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:... 4.4.3.5.5 Is identified as having a high risk pregnancy; 4.4.3.5.5.1 Pregnant members 18 years of age and younger (p. 50, New Mexico Amended Version Sample RFP, 2022).

4.4.5 Comprehensive Needs Assessment for Care Coordination Level 2 and Level 3...4.4.5.5 At a minimum, the CNA shall: ... 4.4.5.5.5 Determine a social profile including but not limited to: living arrangements; demographics; transportation; employment; natural supports; financial resources (other insurance, food, utilities); Medicare services; other community resources in place such as senior companion or meals-on-wheels; living environment (related to health and safety); IADLs, Individualized Education Plan (IEP); Individual Service Plan (ISP) for DD or medically fragile Members (if applicable) (pp. 51-52, New Mexico Amended Version Sample RFP, 2022).

¹⁶⁴ Non-Community Benefit Services Included Under Centennial Care... Dental Services (p. 298, New Mexico Amended Version Sample RFP, 2022).

Adult Benefit Plan Services Included Under Centennial Care...Dental services (p. 314).

¹⁶⁵ 7.5.6. Care Management 7.5.6.1. Care Management comprises the Contractor's clinical programs that must include, at a minimum, Level 1 Care Coordination and Level 2 Case Management as described in this section. 7.5.6.2. The Contractor must put a system in place that promotes continuity of care and Care Management. The Contractor must take a comprehensive and collaborative approach to coordinate care for the populations and conditions as specified by the State through effective Care Coordination and Case Management programs, partnerships with PCPs and Specialists, other Providers, Members, Member/family outreach and education, and the ability to holistically address Member health care needs. Care Coordination or Case Management must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including Behavioral Health and related issues, such as lack of social or family support. 7.5.6.3. The Contractor will have a geographically based Case Manager for in-person assistance. Upon request of the State, Case Managers must be available to conduct home visits of Members within forty-eight (48) hours of identification as high-risk for serious health, safety and welfare issues. (p. 144, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

See pages 144-161 for complete details on the state's case management and care coordination programs.

¹⁶⁶ 7.4.8.3. In addition to routine Care Coordination with other vendors or entities, the Contractor is responsible for designating a specific clinician or case manager to ensure continuity of services for Members with special needs. These Members may include, but are not limited to...women with high-risk pregnancies). Care Coordination must address critical issues such as out-of-home placement, specialized mental health services and therapies, and needs that may typically be filled by community resources and social service programs. (p.132, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.5. Health Needs Assessment The Contractor must conduct a Health Needs Assessment Screening for all new Members with the following timeframes from the date of enrollment with the Contractor: 7.5.5.1. The Contractor must arrange for or conduct an initial screening assessment of new Members, to confirm the results of a positive identification and to determine the need for Care Coordination and/or Case Management services within sixty (60) Calendar Days of enrollment. Screening assessment for pregnant women... must be conducted within thirty (30) Calendar Days (p. 143, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

5.6. Care Management 7.5.6.1. Care Management comprises the Contractor's clinical programs that must include, at a minimum, Level 1 Care Coordination and Level 2 Case Management as described in this section. 7.5.6.2. The Contractor must put a system in place that promotes continuity of care and Care Management. The Contractor must take a comprehensive and collaborative approach to coordinate care for the populations and conditions as specified by the State through effective Care Coordination and Case Management programs, partnerships with PCPs and Specialists, other Providers, Members, Member/family outreach and education, and the ability to holistically address Member health care needs. Care Coordination or Case Management must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including Behavioral Health and related issues, such as lack of social or family support. 7.5.6.3. The Contractor will have a geographically based Case Manager for inperson assistance. Upon request of the State, Case Managers must be available to conduct home visits of Members within forty-eight (48) hours of identification as high-risk for serious health, safety and welfare issues. (p.144, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.6. Level 1 – Lower Risk: Care Coordination 7.5.6.6.1. Level 1- Care Coordination is designed to assist Members with social determinant of health needs, challenges in accessing health and community resources, or other Member needs that fragment the Member's care or lead to poor health outcomes. The Contractor must offer and provide Care Coordination to reduce fragmentation, improve Member's access to necessary services and address social determinant of health needs for eligible Members. 7.5.6.6.2. The Contractor's Care Coordination services are provided to Members who have short-term or intermittent needs for coordination of care, to limit Member and Provider confusion, the State requires Contractors to use the title "Care Coordinator" for staff who perform Care Coordination supports for Members as defined in this Contract. 7.5.6.6.3. A Care Coordinator for purposes of this Contract is a para-professional, whose background is most frequently anchored in the disciplines of social work or community health systems to improve health outcomes. Care Coordination services may be provided by non-licensed staff, including

Community Health Workers, Promotores or Peer Support Specialists, and Doulas for Contractors who may offer this service as a Value Added Service. 7.5.6.6.4. The type of interventions provided to Members under the Care Coordination program may include, but are not limited to: Coordinating the authorization of needed services such as timely approval of durable medical equipment, pharmacy, and medical supplies; Ensuring access to Medically Necessary physical health or Behavioral Health through assisting with appointments and transportation services; Providing coaching and social support; Providing coordination of Member's care with treating Providers such as primary care and Behavioral Health Services; Ensuring access to community based services and resources to address identified social or economic factors impacting the Member's health outcomes; Ensuring appropriate referrals are made and services are delivered, including any follow-up action; Providing Member education and resources to support Member shared decision-making; Screening for and addressing social determinants of health, including identification of community resources and actively linking Members to those resources; Following up after an emergency department visit to assist the Member in reengagement with primary care treating Providers; Providing culturally appropriate health education and information; and Provision of face-to-face Care Coordination and in the communities where Members reside... (pp. 148-149, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.2. The Contractor must offer a Case Management program for all Members identified as eligible within the Nevada Medicaid population that includes Case Management support for Members identified as high-risk. These populations include...Members experiencing a high-risk pregnancy. (p. 150, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.10. High Risk Maternal Case Management 7.5.6.7.10.1 The Contractor will make a good faith effort to screen Medicaid and CHIP pregnant Members for maternal high risk factors. 7.5.6.7.10.2. Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, Personal Care Services or Home Health care, substance abuse services, and Care Coordination services, in addition to maternity care. 7.5.6.7.10.3. All Case Management requirements and standards outlined within Section 7.5.6.7 apply to the Contractor's High Risk Maternal Care Management program. 7.5.6.7.10.4. Any identification of high-risk factors will require the PCP, OB/GYN Provider, Case Manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Contractor's High Risk Maternal Case Management Program 7.5.6.7.10.5. The Contractor must demonstrate ongoing and active efforts to educate Providers on how to make referrals to the Contractor's High Risk Maternal Case Management Program for Members identified as pregnant for screening. 7.5.6.7.10.6. As appropriate, the Contractor must assist the Member in contacting appropriate agencies for Care Coordination of noncovered/carved-out plan services or community health information. The Contractor's Case Manager will begin medical Case Management services for those risk factors identified. 7.5.6.7.10.7. The State and/or the External Quality Review Organization (EQRO) will conduct on-site reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies. (pp.152-153, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁶⁷ 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:... 7.4.2.1.7. Certified Community Behavioral Health Centers (CCBHCs); 7.4.2.1.25. Mental Health Services Inpatient Psychiatric Hospital; Inpatient Psychiatric Services; Mental Health Outpatient Clinic; Mental Health Rehabilitative Treatment; Psychologist; Outpatient Psychiatric; Residential Treatment Centers (RTC); Care Management; Medication Management; (pp. 99-100, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁶⁸ 7.5.6.7. Level 2 – High: Case Management... 7.5.6.7.7. Members are identified for Case Management through an array of methods including risk stratification, health needs assessment or other physical or Behavioral Health screenings, Provider referral, State agency referral, Member self-referral, or health event that triggers Case Management such as:... pregnant women with a Behavioral Health disorder, especially a substance use disorder. (p. 152, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁶⁹ 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following: ... 7.4.2.1.3. Alcohol and Substance Abuse Treatment, including Intensive Outpatient Treatment; ... 7.4.2.1.7. Certified Community Behavioral Health Centers (CCBHCs); 7.4.2.1.25. Mental Health Services Inpatient Psychiatric Hospital; Inpatient Psychiatric Services; 7.4.2.1.26. Methadone Treatment; ... 7.4.2.1.43. Special Clinics (e.g., Comprehensive Rehabilitation Facility, Genetics, Family Planning, Methadone Public Health Clinic, Community Health Clinic (State Health Division), School Based Health Centers, Special Children's Clinic, TB Clinic, HIV, Substance Abuse Agency Model); (pp. 99-101, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁷⁰ 7.5.6.7. Level 2 – High: Case Management... 7.5.6.7.7. Members are identified for Case Management through an array of methods including risk stratification, health needs assessment or other physical or Behavioral Health screenings, Provider referral, State agency referral, Member self-referral, or health event that triggers Case Management such as: ... pregnant women with a Behavioral Health disorder, especially a substance use disorder. (p. 152, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁷¹ 7.5.6.7.2. The Contractor must offer a Case Management program for all Members identified as eligible within the Nevada Medicaid population that includes Case Management support for Members identified as high-risk. These populations include Members with SED/SMI and Members with comorbid medical and Behavioral Health conditions, including substance use disorders, and Members experiencing a high-risk pregnancy.... 7.5.6.7.4. The Contractor's Case Management program must include, at a minimum, the following: ... The care treatment plan must also include coordination with State and county agencies, such as ADSD, DCFS, Governor's Office of Consumer Health Assistance (GovCHA), DPBH; DWSS, and SAPTA as well as other public assistance programs, such as the Women, Infant, Children (WIC) program; teen pregnancy programs; parenting programs; and Child Welfare programs. (pp. 150-151, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁷² 7.5.6.7.10. High Risk Maternal Case Management... 7.5.6.7.10.2 Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to... nutritional services... in addition to maternity care. (p. 152, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁷³ 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following: ... 7.4.2.1.9. Dental and Dental Related Services for emergency and palliative care that is provided in an emergent or urgent care setting; (p. 99, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁷⁴ App'x K.2. Prepaid Benefit Package Definitions of Covered Services. 6. Preventive Health Services.... K.2.6.b. The Contractor must offer the following preventive health services essential for promoting health and preventing illness: K.2.6.b.vii. Extended care coordination, as needed, for pregnant women. (pp. K-19, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁷⁵ App'x K. 29. Mental Health Services. 29.a. Inpatient Services. All inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the PHL . . . 29.b. Outpatient Services. Outpatient services including but not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, education, symptom management, case management services, crisis intervention and outreach services, clozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). (pp. K-38, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁷⁶ App'x K.2. Prepaid Benefit Package Definitions of Covered Services. 14. Home Health Services. K.2.14.d. The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status . . . (pp. K-26, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁷⁷ App'x K. 30. SUD Inpatient Detoxification Services. 30.a. Medically Managed Inpatient Detoxification. These programs provide medically directed twenty-four (24) hour care on an inpatient basis to individuals who are at risk of severe alcohol or substance abuse withdrawal, incapacitated, a risk to self or others, or diagnosed with an acute physical or mental co-morbidity. Specific services include, but are not limited to: medical management, bio-psychosocial assessments, stabilization of medical psychiatric / psychological problems, individual and group counseling, level of care determinations and referral and linkages to other services as necessary. Medically Managed Detoxification Services are provided by facilities licensed by OASAS under Title 14 NYCRR § 816.6 and the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law. 30.b. Medically Supervised Inpatient Withdrawal. These programs offer treatment for moderate withdrawal on an inpatient basis. Services must include medical supervision and direction under the care of a physician in the treatment for moderate withdrawal. Specific services must include, but are not limited to: medical assessment within twenty four (24) hours of admission; medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling and linkages to other services as necessary. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Inpatient Withdrawal services are provided by facilities licensed under Title 14 NYCRR § 816.7. K.31. SUD Inpatient Rehabilitation and Treatment Services. K.31.a. Services provided include intensive management of chemical dependence symptoms and medical management of physical or mental complications from chemical dependence to clients who cannot be effectively served on an outpatient basis and who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free-standing facility. Specific services can include, but are not limited to: comprehensive admission evaluation and treatment planning; individual group, and family counseling; awareness and relapse prevention; education about self-help groups; assessment and referral services; vocational and educational assessment; medically and psychiatric consultation; food and housing; and HIV and AIDS education. These services may be provided by facilities licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to provide Chemical Dependence Inpatient Rehabilitation and Treatment Services under Title 14 NYCRR Part 818. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. K.31.b. Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year. K.32. SUD Residential Addiction Services. The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Residential addiction services include individual centered residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus, designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help individuals achieve changes in their substance use disorder behaviors. Services also address an individual's major lifestyle, attitudinal, and behavioral problems that the potential to undermine the goals of treatment. These programs are certified under 14 NYCRR Part 820. K.33. SUD Outpatient Services. 33.a. Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs. Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 to deliver service to individuals who suffer from chemical abuse or dependence and/or their family members or significant others. Such services may be provided at the certified site or in the community include and provide chemical dependence outpatient treatment (including intensive outpatient services) and continuing care treatment. K.33.b. Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs. Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide outpatient rehabilitation services for individuals with more chronic SUD conditions and emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. The individual must have an adequate support system and either substantial deficits in interpersonal and functional skills or health care needs requiring attention or monitoring by health care staff. These services are provided in combination with all other clinical services provided by CD-OPs. Programs are certified by OASAS as Chemical Dependence Outpatient Rehabilitation programs under Title 14 NYCRR § 822. K.33.c. Outpatient Chemical Dependence for Youth Programs. Outpatient Chemical Dependence for Youth Programs (OCDY) licensed under Title 14 NYCRR Part 832, established programs and service regulations for OCDY programs. OCDY programs offer discrete, ambulatory clinic services to chemically-dependent youth in a treatment setting that supports abstinence from chemical dependence (including alcohol and substance abuse) services. K.33.d. Opioid Treatment Program (OTP). The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. Opioid Treatment Program (OTP) means one or more OASAS certified sites where methadone or other approved medications are administered to treat opioid dependency, following one or more medical treatment protocols as defined by 14 NYCRR Part 822. OTPs may provide patients with any or all of the following: Opioid detoxification; Opioid medical maintenance; and Opioid taper. The term "OTP" encompasses medical and support services at the certified site or in the community including counseling, educational and vocational rehabilitation. OTP also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 1301. Facilities that provide opioid treatment do so as their principal mission and are certified by OASAS under 14 NYCRR Part 822 . . . K.35. SUD Medically Supervised Outpatient Withdrawal. The Contractor shall commence covering this benefit on the effective date of Behavioral Health Benefit Inclusion. These programs offer treatment for moderate withdrawal on an outpatient basis. Required services include, but are not limited to: medical supervision of intoxication and

withdrawal conditions; bio-psychosocial assessments; individual and group counseling; level of care determinations; discharge planning; and referrals to appropriate services. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Outpatient Withdrawal services are provided by facilities licensed under 14 NYCRR §816.7. (pp. K-41-to-K-43, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁷⁸ 10.17. Contractor Responsibilities Related to Public Health. 10.17.g. The Contractor shall provide health education to Enrollees on an on-going basis through methods such as posting information on the Contractor's web site, distribution (electronic or otherwise) of Enrollee newsletters, health education, classes or individual counseling on preventive health and public health topics, such as . . . 10.17.g.xv. Physical fitness and nutrition. (pp. 10-14, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁷⁹ Section 10. Benefit Package Requirements. 10.25. Women, Infants, and Children. The Contractor shall develop linkage agreements or other mechanisms to refer Enrollees who are pregnant and Enrollees with children younger than five (5) years of age to WIC local agencies for nutritional assessments and supplements. (pp. 10-30, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁸⁰ 21.17. Dental Networks. 21.17.a. The Contractor's dental network shall include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their Service Area and to achieve a ratio of at least one (1) primary care dentist for each 2,000 MMC and/or Family Health Plus Enrollees and each 500 HIV SNP Enrollees. Networks must also include at least one (1) pediatric dentist and one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network should include dentists with expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients). (pp. 21-17-to-21-18, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹⁸¹ *See Appendix K, Quality of Care, for requirements and expectations regarding the MCO's responsibilities for developing a population health management program.* (pp. 135-152, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁸² 1. Basic Benefit Package... Services covered by the MCP benefit package shall include:... u. Behavioral health services, including those provided by Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified providers, as described in OAC Chapter 5160-27 for adult members and children not enrolled in the OhioRISE plan. For members under the age of 21 not enrolled in the OhioRISE plan, MCP covered behavioral health services include Child and Adolescent Needs and Strengths (CANS) assessments as described in OAC rule 5160-27-02 completed on or before the OhioRISE enrollment date and Mobile Response and Stabilization Services (MRSS) as described in OAC rule 5160-27-13 prior to OhioRISE eligibility and enrollment. For members who are enrolled in the OhioRISE plan, the MCP is required to cover certain behavioral health services per the OhioRISE Mixed Services Protocol developed by ODM. (p. 89, Appendix G, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁸³ App'x G.3. Clarifications. G.3.c. Help Me Grow. In accordance with ORC section 5167.16, upon request and in coordination with the Help Me Grow program, the MCP shall arrange depression screening and cognitive behavioral health therapies for members enrolled in the Help Me Grow program and who are either pregnant or the birth mother of an infant or toddler under three years of age. Screening shall be provided in the home and therapy services shall be provided in the home when requested by the member. (pp. 92, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁸⁴ App'x G.3. Clarifications. G.3.f. Substance Use Disorder (SUD) Treatment. The MCP will continue to work with ODM in development of the 1115 SUD demonstration waiver to provide services to individuals with a SUD diagnosis. The MCP must utilize the American Society of Addiction Medicine (ASAM) level of care criteria and cannot add additional criteria when reviewing level of care for SUD treatment provided in a community behavioral health center or a hospital billing outpatient hospital behavioral health (OPHBH) services. The MCP must use the ASAM criteria in determining coverage for inpatient hospital services for individuals, however, the MCP must also use other clinical criteria (i.e. MCG or InterQual) and must authorize services when either criteria indicate inpatient services are necessary. The MCP must use the adolescent ASAM level of care criteria for individuals under the age of 21 years. Additional work will include increasing care coordination efforts and monitoring IMD network adequacy. Upon implementation of a standardized substance use disorder (SUD) treatment form, when properly submitted by a provider, the MCP is required to accept the identified form to prior authorize SUD services and determine level of care. Pursuant to ORC Chapter 340, boards of . . . mental health services serve as the community addiction and mental health planning agencies for the county or counties under their jurisdiction. These boards may advocate on behalf of Medicaid recipients enrolled in managed care whom have been identified as needing behavioral health services and are required to: G.3.d.i. Evaluate the need for facility services, addiction services, mental health services, and recovery supports; and G.3.d.ii. Establish a unified system of treatment for mentally ill persons and persons with addictions . . . G.3.e. The MCP is not prohibited from contracting with an IMD to provide mental health services to members' ages 21 through 64, but Medicaid will not compensate the MCP for the provision of such services beyond 15 days per calendar month either through direct payment or considering any associated costs in Medicaid rate setting. (pp. 93, (p. 88, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁸⁵ App'x G. Coverage and Services G.1. Basic Benefit Package. The MCP shall ensure members have timely access to all services outlined in OAC rule 5160-26-03 in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid and in accordance with 42 CFR 438.210, with limited exclusions, limitations, and clarifications (specified in this appendix), including emergency and post-stabilization services pursuant to 42 CFR 438.114. For information on Medicaid-covered services, the MCP shall refer to the Ohio Department of Medicaid (ODM) website. Services covered by the MCP benefit package shall include: G.1.p. Dental services. (pp. 89, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁸⁶ 8. Care Coordination Contractor shall provide all of the elements of Care Coordination as set for the below in this Sec. 8, Ex. B, Part 4... a. Support the appropriate flow of relevant information; identify a lead Provider or primary care team to manage Member care and coordinate all Member services; and, in the absence of full health information technology capabilities, implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow up;... (p. 109, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health) *See Exhibit B for full care coordination details.*

¹⁸⁷ 1. Behavioral Health Requirements With respect to the provision of Behavioral Health Care services Contractor shall do all of the following: a. Be responsible for providing Behavioral Health services for all Members and Care Coordination for members accessing non-covered Behavioral Health services in accordance with the applicable terms and conditions of this Contract, including without limitation Ex. B, Part 2... (p. 279, Effective October 2019, Exhibit M Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health) *See Exhibit M for full behavioral health requirements.*

¹⁸⁸ 6. Screening Members. Contractor shall require Providers to do all of the following: 6.e. Screen Members for, and provide prevention, early detection, brief intervention and Referral to Behavioral Health services . . . 6.e.(2) At an initial prenatal exam. (p. 282, Exhibit M Behavioral Health, Effective October 2019,, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁸⁹ 6. Screening Members. Contractor shall require Providers to do all of the following: 6.c. Screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have . . . Substance Use disorders... 7. Substance Use Disorder Contractor shall: a. Provide SUD services to Members, which include Outpatient, intensive outpatient, Medication Assisted Treatment, including opiate substitution services, and residential, and withdrawal management services, consistent with OAR Chapter 309, Divisions 18, 19, and 22 and Chapter 415, Divisions 20

and 50...(pp. 282 - 283, Exhibit M Behavioral Health, Effective October 2019, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health) *See Exhibit B for full details of substance use disorder coverage.*

¹⁹⁰ 6. Screening Members. Contractor shall require Providers to do all of the following: 6.d. Assess for opioid use disorders for populations at high risk for severe health outcomes, including overdose and death, including pregnant Members . . . (p. 282, Effective October 2019, Exhibit M, Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁹¹ 6. Screening Members. Contractor shall require Providers to do all of the following: 6.b. Screen Members for adequacy of supports for the Family in the home (e.g., . . . nutrition/food . . .). (pp. 282, Effective October 2019, Exhibit M - Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁹² d. Oral Health Services (1) Contractor shall provide to Members all Oral Health Covered Services within the scope of the Member's Benefit Package of Dental Services, in accordance with the terms of this Contractor and as set forth in OAR Chapter 410 division 141 applicable to Dental Organizations... (p. 74, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁹³ 2. Access to Care... b... Pregnant women shall be provided oral Health Care according to the timelines outlined in OAR 410-123-1510. (p. 93, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹⁹⁴ D. Coordination of Care The PH-MCO must coordinate care for its Members. The PH-MCO must provide for seamless and continuous coordination of care across a continuum of services for the Member with a focus on improving health care outcomes. The continuum of services may include the In-Plan comprehensive service package, out-of-plan services, and non-MA covered services provided by other community resources... (p. 63, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

¹⁹⁵ 16. Waiver Services/State Plan Amendments. 16.b. Healthy Beginnings Plus (HBP) Program. The PH-MCO maternity program must provide a maternal continuum of care by instituting a community-based maternal home visiting program. An in-person maternal home visiting program must be an extension of the PH-MCO's traditional case management program that transitions maternal family care to an evidence-informed or evidence-based home visiting program. The PH-MCO's must provide a full description of its community-based maternal home visiting program that fulfills the Department's HBP Program Description objectives for review and approval by the Department as per Exhibit B(5).A. Home Visiting Program. (pp. 55, [Pennsylvania] HealthChoices Physical Health Agreement, Jan. 1, 2022); Exhibit B(5a). HOME VISITING PROGRAM. I. Home Visiting Program Requirements and Goals. R. The home visitor must complete maternal, infant and family needs and risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. (pp. B(5a)-4, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹⁹⁶ Behavioral health services are provided by BH-MCOs, separately from physical health MCOs.

¹⁹⁷ I. Home Visiting Program Requirements and Goals. I.C. Home Visiting activities must primarily be focused on: I.C.14. Increasing follow up care on positive postpartum depression screenings and/or other behavioral healthcare needs.... T. The Maternal Needs and Risk Assessment must include at a minimum the following:... mental health (depression, anxiety)... (pp. B(5a)-1-to-B(5a)2, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹⁹⁸ Exhibit DDD. PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM. DDD.B. The PH-MCO will ensure the PCMH provider meets the following requirements: DDD.B.4. Will deploy a community-based care management team as described below: . . . Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to . . . substance use disorder . . . treatments. (pp. DDD-1-to-DDD-2, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹⁹⁹ Exhibit B. B(5a).W. The Home Visiting Program must minimally address the following: W.5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol). (pp. B(5a)-6, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

²⁰⁰ Exhibit B(5a). HOME VISITING PROGRAM. I. Home Visiting Program Requirements and Goals... T. The Maternal Needs and Risk Assessment must include at a minimum the following:... nutrition, breastfeeding... social determinants of health (food insecurity...) ... W. The Home Visiting Program must minimally address the following: I.W.15. Nutrition Counseling. (pp. B(5a)-4. 6, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

²⁰¹ 2.06.05. Care Management and Care Coordination. 2.06.05.01. Coordination of Care. The Contractor will ensure coordination of care of all covered benefits under this Agreement including those provided for children, adolescents and adults for RItE Care, Rhody Health Partners and the Affordable Care Act Expansion Populations. Coordination of care includes identification and follow-up of members with significant health and social needs that are at high risk of poor health outcomes, ensuring coordination of services and appropriate referral and follow-up . . . Care coordination services are short term and time limited and should not be confused with intensive care management and/or other interventions. Services may include assistance with making or keeping needed medical or behavioral health appointments, hospital discharge planning, health coaching, and referrals related to the member's immediate needs. Members are identified for care coordination because their needs do not meet the level of intensive care management as defined in this contract. (pp. 84–85, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

²⁰² 2.07.06.02. Adolescent Self-Sufficiency Collaborative. Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. (pp. 90, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

²⁰³ 2.06.01.03 Behavioral Health Services ATTACHMENT O & ATTACHMENT P of this Agreement presents the continuum of care for children, adolescence and adult behavioral health services. These services will be provided by the Contractor as an in-plan benefit. The Contractor needs to comply with the requirements of ATTACHMENT O & ATTACHMENT P. The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Quantitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-quantitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance. The Contractor is required to ensure that its non-

quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review. (p. 75, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

See Attachment O and P for more details on covered behavioral health services.

²⁰⁴ 2.06.01.03. Behavioral Health Services. The Contractor will cover . . . substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. (pp. 75, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

See Attachment O and P for more details on covered substance use services.

²⁰⁵ 2.07.05 Rhode Island Department of Human Services The Contractor agrees to assist members in accessing necessary services provided by the RI Department of Human Services (DHS). These services include but are not limited to, services of the Office of Rehabilitation Services, and the State Nutrition Assistance Program (SNAP). (p. 89, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

²⁰⁶ 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... Nutrition Services The Contractor agrees to incorporate comprehensive nutrition assessments, education, and counseling into preventive medical care, including prenatal and preventive pediatric visits. Referrals will be made to a licensed dietitian for therapeutic nutrition counseling for certain conditions in accordance with EOHHS Nutrition Standards for members. The nutrition standards are included as ATTACHMENT E of this Agreement. (p. 80, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.07.06 Rhode Island Department of Health... The State operates a WIC Nutrition program through the Department of Health for pregnant, postpartum and breast-feeding women and children, birth to age five who are at risk for nutritionally related health and developmental conditions. For its part, the Contractor will have written policies and procedures for referring pregnant women and children to the WIC program. (p. 90, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

²⁰⁷ 1.31 EMERGENCY DENTAL CONDITION Emergency Dental Condition means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth. (p. 22, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

2.07.10 Dental Services The Contractor agrees to assist a member in obtaining dental services when so requested by a member. The Contractor is required to provide information on the RIte Smiles program and member marketing materials. The Contractor will collaborate with the RIte Smiles program to coordinate and promote access to dental services for children and young adults. (p. 92, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

²⁰⁸ The CONTRACTOR shall: 4.2.18.3. Be responsible for the Care Management and Coordination of maternity benefits and services (i.e., Continuity of Care, transfers, and payment), as stipulated with Section 4 and Section 5 of this contract. 4.2.18.4. Require care coordination through the gestational period according to the member's needs. (pp. 66, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

²⁰⁹ Section 4. CORE BENEFITS AND SERVICES The CONTRACTOR shall cover the physical health and Behavioral Health Services outlined within this Section of this contract... 4.2.5. Behavioral Health Services The CONTRACTOR shall: 4.2.5.1. Ensure the provision of all medically necessary Behavioral Health Services set forth in the Medicaid Managed Care Policy and Procedure Guide, the Department's Licensed Independent Practitioner Manual, the Physicians, Laboratories, and Other Medical Professionals Provider Manual, the Clinic Services Manual, the Rehabilitative Behavioral Health Services Manual, the Community Mental Health manual, the Autism manual, and the Psychiatric Hospital Services manual. (p. 57, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

²¹⁰ A.2.8.4 Risk Level and Program Content and Minimum Intervention 2.8.4.1 The CONTRACTOR shall establish and implement cohorts with content and interventions, based on documented objectives, member assessments and risk stratification. Activities, interventions, and education objectives appropriate for members will vary for each cohort, with increasing engagement and intensity as level of risk increases. The CONTRACTOR shall develop risk level programs ranging from no risk to high risk. All Population Health cohorts shall include the provisions of clinical reminders around NCQA HEDIS/gaps in care, and after-hours assistance with urgent or emergent member needs. The CONTRACTOR shall develop and operate all Population Health cohorts using an "opt out" methodology. 2.4.8.2 Care Coordination 2.8.4.2.1 For all eligible members the CONTRACTOR shall provide a Care Coordination cohort designed to help non-CHOICES members and non-ECF CHOICES members who may or may not have a chronic disease but have acute healthcare needs, health service needs, or risks which need immediate attention. The goal of the Care Coordination cohort is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and should not be confused with CHOICES Care Coordination or ECF CHOICES Support Coordination. Services may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. Members receiving care coordination may be those members that were identified for but declined High Risk cohorts. 2.8.4.2.2 CONTRACTOR shall provide enhanced care coordination to members with an identified unmet social need. The social determinants of health data that the CONTRACTOR collects must be incorporated into care coordination and targeted intervention strategies for members with an identified unmet social need in accordance with this Contract. (pp. 43-44, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

²¹¹ A.2.8.3. Program Content and Minimum Interventions. The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health Programs listed in Section A.2.8.1 of this Contract... 2.8.4.2 Low Risk Maternity Program The CONTRACTOR shall provide a Low Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications. 2.8.4.2.1 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program. 2.8.4.2.1.1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions: 1. Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract. 2. One non-interactive intervention to the member for the duration of the pregnancy to include, at a minimum, information on pregnancy, newborn, and inter-conception health. 3. Access number to appropriate support, to include a maternity nurse/social worker, when appropriate, if member would like to engage in sustained maternity management. 4. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required. 5. Referrals to appropriate community-based resources and follow-up for these referrals.

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

²¹² 2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered physical health and behavioral health services provided to enrollees during their period of enrollment with the CONTRACTOR. The CONTRACTOR shall also be responsible for the provision and costs of covered long-term care services provided to CHOICES and I/DD MLTSS Programs members. (p. 15, no date, Amendment 14, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

²¹³ A.2.8.3. Program Content and Minimum Interventions. The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health Programs listed in Section A.2.8.1 of this Contract... 2.8.4.2 Low Risk Maternity Program The CONTRACTOR shall provide a Low Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications. 2.8.4.2.1 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program. 2.8.4.2.1.1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions: 1. Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract.. 4. Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.

2.8.4.6 High Risk Maternity Program The CONTRACTOR shall provide a High Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. 2.8.4.6.1 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for the High Risk Maternity Program to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days. 2.8.4.6.2 The CONTRACTOR shall provide to members enrolled in the High Risk Maternity Program the following minimum standard interventions: One interactive contact to the member per month of pregnancy to provide intense case management including the following:... Comprehensive HRA to include screening for mental health and substance abuse. (pp. 9-11, 13, no date, Amendment 11, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

²¹⁴ A.2.8.3. Program Content and Minimum Interventions. The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the Wellness, Low Risk Maternity, Health Risk Management, Chronic Care Management, High Risk Pregnancy and Complex Case Management Population Health Programs listed in Section A.2.8.1 of this Contract... 2.8.4.2 Low Risk Maternity Program The CONTRACTOR shall provide a Low Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications. 2.8.4.2.1 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the High Risk Maternity Program. 2.8.4.2.1.1 The CONTRACTOR shall provide to members eligible for the Low Risk Maternity Program the following minimum standard interventions: 1. Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section A.2.8.4.5.1 of this Contract.

2.8.4.6 High Risk Maternity Program The CONTRACTOR shall provide a High Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. 2.8.4.6.1 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section A.2.8.4.5.1 of this Contract to contact newly identified members eligible for the High Risk Maternity Program to inform the member about the program. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but who appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days. 2.8.4.6.2 The CONTRACTOR shall provide to members enrolled in the High Risk Maternity Program the following minimum standard interventions: One interactive contact to the member per month of pregnancy to provide intense case management including the following:... Comprehensive HRA to include screening for mental health and substance abuse. (pp. 9-11, 13, no date, Amendment 11, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

²¹⁵ 2.8.4.3.1. For all eligible members, the CONTRACTOR shall provide cohort(s) designed to provide outreach to members with no identified health risks. The goal of the cohort(s) is keeping members healthy. No Risk (Wellness) Minimum Intervention. One non-interactive educational quarterly touch to address the following within one year: . . . G. Healthy nutrition. (p. 44, no date, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

²¹⁶ 8.1.24.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:... 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO must also educate Providers on the prior authorization processes for these benefits and services. (pp. 8-157 to 8-158, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8, Texas; p. 163, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

²¹⁷ 1.6.4 Behavioral Health Services The MCO must focus on access to, and delivery of, Behavioral Health Services. The MCO must provide Members with timely access to Medically Necessary Behavioral Health Services, such as mental health and substance abuse treatment and counseling, as well as timely and appropriate follow-up care. Contract requirements emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for behavioral health concerns, or who are receiving both primary physical health and Behavioral Health Services. The Provider Network must include Providers experienced in working with children and young adults with Intellectual and Developmental Disabilities. (p. 128, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms &

Conditions; p. 1-1-8, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8; p. 10, Effective March 1, 2022, Document Version 2.16, Attachment B-1 – HHSC STAR Health MCO RFP, Section 8, Texas).

²¹⁸ 8.1.12. Service for Members with Special Health Care Needs. 8.1.12.1. Identification. The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC requires that the MCO designate Members in the following groups as MSHCN: . . . 8.1.12.1.2. Pregnant women identified as high risk, including: . . . 8.1.12.1.2.c. Pregnant Members with mental health . . . diagnoses. (pp. 122, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

²¹⁹ 8.1.12. Service for Members with Special Health Care Needs. 8.1.12.1. Identification. The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC requires that the MCO designate Members in the following groups as MSHCN: . . . 8.1.12.1.2. Pregnant women identified as high risk, including: . . . 8.1.12.1.2.c. Pregnant Members with . . . substance use disorder diagnoses. (p. 122, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

²²⁰ 8.1.2.3. Value-added Services The MCO may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be actual Healthcare Services, health-related benefits, Family Support Services, or positive incentives that HHSC agrees will promote wellness and improved health outcomes among Members. Value added Services that promote wellness may include nutritional support services... (p. 8-37, Effective March 1, 2022, Document Revision V1.16, Attachment B-1 – HHSC STAR Kids MCO RFP, Section 8)

²²¹ 8.1.10. Special Supplemental Nutrition Program for Women, Infants, and Children - Specific Requirements. The MCO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin. The MCO must make referrals to WIC for Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract. (p. 119, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

8.1.34.4 Referral to Community Organizations The MCO must provide information about and referral to community organizations that may not be providing Covered Services, but are otherwise important to the health and wellbeing of Members. These organizations include, but are not limited to: 1. State/federal agencies (e.g.... nutritional assistance...) (p. 205, Effective March 1, 2022, Document Revision V1.39, Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

²²² 4.13.5 Case Management and Care Coordination Program (A) The Contractor shall have policies and procedures in place to assure continuity and coordination of overall health care for all Enrollees including a mechanism to ensure that each Enrollee has an ongoing source of Primary Care. (B) The Contractor's case management program shall be designed around a collaborative process of assessment, planning, facilitation, and advocacy using available resources to promote quality, timely, safe and cost-effective outcomes. The Contractor shall use the information the Department provides on Enrollees with Special Health Care Needs to coordinate care and determine case management needs. (C) The Contractor shall retain ultimate responsibility for case management and care coordination services even if using a Provider or third party contractor for delivery of the services. (D) A case management program can include, but is not limited to: (1) methodologies to determine the frequency and duration of case management services through application of the Contractor's criteria; (2) mechanisms to refer to and coordinate with other state agencies and community resources as necessary; (3) assisting with and the monitoring of Enrollees' follow-up and specialty care to ensure compliance with optional treatment plans and ensure that Enrollees receive recommended follow up and specialty care; (4) coordination with the Contractor's disease management program; (5) referral of Enrollees to Medical Homes, where

appropriate; and (6) protocols to address Enrollees who are non-compliant. (p. 47, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²³ 1.3.25 High-Risk Prenatal Services... (D) The Contractor shall have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers shall be consistent with standards of practice and linked to the Contractor's care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care providers shall be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy.... (F) Assessment tools used by prenatal care providers and the Contractor shall include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the Contractor and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care. (p. 10, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²⁴ 4.10 Covered Services—Mental Health and Substance Use Disorders 4.10.1 Mental Health and Substance Use Disorders, Generally (A) When an Enrollee presents with a possible mental health or substance use disorder to the Enrollee's Primary Care Provider, it is the responsibility of the Primary Care Provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health or substance use disorders may be handled by the Primary Care Provider or referred to the Enrollee's PMHP when more specialized services are required for the Enrollee. (B) The Primary Care Provider may seek consultation from the PMHP when the Primary Care Provider chooses to manage the Enrollee's symptoms. (p. 44, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²⁵ 1.3.25 High-Risk Prenatal Services... (M) Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:... (5) prenatal and postnatal psychosocial counseling (N) Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness shall be referred to an appropriate mental health care provider. (pp. 11-12, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²⁶ 4.10 Covered Services—Mental Health and Substance Use Disorders 4.10.1 Mental Health and Substance Use Disorders, Generally (A) When an Enrollee presents with a possible mental health or substance use disorder to the Enrollee's Primary Care Provider, it is the responsibility of the Primary Care Provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health or substance use disorders may be handled by the Primary Care Provider or referred to the Enrollee's PMHP when more specialized services are required for the Enrollee. (B) The Primary Care Provider may seek consultation from the PMHP when the Primary Care Provider chooses to manage the Enrollee's symptoms. (p. 44, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²⁷ 1.3.25 High-Risk Prenatal Services... (M) Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:... (4) nutritional assessment and counseling... (p. 12, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

²²⁸ 8.1. F Coordination of Care Provisions Coordination of Care Provisions a. General In accordance with 42 CFR § 438.208, the Contractor shall have systems in place that ensure coordinated patient care for all members and that provide particular attention to the needs of members with complex, serious and/or disabling conditions. The systems, policies, and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers. (p. 132, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract) See 8.1.F for more on care coordination and case management provisions.

²²⁹ e. ARTS Clinical Care Coordination... The Contractor shall develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches. (p. 152, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

e. Special Needs for Pregnant Women Within three (3) days of a member being identified as high-risk, the Contractor should make its best effort to contact the member and/or the member's physicians to identify and assess the specialized needs of the member (medical, psychosocial, nutritional, etc.). At a minimum, the Contractor shall provide the following services to members identified as having high risk pregnancies: Case Management Services Case management services, including assessing and planning of services; referring members to appropriate services and resources for evaluation and follow-up on identified issues and coordinating services with other agencies and providers; and, monitoring ongoing progress and ensuring services are delivered; (p. 194, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³⁰ 5. FAMIS Exceptions and Special Provisions for Medallion 4.0 Covered Services a. Behavioral Health and Substance Use Disorder The Contractor shall cover behavioral health and substance abuse treatment services in accordance with the FAMIS State Plan, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) (see the CMS State Official Letter dated January 16, 2013; SHO # 13-001; available at: <http://www.medicaid.gov/Federal-PolicyGuidance/downloads/SHO-13-001.pdf>), and the SUPPORT Act Section 5022 (see CMS SHO letter dated March 2, 2020; SHO # 20-002; available at: <https://www.medicaid.gov/sites/default/files/Federal-PolicyGuidance/Downloads/sho20001.pdf>)... d. Mental Health Services (MHS) In addition to traditional outpatient behavioral health services such as individual and group psychotherapy, the Contractor shall provide coverage of the following Mental Health Services (MHS) for FAMIS members: Peer Recovery Support, Behavioral Therapy Services, Intensive In-Home, Therapeutic Day Treatment, Crisis Intervention, and Mental Health Case Management services. For purposes of ensuring parity under financial requirements (FR) provisions in the federal Mental Health Parity and Addiction Equity Act, there will be no copay for outpatient behavioral health services, including MHS services, provided to FAMIS members. (p. 426, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³¹ 8.2.X Prenatal Care Requirements... b. Depression Screenings and Referrals The Contractor shall, through agreements with its providers, make every reasonable effort to screen pregnant women (or refer to an appropriate practitioner to screen) for mental health concerns in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. The Contractor shall have a process to refer women who screen positive for mental health concerns to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment. All Contractor staff conducting these screens shall be trained in the administration of such screens and shall have the necessary training to ensure appropriate member support and treatment for identified mental health concerns. (p. 121, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³² 5. FAMIS Exceptions and Special Provisions for Medallion 4.0 Covered Services a. Behavioral Health and Substance Use Disorder The Contractor shall cover behavioral health and substance abuse treatment services in accordance with the FAMIS State Plan, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) (see the CMS State Official Letter dated January 16, 2013; SHO # 13-001; available at: <http://www.medicaid.gov/Federal-PolicyGuidance/downloads/SHO-13-001.pdf>), and the SUPPORT Act Section 5022 (see CMS SHO letter dated March 2, 2020; SHO # 20-002; available at: <https://www.medicaid.gov/sites/default/files/Federal-PolicyGuidance/Downloads/sho20001.pdf>)... e. Inpatient Substance Use Disorder Treatment Services Medically necessary inpatient substance use treatment services are covered for 365 days per confinement. This coverage does not include residential services or other 24-hour therapeutically planned structural services. f. Outpatient Substance Use Disorder Treatment Services The Contractor shall provide coverage of outpatient, intensive outpatient, partial hospitalization, medication-assisted treatment, case management, and peer support services for the treatment of substance use disorder. For purposes of ensuring parity under financial requirements (FR) provisions in the federal Mental Health Parity and Addiction Equity Act, there will be no copay for outpatient SUD treatment services provided to FAMIS members. (p. 426, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³³ e. Special Needs of Pregnant Women Within three (3) days of a member being identified as high-risk, the Contractor should make its best effort to contact the member and/or the member's physicians to identify and assess the specialized needs of the member (medical, psychosocial, nutritional, etc.). At a minimum, the Contractor shall provide the following services to members identified as having high risk pregnancies:... Substance Use Intervention: The Contractor shall develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use. These structures shall focus on planning strategies to facilitate a recovery environment that addresses improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches. (p. 195, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2.X Prenatal Care Requirements... c. Ancillary Services... d. Expanded Prenatal Care Services The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510:... Addiction and recovery treatment services. (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³⁴ 8.2 AA Nutritional Supplements and Supplies Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for members under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Sole source means that the member is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that the nutritional supplements are medically indicated for the treatment of the member's condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Specialized formula for children and enteral nutrition/medical foods for members under twenty-one (21) are carved out of this Contract. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition. (p. 197, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.8.A Nutritional Insufficiency Initiative As nutritional insufficiency of Medicaid enrollees is a significant concern for the Commonwealth, the Contractor shall work collaboratively with the Department to develop and implement an innovative pilot program that all plans will participate in to address nutritional insufficiency to support healthy Virginians and particularly healthy Virginia children. (p. 242, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³⁵ b. WIC Referrals Section 1902(a)(11)(C) of the Social Security Act, as amended, requires the State Plan to provide for the coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), administered by the Virginia Department of Health (VDH). The Contractor shall refer potentially eligible women, infants, and children to the WIC Program. (p. 189, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2.X Prenatal Care Requirements... c. Ancillary Services... d. Expanded Prenatal Care Services The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510: Nutritional assessment, counseling, and follow-up, as well as blood glucose meters. (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

e. Special Needs of Pregnant Women... Lactation Consultation and Breast Pumps: The Contractor shall cover lactation consultation and breast pumps. (p. 195, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²³⁶ 14 CARE COORDINATION 14.1. Continuity of Care The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition, including children receiving WISE services and TAY who have a current care plan, and Enrollees who are being released from correctional facilities. The Contractor shall ensure continued access to services during a transition between FFS and the Contractor's MCO or BHSO program, or from one MCO or BHSO to another, in compliance with HCA's Transition of Care Policy (42 C.F.R. § 438.62). The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are supported with a

continuity of care period that is no less than ninety (90) days for all new Enrollees. The Contractor shall honor service authorizations made by other systems such as FFS and Apple Health Managed Care Organizations (42 C.F.R. § 438.208). (p. 256, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.7 Care Management Services The Contractor shall implement activities for Enrollees identified as requiring Complex Case Management (CCM), or those with multiple chronic conditions. (p. 266, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

See Section 14 for more details on care coordination and care management services.

²³⁷ 17.1.10 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, Mental Health Professionals, substance use disorder specialists, certified dietitians, and interns and residents under the supervision of a teaching physician... 17.1.10.3 Depression screening for mothers/caregivers of children up to six months old. (p. 304, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

²³⁸ 6.22 SUD Access to Services... 6.22.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of withdrawal management, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours. (p. 144, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.23 Outreach to At Risk Pregnant Women 14.23.1 The Contractor shall provide outreach to pregnant women identified as at risk due to opioid use disorder. Outreach shall include providing information and education, disseminating up-to-date and accurate health education information concerning the effects of opioid use and the risks to both themselves and their babies (RCW 71.24.560(3)). (p. 289, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

²³⁹ 17.1.10 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, Mental Health Professionals, substance use disorder specialists, certified dietitians, and interns and residents under the supervision of a teaching physician... 17.1.10.16 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia. (p. 305, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

²⁴⁰ 17.1.19 Enteral nutrition products, including the following: 17.1.19.1 Parenteral nutritional supplements and supplies for all clients... 17.1.19.3 Medically necessary oral enteral nutrition products, including prescribed infant formulas not covered by WIC or additional quantities beyond amounts allowed by WIC, for clients 20 years of age and under... 17.1.22 Medical Equipment and Supplies and any applicable sales tax including, but not limited to:... breast pumps... (pp. 309-310, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

17.4.4. The following services are covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible... 17.4.4.4 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health; (p. 333, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

²⁴¹ The HMO will provide care coordination and case management services as defined in Article I. As part of the Care Management model, the HMO will employ care coordinators and case managers to arrange, deliver, and monitor Medicaid-covered services to meet the member's needs. The HMO shall use care management staff (i.e., care coordinators, case managers, behavioral

health professionals, and/or nurses) trained in the cultural, health and socioeconomic needs of the BadgerCare Plus and Medicaid SSI population in order to conduct care coordination activities. The care coordinators and case managers will work together with the member and the primary care provider to provide appropriate services for HMO members. The HMO must develop care management guidelines to operationalize their care management model which must receive Department approval prior to its implementation; any subsequent changes to the guidelines are also subject to Department approval. (p. 45, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

²⁴² Article IV: Services A. BadgerCare Plus and/or Medicaid SSI Services... 1. Provision of Contract Services... c. Prenatal Care Coordination (p. 65, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services. (p. 95, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

See provision for more details on the OB MH initiative.

²⁴³ Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant women (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components: a. Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems. b. Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders. (p. 172, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

²⁴⁴ H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 4. Health education and disease prevention programs, including... nutrition... (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

²⁴⁵ H. Health Education and Disease Prevention The HMO must inform all members of ways they can maintain their own health and properly use health care services. The HMO must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:... 5. Health education and disease prevention programs, including... breast feeding promotion and support... Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well as list of the local WIC agencies can be found on the WIC website (<http://www.dhs.wi.gov/wic/>). (p. 145, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

²⁴⁶5.3 Continuity and Coordination of Care In accordance with 42 CFR §438.208(b)(1), the MCO must ensure an integrated approach to the continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for administering the enrollee's overall health care services; the MCO must provide the enrollee with information on how to contact the designated individual or entity. The MCO must submit its care coordination program description in writing for BMS review and approval annually on October 1. If the MCO

makes significant changes to its care coordination program, it must submit any changes to BMS for approval prior to implementing the change. 1. The MCO's care coordination program must describe the following components: MCO's care coordination staffing, including the number of staff by role, qualifications, and physical location; 2. Training topics and frequency of training provided to MCO care coordination staff; 3. MCO's risk stratification framework, including the criteria and threshold for each tier; 4. Assignment of MCO care coordination staff, including caseloads by risk stratification and assignment methodology; 5. MCO's requirements related to required periodic EPSDT schedules; 6. MCO's roles and responsibilities to support Care Coordination Entities (CCEs) in providing care coordination to the MCO's enrollee and ensuring the enrollees' needs are met; 7. MCO's roles and responsibilities for performing care coordination activities when the MCO is exclusively providing care coordination to enrollees; 8. How the MCO will notify enrollees of care coordination assignment; 9. MCO's data and information systems and how they will be used to support MCO's responsibilities for care coordination regardless of which entities are providing care coordination; and 10. How the MCO will monitor the care coordination program for individual and systemic improvements. The MCO must have documented procedures to: 1. Ensure the services that the MCO provides to the enrollee are integrated with services provided by other MCOs; 2. Ensure a comprehensive case management approach is applied; and 3. Communicate clinical information among providers in a timely manner for efficient treatment and follow up. Regardless of the mechanism adopted for coordination of services, the MCO must ensure that each enrollee has an ongoing source of primary care. The MCO must have programs for coordination of care that include coordination of services with community and social services locally available through contracting or non-contracting with providers in the area served by the MCO. The MCO must also ensure that enrollees are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens. In the instance where an enrollee transfers enrollment to another MCO or FFS, the MCO is required to provide clinical information to the MCO or BMS, as appropriate, to promote continuity of care. (p. 118, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

10.5 Coordination of care: Notwithstanding internal care coordination of care requirements outlined in Article III, Section 5.3 of this Contract, the MCO's primary care provider must coordinate the enrollee's health services, as appropriate, with behavioral health providers. The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units. If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process. (p. 166, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

²⁴⁷ 10. BEHAVIORAL HEALTH SERVICES 10.1 MCO Behavioral Services Administration The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.¹⁷ The benefit must be provided in accordance with 42 CFR part §438 Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted BMS annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS. (p. 164, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

²⁴⁸ 10.3 Behavioral Health Covered Services The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include: mental health outpatient services, mental health inpatient services, SUD outpatient services (including but not limited to pharmacologic management and including methadone treatment), targeted case management, behavioral health rehabilitation and clinic services, and psychiatric residential treatment services. The MCO must follow BMS FFS policies specific to the drug testing limit requirements contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services. The MCO may implement its own prior authorization requirements for these services. (p. 166, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

²⁴⁹ 3.5.2 Health Education and Preventive Care... The MCO must provide programs of wellness education. Such programs may include... nutritional education... (p. 102, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

²⁵⁰ 5.3.3.3 WIC Program The MCO must work with BMS to provide for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants and Children (WIC) and must provide timely notice and referral to WIC in accordance with section 1902(a)(53) of the Social Security Act. The MCO must refer potentially eligible women (e.g., pregnant, breastfeeding, and less than six (6) months postpartum), infants, and children under the age of five (5) to WIC. The MCO must include timely (not more than sixty (60) calendar days after referral) transfer of enrollee's medical information (length/height, weight, hemoglobin, and medical condition which influences consumption, adsorption, or utilization of food nutrients) to WIC and comply with all State and Federal privacy laws in doing so. (p. 123, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

²⁵¹ 9.2 The MCO must provide enrollees twenty-one (21) years of age and older with diagnostics, preventive, and restorative dental services, excluding cosmetic services, limited to a \$1,000 per enrollee per calendar year as specified in WV Policy- Chapter 505 Oral Health Services. The MCO must place appropriate prior authorization limits on all covered adult dental services a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract and clinical guidelines. Covered adult dental services will require authorization prior to services being rendered and have a coverage limit of \$1,000 per calendar year. MCO must develop and submit their policy and procedures for dental services to BMS for prior approval. (P. 163, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

Table 3. Coverage and performance obligations for services related to social drivers for perinatal persons

This table allows readers to view the extent to which any single state addresses any one of the major domains of managed care and maternity care services within its state purchasing agreements, as well as the actual language used by the state in addressing any maternity care domain.*

State	Housing support services		Transportation services		Special support services, policies or procedures for certain very high-risk or historically underserved populations [†]		Coordination with Key Agencies Serving Members (Schools, Child Welfare, and Justice System)
	General provisions incl. In contract	Maternity-specific provision incl. in contract [‡]	General provisions incl. In contract	Maternity-specific provision incl. in contract [§]	General provisions incl. In contract	Maternity-specific provision incl. in contract	General provisions incl. In contract
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
AZ	Y	Y ¹	Y ²	Y ³	Y ⁴	Y ⁵	Y ⁶
CA	Y ⁷	N	Y ⁸	N	Y ⁹	N	Y ¹⁰
CO	Y ¹¹	N	Y ¹²	N	Y ¹³	Y ¹⁴	Y ¹⁵
DC	Y ¹⁶	N	Y ¹⁷	N	Y ¹⁸	N	Y ¹⁹
DE	Y ²⁰	N	Y ²¹	N	Y ²²	N	Y ²³
FL	Y ²⁴	N	Y ²⁵	N	Y ²⁶	N	Y ²⁷
GA	N	N	Y ²⁸	N	Y ²⁹	Y ³⁰	Y ³¹
HI	Y ³²	N	Y ³³	N	Y ³⁴	Y ³⁵	Y ³⁶
IA	N	N	Y	N	N	N	Y ³⁷
IL	Y ³⁸	N	Y ³⁹	N	Y ⁴⁰	Y ⁴¹	Y ⁴²
IN	Y ⁴³	N	Y ⁴⁴	Y ⁴⁵	Y ⁴⁶	Y ⁴⁷	Y ⁴⁸
KS	Y ⁴⁹	N	Y ⁵⁰	N	Y ⁵¹	N	Y ⁵²
KY	Y ⁵³	N	Y ⁵⁴	N	Y ⁵⁵	Y ⁵⁶	Y ⁵⁷
LA	Y ⁵⁸	N	Y ⁵⁹	N	Y ⁶⁰	Y ⁶¹	Y ⁶²
MA	Y ⁶³	N	Y ⁶⁴	N	Y ⁶⁵	Y ⁶⁶	Y ⁶⁷

* Note: All language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of July 2022, unless otherwise noted.

[†] This includes cultural competency plans that aim to provide training to equip providers with additional skills to meet patient needs, efforts to hire staff that are reflective of patient diversity, and development of committees specifically to identify access challenges among underserved patients; MCO-level initiatives; other provider-lead initiatives.

[‡] This screening to identify need for housing supports, referrals to housing support services, and required relationships with community health centers or other clinics specializing in the delivery of care to homeless populations.

[§] This routine transportation for health care visits and transportation around the time of birth (e.g., transport to perinatal regional centers for specialty care at the time of birth for mother or infant).

State	Housing support services		Transportation services		Special support services, policies or procedures for certain very high-risk or historically underserved populations [†]		Coordination with Key Agencies Serving Members (Schools, Child Welfare, and Justice System)
	General provisions incl. In contract	Maternity-specific provision incl. in contract [‡]	General provisions incl. In contract	Maternity-specific provision incl. in contract [§]	General provisions incl. In contract	Maternity-specific provision incl. in contract	General provisions incl. In contract
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
MD	Y ⁶⁸	N	Y ⁶⁹	N	Y ⁷⁰	Y ⁷¹	N
MI	Y ⁷²	N	Y ⁷³	Y ⁷⁴	Y ⁷⁵	N	N
MN	Y ⁷⁶	N	Y ⁷⁷	Y ⁷⁸	Y ⁷⁹	Y ⁸⁰	Y ⁸¹
MO	N	Y ⁸²	Y ⁸³	Y ⁸⁴	Y ⁸⁵	Y ⁸⁶	Y ⁸⁷
MS	Y ⁸⁸	N	Y ⁸⁹	Y ⁹⁰	Y ⁹¹	Y ⁹²	Y ⁹³
ND	N	N	Y ⁹⁴	N	Y ⁹⁵	N	N
NE	N	N	Y ⁹⁶	N	Y ⁹⁷	N	N
NH	Y ⁹⁸	N	Y ⁹⁹	Y ¹⁰⁰	Y ¹⁰¹	Y ¹⁰²	Y ¹⁰³
NJ	Y ¹⁰⁴	N	Y ¹⁰⁵	N	Y ¹⁰⁶	Y ¹⁰⁷	Y ¹⁰⁸
NM	Y ¹⁰⁹	Y ¹¹⁰	Y ¹¹¹	N	Y ¹¹²	Y ¹¹³	Y ¹¹⁴
NV	Y ¹¹⁵	N	Y ¹¹⁶	N	Y ¹¹⁷	Y ¹¹⁸	Y ¹¹⁹
NY	Y ¹²⁰	N	Y ¹²¹	N	Y ¹²²	Y ¹²³	Y ¹²⁴
OH	Y ¹²⁵	N	Y ¹²⁶	N	Y ¹²⁷	N	Y ¹²⁸
OR	Y ¹²⁹	N	Y ¹³⁰	N	Y ¹³¹	N	Y ¹³²
PA	Y ¹³³	N	Y ¹³⁴	Y ¹³⁵	Y ¹³⁶	N	Y ¹³⁷
RI	Y ¹³⁸	N	Y ¹³⁹	N	Y ¹⁴⁰	N	N
SC	N	N	Y ¹⁴¹	N	Y ¹⁴²	N	N
TN	Y ¹⁴³	N	Y ¹⁴⁴	N	Y ¹⁴⁵	Y ¹⁴⁶	N
TX	Y ¹⁴⁷	N	Y ¹⁴⁸	N	Y ¹⁴⁹	Y ¹⁵⁰	Y ¹⁵¹
UT	N	N	N	N	Y ¹⁵²	Y ¹⁵³	Y ¹⁵⁴
VA	Y ¹⁵⁵	N	Y ¹⁵⁶	N	Y ¹⁵⁷	Y ¹⁵⁸	Y ¹⁵⁹
WA	Y ¹⁶⁰	N	Y ¹⁶¹	N	Y ¹⁶²	N	Y ¹⁶³
WI	Y ¹⁶⁴	N	Y ¹⁶⁵	N	Y ¹⁶⁶	Y ¹⁶⁷	Y ¹⁶⁸
WV	Y ¹⁶⁹	N	Y ¹⁷⁰	N	Y ¹⁷¹	N	Y ¹⁷²
Total	Y = 32 N = 7	Y = 3 N = 36	Y = 38 N = 1	Y = 8 N = 31	Y = 38 N = 1	Y = 23 N = 16	Y = 32 N = 7

¹ Permanent Supportive Housing: Safe, stable and affordable housing aligned and coordinated with an individual's behavioral health, medical, and other supportive services, consistent with the member's needs and goals in the least restrictive community setting, is a critical component of an individual's overall well-being and care. Any of these services may be medically necessary if those services assist members to secure or maintain permanent housing placement. The Contractor is responsible for supporting all members with a housing need and with services to secure and maintain safe, sustainable, and appropriate permanent supportive housing. The Contractor shall: 1) ensure housing needs are evaluated as part of identifying independent living goals and service planning; 2) ensure all members have information about and assistance securing available housing resources including market rate, mainstream subsidy and AHCCCS subsidized housing programs; 3) assist members by reducing barriers to housing and utilizing a Housing First approach; 4) provide specialized engagement, housing, and supportive service coordination for members with housing needs including individuals at risk of or experiencing homelessness; and 5) ensuring the availability of Title XIX/XXI wrap-around services including home-based services as necessary to assist members in maintaining housing and coordinating with service plan goals. The Contractor shall perform the following key duties: 1. Identifying members with housing needs, including individuals experiencing homelessness, and develop a monitoring process to support transition or post-transition activities including, but not limited to, requests and referrals, transition wait times, eligibility documentation and verification, transition barriers and special needs, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition, 2. Maintaining ongoing communication with the RBHA(s) for Contractor/RBHA shared members who are in need of, who qualify for, and who are currently receiving Non Title XIX/XXI supportive housing services (rent/utility subsidies and relocation services) in order to ensure adequate coordination of care and housing based supportive services for these members, 3. Having policies in place outlining coordination of care processes to assist members in attaining and maintaining housing and supportive services, including procedures for collaboration with the RBHA, 4. Participating in local HUD Continuum of Care for the Contractor's GSA to identify, engage and coordinate services and housing for Contractor members experiencing homelessness, and 5. Ensuring that a staff person(s) is designated as the Housing Specialist expert(s) on housing and education resources within the Contractor's service area. In general, this individual shall be available to assist members with up to date information designed to aid members in making informed decisions about their independent living goals. Refer to Section D, Paragraph 15, Staff Requirements. The Contractor shall attend the quarterly AHCCCS Housing Meeting and submit Housing deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall track and report on the Housing request and referral system used by the Contractor. The Contractor shall submit a Supportive Housing Report for all members who have requested or been referred for housing assistance as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Supportive Housing Report shall include information regarding members who have been identified as having an affordable housing need, through the Contractor's established process/system for members to request and be referred to affordable housing resources, including those members referred to the RBHA for Non-Title XIX/XXI supportive housing services (rent/utility subsidies and relocation services). Additionally, the Supportive Housing Report shall include the following: 1. Member Name, 2. AHCCCS ID, 3. SMI Indicator, 4. Currently Homeless 5. Date of Member Request, 6. Date of Housing Referral to Housing Provider. 7. Date Housing Provider made direct contact with Referred Member or Designated Representative (voice message/email/regular mail do not qualify), 8. Outcome of Housing Referral, 9. Date Housed, and 10. New Address. (pp. 103-105, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

39. Housing Specialist designated as the subject matter expert(s) on the provision of housing and housing resources to members within the Contractor's service area. The Contractor shall ensure that it has a designated staff person(s) as a Housing Specialist. The Housing Specialist is required to reside in Arizona within the Contractor's assigned Geographic Service Area. The Housing Specialist is an expert(s) on housing programs and resources within the Contractor's service area. The Housing Specialist may be designated as the expert in other areas as well as housing, but they must be clearly identified and function as the Housing Specialist. While the Contractor must have at least one designated Housing Specialist, the Contractor shall have sufficient dedicated housing staffing reporting to the Housing Specialist based on the geographic service area size and member enrollment numbers in order to adequately meet contractual and policy housing service requirements. Key duties of the Housing Specialist include: 1. Assist provider network's support staff (e.g. case managers) with up to date information designed to aid members in making informed decisions about and accessing their independent living housing options including AHCCCS Non-Title XIX/XXI Housing Subsidy Programs (e.g. scattered site vouchers, Community Living Programs), mainstream housing subsidy programs (e.g. HUD Housing Choice Vouchers, local Public Housing Authority Programs); and market rate housing options, 2. Provide education and

training to providers and support staff on housing programs and evidence based practices related to housing services, 3. Supporting provider case managers and network support staff with identifying members with housing needs, making appropriate housing referrals to AHCCCS Housing Subsidy Programs mainstream housing programs and other housing resources for individuals with housing needs, 4. Assisting members and provider case managers to support transition or post-transition activities including, but not limited to, requests and referrals, assistance with eligibility documentation and verification, transition wait times, transition barriers and special needs/accommodations, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition, 5. As specified in the Network Development and Management Plan, the Contractor shall report annually on the status of any affordable housing networking strategies and innovative practices/initiatives it elects to implement, 6. Act as the Contractor's liaison to the quarterly AHCCCS Housing Coordination Meeting led by the AHCCCS Director of Housing Programs as well as other ad hoc AHCCCS Housing Workgroups and initiatives, 7. Serve as the Contractor's liaison to local HUD approved Continuum of Care for the Contractor's service area. The Housing Specialist or the Housing Specialist's designee shall attend appropriate CoC meetings, participate in Continuum of Care coordinated entry and HMIS systems, and assist Continuum of Care in identifying, engaging, and securing appropriate housing and services for members experiencing homelessness, 8. Advocate, plan, and coordinate with provider supportive services to ensure members in independent, and AHCCCS, and mainstream subsidized housing programs, offer appropriate services to maintain their housing, and 9. The Housing Specialist is responsible for identifying housing resources and building relationships with contracted Housing Providers and mainstream public housing authorities for the purposes of developing innovative practices to expand housing options, assisting and coordinating. This may include assisting providers in identifying and applying for AHCCCS SMI Housing Trust Fund projects. The Contractor shall ensure Housing Specialists are familiar with the following standards and practices related to Permanent Supportive Housing, including but not limited to: 1. Federal Fair Housing, Equal Opportunity, Non-Discrimination and other Federal and State Housing laws Fair housing, 2. The Arizona Residential Landlord Tenant Act (ARLTA), 3. Use of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment or other housing assessment and/or housing prioritization tools in the Housing Specialist's service area, 4. Fundamentals of Housing First and the SAMHSA Permanent Supportive Housing program, 5. Housing Quality Standards (HQS), and 6. Current and emerging tools and best practices in permanent supportive housing and services. (pp. 119-120, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

² 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. Refer to 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. (p. 91, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

32. APPOINTMENT STANDARDS... The Contractor shall ensure that populations with ongoing medical needs,... 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... The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. 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. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met. (pp. 174-175, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

³ A. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES The Contractor shall establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the Contractor's maternity care program shall include:... 8. Mandatory availability of maternity care coordination services for

enrolled pregnant women, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the Contractor. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.... 19. Provide timely provision of medically necessary transportation services, as specified in AMPM Policy 310-BB. (p. 4, 6, Effective September 01, 2021, [AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH](#))

⁴ 19. CULTURAL COMPETENCY The Contractor shall participate in AHCCCS' efforts to promote, and shall implement a program that promotes, the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity and meets the requirements of ACOM Policy 405 [42 CFR 457.1230(a), 42 CFR 438.206(c)(2)]. The Contractor shall develop and implement a Cultural Competency Plan which meets the requirements of ACOM Policy 405. An annual assessment of the effectiveness of the Cultural Competency Plan, along with any modifications to the Plan, must be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 127, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

⁵ A. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES The Contractor shall establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the Contractor's maternity care program shall include:... 8. Mandatory availability of maternity care coordination services for enrolled pregnant women, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the Contractor. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers. (p. 4, Effective September 01, 2021, [AMPM Policy 410, AHCCCS MEDICAL POLICY MANUAL CHAPTER 400 – MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH](#))

⁶ 9. SCOPE OF SERVICES The Contractor shall ensure the coordination of services it provides with services the member receives from other entities. The Contractor shall ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements including, but not limited to, 45 CFR Parts 160 and 164, Subparts A and E, and Arizona statute, to the extent that they are applicable [42 CFR 438.208 (b)(2),(b)(4), and b(6), 42 CFR 457.1230(c), and 42 CFR 438.224]. (p. 64, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Collaboration with System Stakeholders: The Contractor shall work in partnership Contractors in its Geographic Service Area(s) to meet, agree upon, and reduce to writing, joint collaborative protocols with: 1. Administrative Office of the Courts, 2. Juvenile Probation and Adult Probation, 3. Arizona Department of Corrections and Arizona Department of Juvenile Corrections, 4. Arizona Department of Child Safety (DCS), 5. Tribal Nations and Providers (Refer to this section below), 6. The Veteran's Administration, and 7. The County jails. The Contractor shall address in each collaborative protocol, at a minimum, the following: 1. Procedures for each entity to coordinate the delivery of covered services to members served by both entities, 2. Mechanisms for resolving problems, 3. Information sharing, 4. Resources each entity commits for the care and support of members mutually served, 5. Procedures to identify and address joint training needs, and 6. Where applicable, procedures to have providers co-located at juvenile detention centers or other agency locations as directed by AHCCCS. In the collaborative protocols with the Administrative Office of the Courts, Juvenile Probation and Adult Probation, the Contractor shall adopt strategies to optimize the use of services in connection with Mental Health Courts and Drug Courts. The Contractor shall work in partnership with the RBHA and Contractors in its Geographic Service Area(s) to meet, agree upon and reduce to writing joint collaborative protocols with local law enforcement and first responders, which, at a minimum, shall address: 1. Continuity of covered services during a crisis, 2. Information about the use and availability of Contractor's crisis response services, 3. Jail diversion and safety, 4. Strengthening relationships between first responders and providers when support or assistance is needed in working with or engaging members, and 5. Procedures to identify and address joint training needs. At a minimum, the MOUs shall include the following Contractor care coordination requirements: 1. Partner with the justice system to communicate timely data necessary for coordination of care in conformance with all applicable administrative orders, 42 CFR Part 2, and Health Insurance Portability and Accountability Act (HIPAA) requirements that permit the sharing of written, verbal and electronic information, 2. Establish and maintain coordination of care processes as specified in AMPM Policy 541 and AMPM Policy 1020, and 3. Utilize data sharing agreements and administrative orders that permit the sharing of written, verbal and electronic information at the time of admission into the facility and at the time of discharge. To the extent permitted by State and federal laws regarding privacy and confidentiality, the data may be shared without the permission of the member if the medications are used to treat substance use disorders and data may consist of: 1. Individual's Name (FN, MI, LN), 2. DOB, 3. AHCCCS ID, 4. Social Security Number, 5. Gender, 6. Court Ordered Treatment (COT) status, 7. Public Fiduciary/Guardianship status, 8. Assigned Behavioral Health Provider Agency, 9. Assigned Behavioral Health Provider's Phone Number, 10. Name of AHCCCS Complete

Care Contractor 11. Primary Care Provider's Name, 12. Primary Care Provider's Phone Number, 13. Diagnoses (Medical and Psychiatric), and 14. Medications. The Contractor shall: 1. Offer customized training that is designed to strengthen staff's ability to effectively work with individuals in the correctional facility, 2. Share information that assists the clinical team in developing treatment plans that incorporate community release conditions, as appropriate, and 3. Develop policies and procedures that identify specific time frames to have the team (i.e. Correctional Facility, the Contractor, Provider and Jail Coordinator) convene to discuss services and resources needed for the individual to safely transition into the community upon release. The Contractor shall submit all written protocols and MOUs as specified in Section F, Attachment F3, Contractor Chart of Deliverables and review and update on an annual basis as needed.

Justice System Reach-in Care Coordination System: To facilitate the transition of members transitioning out of jails and prisons into communities, AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in justice system "reach-in" care coordination efforts. The Contractor shall conduct reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sheriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release. In addition to members identified as having a chronic and/or complex care need, the Contractor shall conduct reach-in care coordination for members in the adult correctional system who have a substance use disorder and/or meet medical necessity criteria to receive Medical Assisted Treatment (MAT). The Contractor shall report the Reach-In Plan and outcome of summaries to AHCCCS, as specified, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall monitor progress throughout the year and submit quarterly reporting to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of the number of members involved in reach-in activities. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness. Administrative and Contractor care coordination requirements are specified in AMPM Policy 1020. The Contractor shall notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Section D, Paragraph 51, Capitation Adjustment. (pp. 152-154, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

⁷ See Table 2, for more on Targeted Case Management and housing/physical environment assessments.

⁸ 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. 1) Contractor shall cover Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services as described in Title 22 CCR Section 51323 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 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 developi 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 MediCal services not covered under this Contract. These services include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefit delivered through Medi-Cal FFS. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

⁹ E. Cultural Competency Training Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers, and Subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health

care structure; traditional home remedies that may impact what the provider is trying to do to treat the patient; and, language and literacy needs. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 9, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹⁰ 3. Initial Health Assessment (IHA) An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract. A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below. B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA. C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits. D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement. (no page #, Effective FY 17-18, Scope of Services, Exhibit A, Attachment 10, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

11. Early Intervention Services Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation. (no page #, Effective FY 17-18, Case Management and Coordination of Care, Exhibit A, Attachment 11, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

¹¹ 10.3 Community and Social Determinants of Health... 10.3.4. The Contractor shall establish relationships and communication channels with Community organizations that provide resources such as... housing... (p. 72, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

12.8. General Information and Administrative Support... 12.8.2. The Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics:... 12.8.2.5. Community-based resources, such as... housing assistance... (p. 80, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹² 10.2 Health Neighborhood... 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. (p. 71, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.2.1.3. Emergency Ambulance Transportation 14.2.1.3.1. The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a twenty-four (24) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies. (p. 87, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.3.48. Transportation, non-emergent, to medical appointments. (p. 96, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.3.51.11. Non-emergency transportation to medical appointments for Covered Services only, through the client's county of residence. (p. 96, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹³ 7.3.9 Contractor Website... 7.3.9.1.6 For PCMPs and behavioral health providers, the Contractor shall make the following information on the Contractor's network providers available to Members as a provider directory in electronic form and in paper form upon request:... 7.3.9.1.6.7. The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training. (p. 43, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁴ 11.1.6. The Contractor shall outreach to women in the perinatal period to improve education and outcomes around maternity support and benefits and advantages. The Contractor shall focus particularly on high-risk pregnant women in the first trimester as well as during the post-partum period as a goal of this outreach. (p. 75, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.2. Coverage of Specific Services and Responsibilities... 14.3.41. Prenatal Plus - Enhanced program for high risk pregnant women that provides a care coordinator, dietitian and mental health professional. The program is offered through four packages with approved services as listed in 10 C.C.R. 2505 – 10 §8.748. (p. 91, 95, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁵ 10.3. Community and Social Determinants of Health... 10.3.2. Recognizing that the conditions in which Members live also impact their health and well-being, the Contractor shall establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations... 10.3.4. The Contractor shall establish relationships and communication channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region. 10.3.4.1. The Contractor shall collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth. (p. 72, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁶ C.5.8.6 Value-Added Benefits... C.5.8.6.3 The Contractor who operates a community facility (Wellness Center) shall at a minimum... 4) provide face-to-face support and resources to Enrollees identified as homeless or facing housing instability. (p. 61, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁷ Table A: Medicaid Covered Services Service: Transportation services Benefit Limit: As described in 42 C.F.R. § 440.170(a), including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions. (p. 86, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁸ C.5.7 Language Access and Cultural Competence C.5.7.1 Cultural Competence... C.5.7.1.3 The Contractor shall distribute its policies and procedures on Cultural Competence to its subcontractors and Network Providers and ensure compliance by all with the policies and procedures. C.5.7.1.4 The Contractor shall conduct Cultural Competence trainings annually for all staff, Network Providers and subcontractors. Such trainings shall address at a minimum: C.5.7.1.4.1 Enhanced awareness of Cultural Competency imperatives and issues related to improving access and quality of care for Enrollees; C.5.7.1.4.2 The Contractor's policies and procedures on Cultural Competence; C.5.7.1.4.3 Requirements of Title VI of the Civil Rights Act of 1964 and the implementing regulations; C.5.7.1.4.4 Requirements of the D.C. Language Access Act of 2004 and the implementing regulations; and C.5.7.1.4.5 The Contractor's policies and procedures on language access, including how staff can access language assistive services on behalf of Enrollees with limited English proficiency C.5.7.1.4.3 Cultural Competency trainings shall also provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices. (p. 56, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

See C.5.7 for more.

C.5.28.8 Home Visiting Outreach for High-Risk Newborns C.5.28.8.1 The Contractor shall ensure that each High-Risk Newborn receives a home visit from a Registered Nurse, licensed in accordance with the D.C. Health Occupations Regulatory Act and its implementing regulations, within forty-eight (48) hours of discharge from the birthing hospital or birthing center. The Contractor shall coordinate with DC Department of Health's (DC Health) Home Visiting Program and report this information to DHCF on a quarterly basis. (p. 90, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

¹⁹ C.5.29.35 Coordination with Child and Family Services Agency and the Department of Youth Rehabilitation Services C.5.29.35.1 The Contractor shall be responsible for coordinating the care of Enrollees that are wards of or under the supervision of the Child and Family Services Agency and the Department of Youth Rehabilitation Services. C.5.29.35.2 The Contractor shall be required to designate a contact for the Child and Family Services Agency (CFSA) and DYRS to develop any policies and procedures needed to coordinate health care for Enrollees affiliated with such agencies. (p. 146, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²⁰ 3.6.2 Member Assessment and Identification/Stratification 3.6.2.1 Within 60 calendar days of the member's Enrollment date, the Contractor shall make best efforts to assess the member's health via a health risk assessment designed for all members. Such health risk assessment shall include screening for physical health conditions and behavioral health conditions and Health-Related Social Needs with a special emphasis on identifying a member's need for resources, referrals, wellness programs and community supports. If the initial attempt to contact the member is unsuccessful, the Contractor shall make subsequent attempts to conduct the health risk assessment. The Contractor shall share the results of the assessment with the State as directed in the QCMMR to prevent duplication of activities. The HRA shall, at minimum, screen for housing, food, and transportation needs, as well as document race, ethnicity, and preferred language. Wherever possible, the Contractor shall use questions from validated, nationally-recognized questionnaires and tools. The Contractor shall submit its HRA to DMMA for review and approval. (p. 102, Effective 2020, Addendum 1, MCO MSA, Delaware)

²¹ See "Housing support services" column in part for transportation screening.

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 non-emergency 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. 168, Effective 2020, Addendum 1, MCO MSA, Delaware)

²² 3.6 Care Coordination... 3.6.1.2.... The Contractor's care coordination program shall be organized into the following levels, which will determine the intensity of interventions provided by the Contractor to meet the member's level of need:... 3.6.1.2.3 Level 2 (high risk): Clinical care coordination (p. 101, Effective 2020, Addendum 1, MCO MSA, Delaware)

See 3.6.2.111 for more on Clinical Care Coordination.

3.9.4 Cultural Competency 3.9.4.1 The Contractor shall encourage and foster Cultural Competency among its providers. This includes contracting with providers from different cultures and offering training on how to provide culturally appropriate care to members from different cultural and ethnic backgrounds, disabilities (physical, intellectual, and behavioral), and regardless of gender, sexual orientation or gender identity. 3.9.4.1.1 Training may be provided in-person, online via live or recorded webinar, online self-study, or by other reasonable means. The Contractor shall document training that is provided so that the provider directory requirements can reflect which providers have completed cultural competency training per Section 3.14.1.6.1.7 of this Contract. (p. 182, Effective 2020, Addendum 1, MCO MSA, Delaware)

3.14.2.11 Cultural Competency 3.14.2.11.1 As required by 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity. 3.14.2.11.2 The Contractor shall encourage and foster Cultural Competency among its employees and providers. (p. 273, Effective 2020, Addendum 1, MCO MSA, Delaware)

²³ 3.8.12.5 Coordination with School-Based Services Provided by the State 3.8.12.5.1 The State contracts with Delaware school districts to provide screening and health-related services that the schools must provide to children with special needs under IDEA. Under Part B of IDEA, school districts must prepare an IEP for each child, which specifies all special education and "related services" needed by the child. Per Federal policy the State can pay for some of the health "related services" if they are covered by Medicaid. Examples of health-related services commonly provided under an individualized education program (IEP) and reimbursed by Delaware Medicaid are physical therapy, speech pathology services, occupational therapy, psychological services and medical screening and assessment services. The least restrictive environment requirement has been interpreted to mean that therapy services should be delivered on school premises. 3.8.12.5.2 The State will continue to pay for these health-related services on an FFS basis. The Contractor is not responsible for paying for these services, but the Contractor must work with school districts and their providers to create and implement procedures for linking and coordinating services for children who attend school and receive health-related services under an IEP. The Contractor must also coordinate with school districts and their providers to prevent the provision of duplicate services. (pp. 176-177, Effective 2020, Addendum 1, MCO MSA, Delaware)

²⁴ D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by "X" in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 3: Approved Expanded Benefits... Housing Assistance (p. 5, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

3. Behavioral Health and Supportive Housing Assistance Pilot a. The Agency shall implement a voluntary pilot program to provide additional behavioral health services and supportive housing assistance services appropriate for Medicaid enrollees ages twenty-one (21) years and older with serious mental illness (SMI), substance use disorder (SUD), or SMI with co-occurring SUD, who are homeless or at risk of homelessness. (pp. 24-25, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²⁵ C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 2A: Required MMA Services... (30) Transportation Services (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by "X" in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1.

Table 3: Approved Expanded Benefits... Non-emergency Transportation – Non-Medical Purposes (p. 5, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

2. Network Capacity and Geographic Access Standards... c. The Managed Care Plan may provide transportation services directly through its own network of transportation providers or through a subcontractor. The Managed Care Plan shall ensure a transportation network of sufficient size to ensure the ability to provide the services required in this Contract. (p. 93, Updated February 2022, AHCA Contract No. FP0XX, Attachment II – Scope of Service – Core Provisions, Florida Managed Medical Assistance (MMA) Program)

²⁶ 4. Cultural Competency Plan As required by 42 CFR 438.206 (c)(2), the Managed Care Plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (p. 64, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

²⁷ 9. Additional Care Coordination/Case Management Requirements... f. The Managed Care Plan shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:... (9) Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement. (p. 36, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

7. Behavioral Health Programs The Managed Care Plan shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system. (p. 41, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²⁸ 4.6.8 Transportation 4.6.8.1 The Contractor shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature. 4.6.8.2 The Contractor is not responsible for providing non-emergency transportation (NET) for its Members. Eligible Medicaid Members are to contact the assigned NET Broker for the county they live in to arrange for transportation. The Contractor is encouraged to collaborate with the NET Brokers and assist both the NET brokers and assigned Members with the coordination of NET services for assigned Members. 4.6.8.3 The Contractor may, however, coordinate other transportation for those Medicaid Members not eligible for transportation under the NET Broker contract. In the event Contractor performs such coordination, DCH shall not be responsible for any payment resulting from such services. The following Categories of Aid are not eligible for NonEmergency Transportation... see page 92 for full list. (pp. 91-92, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²⁹ 4.3.9 Cultural Competency 4.3.9.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each. The cultural Competency Plan must include: 4.3.9.1.1 Training to Member services staff and Contract Providers, including PCPs and Contractor staff at all levels, to receive ongoing education and training in culturally and linguistically appropriate service delivery; 4.3.9.1.2 Plan for interpretive services and written materials, consistent with Section 4.3.10 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in the languages of the commonly encountered group and/or groups represented in the service area; 4.3.9.1.3 4.3.9.1.4 4.3.9.1.5 4.3.9.1.6 4.3.9.2 Identify community advocates and agencies that could assist LimitedEnglish Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral; Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment; Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups; Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State. The Contractor shall submit the Cultural Competency Plan to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter. 4.3.9.3 The Contractor may distribute a summary of the Cultural Competency Plan to the InNetwork Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider. (pp. 76-77, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

4.11.10.6 Levels of Case Management for the GF Program include... 4.11.10.6.3 Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems. (p. 157, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³⁰ 4.11.10.7 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays. (p. 157, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³¹ 4.11 Utilization Management and Coordination and Continuity of Care Responsibilities... 4.11.8 Coordination and Continuity of Care Responsibilities... 4.11.8.8 Coordination with Other Entities 4.11.8.8.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the Georgia Families program. 4.11.8.8.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services. 4.11.8.8.3 The Contractor shall coordinate the services furnished to its Members with the service the Member receives outside the CMO, including services received through any other managed care entity. (pp. 148-153, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

³² Housing screening and coordination provisions are included throughout the contract for specific populations. See Quest Integration (QI) RFP-MQD-2021-008 for more details.

³³ 4.6 Coverage Provisions for Transportation Services A. The Health Plan shall provide transportation to and from Medicaid covered medical appointments when Medical Necessity is established for the Members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. Transportation services include both emergency and non-emergency ground and air services. B. The Health Plan shall also provide transportation to the Members who are referred to a provider that is located on a different island or

in a different service area. The Health Plan may use whatever modes of transportation that are available and can be safely utilized by the Member. In cases where the Member is a minor or requires assistance, the Health Plan shall provide for one (1) attendant to accompany the Member to and from visits to providers when Medical Necessity is established. The Health Plan is responsible for the arrangement and payment of the travel costs (airfare, ground transportation, lodging, and meals) for the Member and the one (1) attendant (where applicable) associated with off-island or out-of-state travel due to Medical Necessity. C. In the event there is insufficient access to specialty providers (including but not limited to psychiatrists and specialty physicians), the Health Plan shall arrange to transport providers. D. Should the Member be dis-enrolled from their QI Health Plan and enrolled into the Medicaid FFS program or another QI Health Plan while off-island or out-of-state, the former QI Health Plan shall be responsible for the return of the Member to the island of residence and for transitioning care to the Medicaid FFS program or the other QI Health Plan. (pp. 168-169, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁴ Cultural competency provisions on page 211-212.

³⁵ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services:... 4) Perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program. (p. 157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁶ 3.8 Coordination with State Programs and Other Programs A. In addition to the Health Coordination requirements in §3.7 and the Health Plan Manual, the Health Plan is also responsible for coordination with State and other programs as described in §3.8... 5. DHS – Foster Care/Child Welfare Services (CWS) Children a. For children with active cases with CWS – In addition to providing all services when Medical Necessity is established under EPSDT, the Health Plan shall be responsible for providing pre-placement physicals prior to placement. Additionally, the Health Plan shall provide comprehensive examinations within forty-five (45) days after placement into a foster care home. The Health Plan also shall cover dispensing medications when a physical examination shows a medical need. b. The Health Plan shall have a process that details how the case worker may also request a change in Health Plan outside of the annual plan change period without limit if it is in the best interest of the child. Disenrollment shall be effective at the end of the month in which the request is made. 6. Department of Education – School-Based Services a. The costs for school-based health services are not included in the capitation rate paid to the Health Plan. (pp. 115-116, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

³⁷ 2.11 Coordination with Other State Agencies and Program Contractors The Contractor agrees to reasonably cooperate with and work with the other program contractors, subcontractors, State agencies and third-party representatives and to support community-based efforts as requested by the Agency, including but not limited to:... 2.11.3 Iowa Department of Education The Contractor shall work closely with the Iowa Department of Education... 2.11.5 The Agency Child Welfare and Juvenile Justice Services The Agency's Division of Adult, Family, and Children Services has responsibility for program standards and the budget for most child welfare and juvenile justice services. The Contractor's membership shall include individuals receiving child welfare/juvenile justice (CW/JJ) services and individuals within the state's foster care or subsidized adoption program. The Contractor shall coordinate with ACFS to meet goals for safety, permanency and well-being of the child and shall authorize appropriate healthcare services to complement CW/JJ services upon request from the Agency field workers or juvenile court officers. As an integral part of the system which provides services and supports to adopted children and their families, the Contractor shall be required to collaborate with the Agency and the Iowa Foster and Adoptive Parents Association to develop services and supports to meet the specialized health needs of children who have been adopted from Iowa's foster care system... 2.11.7 Community Based Agencies The Contractor is expected to support community-based efforts to build better interfaces with agencies, such as: (i) school districts; (ii) area education agencies, (iii) Decategorization Boards; (iv) MHDS regions; (v) local public health entities; (vi) job training, placement and vocational service agencies; (vii) judicial districts; and (viii) the Iowa Department of Corrections. The Agency will work with the Contractor to prioritize community-based efforts to support the success of the program. (pp. 26-27, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

³⁸ 1.1.3.1 Clinical areas to be monitored. At a minimum, the following areas shall be monitored for all populations: ...1.1.3.1.4 assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, and senior centers. (pp. 227-228, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract)

3.1.2. Preventive medicine schedule (services to Enrollees age twenty-one [21] years or older). Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. ... For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee: 3.1.2.5 assessment of social and economic determinants of health: housing, transportation availability, and employment. (pp. 306-307, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

³⁹ 1.1.71 Emergency Services means inpatient and outpatient healthcare services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services. (p. 19, Effective 2018, State of IL Model Contract)

2.7.2. Cultural Competence plan. Contractor's Cultural Competence plan shall address the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence plan shall, at a minimum, address the following: 2.7.2.9 Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation. (p. 48, Effective 2018, State of IL Model Contract)

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, Effective 2018, State of IL Model Contract)

1.1.3.1 Clinical areas to be monitored. At a minimum, the following areas shall be monitored for people with Chronic Health Conditions (such conditions specifically including, without limitation, diabetes, asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, Behavioral Health, including those with one or more comorbidities): 1.1.3.1.38 assistance sufficient to access Behavioral Health services, including but not limited to transportation and escort services. (pp. 227-230, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

3.1.1.4 Contractor shall, at least annually, inform Enrollees about the EPSDT program, including but not limited to the following: the importance of preventive healthcare; the services that are available; how to request assistance in identifying a willing and qualified Network Provider; how to request assistance in obtaining transportation to and from healthcare appointments; and that the services are available at no cost to an eligible recipient, except as may be limited by a spenddown requirement. (pp. 305-306, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

3.1.2. Preventive medicine schedule (services to Enrollees age twenty-one [21] years or older). Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. ... For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee: 3.1.2.5 assessment of social and economic determinants of health: housing, transportation availability, and employment. (pp. 306-307, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract)

⁴⁰ 2.7.1. Contractor shall implement a Cultural Competence plan, and Covered Services shall be provided in a culturally competent manner by ensuring the Cultural Competence of all Contractor staff, from clerical to executive management, and Providers. Contractor shall implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). 2.7.2 Cultural Competence plan. Contractor's Cultural Competence plan shall address the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence plan shall, at a minimum, address the following: 2.7.2.1 involvement of executive management and Providers in the development and ongoing operation of the Cultural Competence plan; 2.7.2.2 the individual executive employee responsible for executing and monitoring the Cultural Competence plan; 2.7.2.3 the creation and ongoing operation of a committee or group within Contractor to assist Contractor to meet the cultural needs of its Enrollees. This committee shall: 2.7.2.3.1 be reflective of the geographical and cultural groups served by Contractor, and 2.7.2.3.2 at minimum have fifty-one percent (51%) of its committee members be Enrollees or community-based participants; 2.7.2.4 the assurance of Cultural Competence at each level of care; 2.7.2.5 indicators within

the Cultural Competence plan that Contractor will use as benchmarks toward achieving Cultural Competence; 2.7.2.6 Contractor's written policies and procedures for Cultural Competence; 2.7.2.7 Contractor's strategy and method for recruiting staff with backgrounds representative of Enrollees served; 2.7.2.8 the availability of interpretive services; 2.7.2.9 Contractor's ongoing strategy and method to ameliorate transportation barriers and its operation; 2.7.2.10 Contractor's ongoing strategy and method to meet the unique needs of Enrollees who have Developmental Disabilities and Cognitive Disabilities and its operation; 2.7.2.11 Contractor's ongoing strategy and method to provide services for home-bound Enrollees and the strategy's operation; 2.7.2.12 Contractor's ongoing strategy and method to engage local organizations to develop or provide cultural-competency training and collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery and its operation; and 2.7.2.13 a description of how Cultural Competence is and will continue to be linked to health outcomes. 2.7.3. Staff. Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to hire staff who reflect the diversity of Enrollee demographics. Contractor shall require all staff, including employees and contract personnel, to complete linguistic and Cultural Competence training upon hire and no less frequently than annually thereafter. 2.7.4. Providers. Contractor shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Contractor's contracts with Providers shall require that Providers comply with Contractor's Cultural Competence plan. Contractor shall confirm the languages used by Providers, including American Sign Language, and ensure physical access to Providers' office locations. 2.7.5. Subcontractors. Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's oversight committee, established pursuant to section 5.40.4, shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act. 2.7.6. Provider monitoring. Contractor shall perform QA evaluations of Provider practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. Contractor shall support Providers in achieving accessibility. (Page 48-49, 2022 State of IL Model Contract) 2.7.7. Readiness Review. Contractor shall submit its completed Cultural Competence plan to the Department at least two (2) weeks prior to the Department's Readiness Review. (pp. 47-49, Effective 2018, State of IL Model Contract)

5.8.6 Specialists as PCPs. Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special healthcare needs the option of choosing a specialist to be their PCP. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to schedule an assessment. Contractor's medical director will approve or deny requests after determining whether the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of a PCP. (p. 83, Effective 2018, State of IL Model Contract)

5.10.3 Cultural Competence. Contractor will provide Cultural Competence requirements at orientation, training sessions, and updates as needed. Contractor, upon request of Provider, shall agree to allow Provider to certify compliance with this provision if completed through another Contractor in the Medicaid program. (p. 85, Effective 2018, State of IL Model Contract)

5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees, Dual-Eligible Adult Enrollees, Enrollees residing in a Nursing Facility, and Enrollees who receive Covered Services under an HCBS Waiver. In addition, any Enrollee may request Care Management. (p. 88, Effective 2018, State of IL Model Contract)

5.13.3. Outreach. Contractor shall use its best efforts to locate all Enrollees who are identified through risk stratification as being high-risk or moderate-risk. For the purpose of this section, the Department will define best efforts on an annual basis. Where appropriate, Contractor shall use community-based organizations to locate and engage such Enrollees. (p. 91, Effective 2018, State of IL Model Contract)

5.14. Interdisciplinary Care Team. 5.14.1. Contractor shall support an ICT for all Enrollees stratified as high-risk (Level 3), Dual-Eligible Adult Enrollees, and Enrollees who receive Covered Services under an HCBS Waiver. The ICT will ensure the integration of the Enrollee's medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties. 5.14.2 Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and

support one another in the oversight of each Enrollee's needs. 15.14.3. ICT functions shall include: 5.14.3.1 providing Care Management for Enrollees; assisting in the development, implementation, and monitoring of IPoCs, including HCBS service plans where applicable; and, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system; 5.14.3.2 ensuring a primary Care Coordinator is responsible for coordination of all benefits and services the Enrollee may need (Care Coordinators will have prescribed caseload limits as set forth in section 5.17.2); 5.14.3.3 assigning a Care Coordinator who has the experience most appropriate to support the Enrollee; 5.14.3.4 using motivational interviewing techniques; 5.14.3.5 explaining alternative care options to the Enrollee; and 5.14.3.6 maintaining frequent contact with the Enrollee through various methods including face-to-face visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request. 5.15. Individualized Plans of Care and Service Plans. 5.15.1. Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as high-risk Level 3 (high risk) and Enrollees in a HCBS Waiver. The IPoC must be developed within ninety (90) days after enrollment. Contractor shall engage Enrollees in the development of the IPoC as much as possible. 5.16. Individual Plan of Care Health Risk Reassessment. Contractor will analyze predictive-modeling reports and other surveillance data of all Enrollees monthly to identify risk-level changes. As risk levels change, reassessments will be completed as necessary and IPoCs updated. Contractor shall review IPoCs of high-risk (Level 3) Enrollees at least every thirty (30) days, and of moderate-risk (Level 2) Enrollees at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, Contractor shall conduct a health-risk reassessment annually for each Enrollee who has an IPoC. In addition, Contractor shall conduct a face-to-face health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment. Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than five (5) Business Days. (pp. 92-95, Effective 2018, State of IL Model Contract)

5.21.4. Communications with Prospective Enrollees, Potential Enrollees, and Enrollees. ...Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to promote the hiring of local staff to ensure Cultural Competence. (p. 107, Effective 2019, State of IL Model Contract)

⁴¹ 5.12 Care Management. 5.12.1. Contractor shall offer Care Management to all: Enrollees stratified as high-risk (level 3) as described at section 5.13.1.4.1, pregnant Enrollees... (p. 88, Effective 2018, State of IL Model Contract)

3.1.3.13.1 ...[care] shall include: ongoing risk assessment and development of an Individualized Plan of Care (IPoC) most likely to result in a successful outcome of pregnancy and a healthy baby, and takes into consideration the medical, psychosocial, cultural/linguistic, and educational needs of the Enrollee and her family. (p. 309, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

3.1.3.13.2. 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. (p. 310, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (pp. 311-312, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

⁴² 1.1.33. Child and Family Team is a group of individuals responsible for the development, implementation, and monitoring of a unified IPoC that engages and involves the Child and family. The Child and Family Team is composed of family members, significant people in the lives of the Child and family, and representatives of the community's human services agencies that can provide needed services. (p. 14, Effective 2018, State of IL Model Contract)

5.20.2.1 School-based health centers. 5.20.2.1.1 Contractor shall offer contracts to all the school health centers recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for school-based health center services provided by those school-based health centers with which Contractor has contracts. 5.20.2.1.2 For Illinois school-based health centers outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of school-based health center services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require school-based health centers to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. (p. 104, Effective 2018, State of IL Model Contract)

3.1.4 Coordination with other service providers. Contractor shall encourage Network Providers and Subcontractors to cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include WIC programs, Head Start programs, Early Intervention programs, day care programs, and school systems, among others. Such cooperation may include performing annual health examinations for school and the sharing of information (with the consent of the Enrollee, parent or legal guardian, if the Enrollee is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927. Contractor shall coordinate with the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs, which shall include, but is not limited to: 3.1.4.1 coordinating services and sharing information with existing FCM/BBO providers for its Enrollees; 3.1.4.2 developing internal policies, procedures, and protocols for the organization and its provider network for use with FCM/BBO Providers serving Enrollees; and 3.1.4.3 conducting periodic meetings with FCM/BBO Providers performing problem resolution and handling of Grievances and issues, including policy review and technical assistance. (pp. 314-315, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

⁴³ 6.8 Disease Management. Members served in the Contractor's disease management, care management and complex case management services may require additional resources to meet their biopsychosocial needs. To meet these needs, the Contractor shall make every effort to assist members in navigating community resources and linking members with community-based services such as...housing and housing supports.... (p. 80, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁴ 6.8.2 Care Management. ...Care management services include direct consumer contacts in order to assist members with... transportation needs..... 6.8.3 Complex Case Management... The Contractor's case management services and care plan development shall involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy to help link the member with providers or programs capable of helping the member achieve the defined goals of the care plan. The member's health care providers shall be included in the development and execution of member care plans. ...Members shall receive the same educational materials delivered to those persons receiving case management including direct consumer contacts in order to assist members with... transportation needs.... (pp. 82-83, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.15 Enhanced Services. Enhanced services may include, but are not limited to, such items as: Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.). (p. 88, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.18 Non-Emergency Medical Transportation Services Non-emergency medical transportation (NEMT) services are a covered benefit under the HIP program for HIP Maternity and HIP State Plan members per Exhibit 3 Program Description and Covered Benefits that the Contractor is responsible for managing and reimbursing. NEMT services are intended for members who have no other means of transportation available to them. Under the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209 the Contractor must provide for a mechanism, which may include attestation, that ensures any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary services receiving payments under

such plan (but excluding any public transit authority), meets specified minimum requirements. These minimum requirements under the State plan must include that: Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services; Each such individual driver has a valid driver's license; Each such provider has in place a process to address any violation of a State drug law; and Each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations. (pp. 89-90, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁵ 6.1 Covered Benefits and Services. In addition, HIP will cover additional pregnancy-only benefits which will only be available for pregnant HIP members enrolled in either the HIP Plus or HIP Basic plans. The additional pregnancy-only benefits are specified in the applicable ABP and include such services as nonemergency transportation...(p. 64, Amendment #14, 2021 Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁶ 2.4.3 Training. On an ongoing basis, the Contractor shall ensure that each staff person, including members of subcontractors' staff, has appropriate education and experience to fulfill the requirements of their position, as well as ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management information systems, training on fraud and abuse and the False Claims Act, HIPPA, HI-TECH, etc.). (p. 21, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.7.2 Behavioral Health Provider Network. ... The Contractor is responsible for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of its member population and are competent in respectfully and effectively interacting with individuals with varying racial, ethnic and linguistic differences. The Contractor shall provide to OMPP its written training plan, which shall include dates, methods (e.g., seminar, web conference, etc.) and subject matter for training on integration and cultural competency. (p. 76, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.8.3 Complex Case Management. The Contractor's protocol for referring members to complex case management shall be reviewed by OMPP and shall be based on a member's designation as medically frail, identification through the health needs screening as having special care needs, a condition of interest named above, or a chronic or co-morbid disease utilization history and/or member request that indicates the need for real-time, proactive intervention. Persons with clinical medical training shall be required to develop the member's care plan. The Medical Director shall be available to consult with the clinicians on the care management team as needed to develop the care plans for high-risk cases. Care plans developed by the Contractor shall include clearly stated health care goals to address the medical, social, educational, and other services needed by the individual and defined milestones to document progress, clearly defined accountability and responsibility and timely, thorough review with appropriate corrections ("course changes") as indicated. The Contractor's case management services and care plan development shall involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy to help link the member with providers or programs capable of helping the member achieve the defined goals of the care plan. The member's health care providers shall be included in the development and execution of member care plans. Care plans and case management shall take into account co-morbidities being jointly managed and executed, as separate care plans for each medical problem in the same member may fragment care and add to the potential of missing interactive factors. The Contractor shall contact members telephonically and in-person as indicated by their need. Care managers should engage in care conferences with the member's health care providers, as necessary. (pp. 82-83, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.1 Marketing and Outreach. The Contractor shall conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor shall provide information to potential eligible individuals who live in medically underserved rural areas of the State. (p. 90, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

7.11 Cultural Competency In accordance with 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of care in a culturally competent manner. The Contractor shall incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of health care services for its members. The CLAS standards are available at <https://www.thinkculturalhealth.hhs.gov/clas/standards>. (p. 115, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

8.0 Provider Network Requirements. The Contractor shall also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its member populations. The network shall be able to handle the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner. (p. 116, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁷ 6.10 Other Covered Benefits and Services. In addition to the benefits and services listed above, the Contractor shall also cover the following: ...The Contractor shall provide prenatal care programs targeted to avert untoward outcomes in high-risk pregnancies. (p. 83, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

9.2.3 Notification of Pregnancy (NOP) Incentives. OMPP has implemented a Notification of Pregnancy (NOP) process that encourages MCEs and providers to complete a comprehensive risk assessment (i.e., a NOP form) for pregnant members. The Contractor shall comply with the policies and procedures set forth in the IHCP Provider Bulletin regarding the NOP process dated May 22, 2014 (BT201425), and any updates thereto. The provider shall be responsible for completing the standard NOP form, including member demographics, any high-risk pregnancy indicators, and basic pregnancy information. The Contractor receiving the NOP shall contact the member to complete a comprehensive pregnancy health risk assessment within twenty-one (21) calendar days of receipt of completed NOP form from the provider. Only one assessment should be completed per member per pregnancy, regardless of whether the member receives pregnancy services through the Presumptive eligibility for pregnant women program. NOP requirements and conditions for payment are set forth in the HIP MCE Policies and Procedures Manual. ...The Contractor shall have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in a prenatal case management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p. 144, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁸ 7.4 Member Information, Outreach and Education. The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with school-based health centers, community mental health centers, WIC clinics, county health departments and prenatal clinics to promote health and wellness within its membership. In the first and third quarter of every Contract year, the Contractor shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The Contractor shall use the federal poverty level of 130% to identify potentially eligible members. The Contractor shall conduct an educational outreach campaign to the members identified as potentially eligible. The Contractor does not need to outreach to all potentially eligible members at once, but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every Contract year). (p. 99, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁴⁹ Case Management – A collaborative process of assessment, planning, facilitation, service coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs (behavioral health, physical health, and long-term services and supports) through communication and referral to available resources to ensure needs are met. Additionally, case management addresses Social Determinants of Health and Independence that include but are not limited to housing... assistance. (p. 2, no date, Attachment A - Definitions and Acronyms. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

Note: Attachment L is a table that outlines the types of services that should be coordinated for high-risk, vulnerable populations. Housing supports show up in many of the "community services" that should be coordinated for these populations. (pp. 1-4, no date, Attachment L, Services Coordination Matrix, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW. ...B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: ...5. Addresses the Social Determinants of Health and Independence, including housing. ... D. The CONTRACTOR(S) Service Coordination model requires at a minimum that the following groups be enrolled in Service Coordination: ...8. Other individuals who the CONTRACTOR(S) determines would benefit from Service Coordination. The CONTRACTOR(S) shall use at a minimum information regarding Social Determinants of Health and Independence, such as housing instability... in identifying other individuals who would benefit from Service Coordination. The CONTRACTOR(S) may also use other tools, including proprietary algorithms, to identify additional Members for Service Coordination. The CONTRACTOR(S) shall submit the criteria used for determining other Members who will receive Service Coordination to the State for review and approval. (pp. 31-33, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.6. MANAGED CARE ORGANIZATION SERVICE COORDINATION ROLES AND RESPONSIBILITIES. ... B. The CONTRACTOR(S) is ultimately responsible for all Service Coordination activities below and displayed in Attachment L, and shall ensure the following tasks are performed: ...7. For Members with chronic/complex conditions and other Members who the CONTRACTOR(S) has identified as in need of Service Coordination who do not fall into another Service Coordination population, the CONTRACTOR(S) shall: ...f. Provide support...housing, including making referrals, advocacy and follow-up. (p. 46, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.7. COMMUNITY SERVICE COORDINATION ROLES AND RESPONSIBILITIES. A. The community service coordinator shall serve as the single point of contact for the Member. The CONTRACTOR(S) shall provide oversight of its contracted community service coordinators to ensure that the following activities outlined in Attachment L and below are performed: ...8. Support for... housing, including, but not limited to, making referrals, advocacy and follow up. (p. 48, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.8.3.1. SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE. A. The CONTRACTOR(S) shall develop a process for identifying Social Determinants of Health and Independence needs when interacting with Members and connecting them to necessary resources when appropriate. Such needs could include, but not limited to safe housing... within the UM program and UM activities. (p. 111, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.17.2. CONTRACTOR(S) KEY PERSONNEL C. Key Personnel include: ...21. A full-time staff person exclusively dedicated to overseeing Housing Services and Supports for LTSS and Behavioral Health programs and services. This person shall have at least three (3) years' experience in assisting the elderly and persons with disabilities to secure accessible, affordable housing through Federal (such as HUD, Shelter Plus Care, SAMHSA, and USDA), as well as, local programs. The Housing Specialist shall work under the Housing First Model, honoring Member choice. The Housing Specialist shall be responsible for working with the aforementioned housing agencies and other Housing programs to help develop and access affordable housing services for Members receiving LTSS, educating and assisting Care/Support Coordinators regarding affordable housing services for KanCare Members, and liaison with KDADS housing coordinators and housing specialists within each Community Mental Health Center on Kansas' broader housing strategy and initiatives. The housing specialist will work with KDADS to ensure that Community Providers are trained and achieving fidelity in evidence-based practices (i.e. Housing First Model). (pp. 197-198, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁵⁰ 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: ...2.36 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: 2.36.1 Mileage reimbursement to medically necessary services. 2.36.2 Lodging and meals for the member and one attendant when the receipt of medical services necessitates an overnight stay. 2.36.3 Transportation to family planning services even if these services are obtained from a Provider not participating in the CONTRACTOR(S)' network. (pp. 10-11, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

Note: Attachment L is a table that outlines the types of services that should be coordinated for high-risk, vulnerable populations. Transportation coordination show up in many of the "MCO service coordination" that should be coordinated for these populations. (pp. 1-4, no date, Attachment L, Services Coordination Matrix, KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW. ...B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: ...5. Addresses the Social Determinants of Health and Independence, including...transportation and other social determinants. (p. 31, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.4.6. MANAGED CARE ORGANIZATION SERVICE COORDINATION ROLES AND RESPONSIBILITIES. ... B. The CONTRACTOR(S) is ultimately responsible for all Service Coordination activities below and displayed in Attachment L, and shall ensure the following tasks are performed: ...3. Coordination of... transportation needs, as appropriate. (p. 46, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

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. D. When returning the Member to the point of origin, Non-Emergency Medical Transportation Providers shall ensure return routes are efficient, do not result in unnecessary delays, and do not include scheduled or unscheduled stops during the return trip. E. CONTRACTOR(S) must develop and implement a quarterly performance auditing protocol to evaluate compliance with these standards for subcontracted Non-Emergency Medical Transportation Providers. F. CONTRACTOR(S) must ensure that an exception process is in place to accommodate Members who require same day Non-Emergency Medical Transportation services in order to access any medically necessary Covered Service(s) under the CONTRACT. G. CONTRACTOR(S) must submit to the State for approval any PA requirements for mileage, lodging, and meal reimbursement. (pp. 76-77, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.8.3.1. SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE. A. The CONTRACTOR(S) shall develop a process for identifying Social Determinants of Health and Independence needs when interacting with Members and connecting them to necessary resources when appropriate. Such needs could include, but not limited to safe housing, food security, transportation, employment and career training, and education, within the UM program and UM activities. (p. 111, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.10.7. MEMBER HANDBOOK REQUIREMENTS. ...E. The content of the Member Handbook must include the following: ...9. How to obtain emergency transportation and medically necessary transportation. (p. 140, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁵¹ Reports and Data Elements. ... 97. Cultural Competency Plan. The Plan must include how the CONTRACTOR(S) ensures that care and services are delivered in a culturally competent manner, training, goals and an annual assessment of the plan. (p. 22, no date, Attachment H – Reports and Data Elements. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

5.5.2. NETWORK DEVELOPMENT ...G. CONTRACTOR(S) shall adhere to the following requirements and considerations for specific Provider types within its Provider network: ... 3. The CONTRACTOR(S) must attempt to contract with graduating residents and Providers that are opening new practices in, or relocating to, Kansas, especially in rural and underserved areas. (p. 70, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.5.4. CULTURAL COMPETENCY AND HEALTH LITERACY IN THE DELIVERY OF CARE. A. The CONTRACTOR(S) shall: Promote and participate in the State's efforts to ensure that Covered Services are delivered in a culturally competent manner to all Members and is responsive to Members' health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. a. Cultural competency refers to the practices and behaviors that ensure that all Members receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a Member's characteristics. b. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand back health information and services needed to make appropriate health decisions. 2. Adhere to requirements for establishing a Provider directory as specified in Section 5.10.8 that indicates each Provider's linguistic capabilities, as well as whether the Provider has completed cultural competence training, and whether the Provider's offices, exam rooms, and equipment accommodate individuals with physical disabilities. 3. Ensure that Members are provided Covered Services without regard to race, color, national origin, sex, sexual orientation, gender identity, age, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, age, or disability. 4. Incorporate in its policies, administration, and service practice the values of (i) honoring Member's beliefs, (ii) sensitivity to cultural diversity, and (iii) fostering in staff and Providers' attitudes and interpersonal communication styles which respect Members' cultural backgrounds. The CONTRACTOR(S) shall have specific policy statements on these topics and communicate them to Subcontractors and Participating Providers. 5. Foster and enhance Participating Providers' understanding and application of techniques to identify and adapt to Members' cultural preferences and health literacy needs as an integrated component of service delivery. Such supports should include interactive and ongoing training, dedicated CONTRACTOR(S)' staff for Participating Providers to consult as needed, a resource library of best practices and national standards, and other resources as appropriate to evidence the importance of cultural competency and health literacy in the delivery of Covered Services. 6. Permit Members to choose any Participating Provider from among the CONTRACTOR(S)' network based on cultural preference. Members may submit grievances to the CONTRACTOR(S) and/or the State related to inability to obtain culturally appropriate care. 7. If the CONTRACTOR(S) identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its Subcontractors or Participating Providers, it shall promptly intervene and require a Corrective Action Plan from the Subcontractor or Participating Provider. Failure to take prompt corrective measures may place the CONTRACTOR(S) in default of its CONTRACT. B. Cultural Competency Plan: Within 90 days of award, the CONTRACTOR(S) shall develop and submit for State approval a Cultural Competency Plan. The Cultural Competency Plan shall be evaluated, updated, and submitted annually to the State. The Cultural Competency Plan shall include, but not be limited to: 1. Description of how care and services are delivered in a culturally competent manner, including how this will be achieved in rural areas of the State via telehealth strategies. 2. Role of Social Determinants of Health and Independence in improving and sustaining positive health Outcomes. 3. Strategies to assess and respond to the health literacy needs of Members 4. Identification of the CONTRACTOR(S)' specific staff responsible for the development and maintenance of the Cultural Competency Plan. 5. Goals for the coming year. 6. Training and education methods utilized by the CONTRACTOR(S) to educate staff, Participating Providers, and Members about cultural competency, including a description of the training programs. 7. Description of how the CONTRACTOR(S) conducts regular assessments of the Provider network to ensure services are provided in a culturally competent manner to diverse populations. (pp. 73-74, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁵² C...3. CONTRACTOR(S) shall also coordinate with other Title V programs such as programs funded under the Individuals with Disabilities Education Act, the Healthy Start Home Visiting Program, the Maternal and Infant and Family Planning Clinics as well as any other programs operated by the State and local health departments. 4. CONTRACTOR(S) shall also cooperate with the justice systems in Kansas, to include but not limited to, Kansas Department of Corrections and Juvenile Justice. D. Local Education Agencies: CONTRACTOR(S) is required to cooperate with these Local Education Agencies for the provision of Covered Services. The State will be monitoring this cooperation in order to assess possible future CONTRACT requirements. E. CONTRACTOR(S) shall coordinate with any Indian Health Service Clinics or tribally operated facilities in their service area. Documentation of such coordination is required. (p. 18, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

⁵³ 34.3 Population Health Management Program Tools. ...C. Enrollee Needs Assessments. The Enrollee Needs Assessment shall at a minimum assess the following: .. 3. Social Determinants of Health, including employment and housing status. ((p. 155, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

34.4 Care Planning. ...The Contractor shall use innovative strategies and solutions to address person-centered goals and outcomes. The Care Plan shall be developed in accordance with 42 C.F.R. 438.208. An Enrollee's Care Plan, at a minimum, shall include: ... C. Description of Enrollee's psychosocial needs including any housing or financial assistance needs; how such needs will be addressed to ensure the Enrollee's ability to live safely in the community; (p. 156, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁵⁴ 22.1 Required Functions. ...The Contractor's Enrollee Services function shall also be responsible for: ...U. Assisting Enrollees in obtaining transportation for both emergency and appropriate nonemergency situations. (p. 88, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

22.2 Enrollee Handbook. The Enrollee Handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information: ...K. Procedures for obtaining transportation for both emergency and non-emergency situations. (p. 90, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.2.11 Transportation Services The Department contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. The Contractor shall contract with providers of transportation of an emergency nature, including emergency ambulance and ambulance stretcher services. (p. 120, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

32.7 Nonemergency Medical Transportation The Department contracts with the Kentucky Transportation Cabinet, Office of Transportation 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 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. (p. 146, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

41.10.2 Care Coordination Teams. ...B. The Care Coordination Team shall: ... 8. Document efforts to obtain Provider appointments, arrange transportation, establish meaningful contact with the Members' PCP, Dental Provider, specialists and other Providers, and arrange for referrals to community based resources. Such documentation shall include details on any barriers or obstacles to arranging or obtaining these services. (p. 196, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services. ...FF. Transportation to Covered Services, including Emergency and Ambulance Stretcher Services (p. 264, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁵⁵ 22.4 Cultural Consideration and Competency The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. The Contractor shall address the special health care needs of its Enrollees needing culturally sensitive services. The Contractor shall conduct ongoing training of staff in the areas of cultural competency development, cultural sensitivity, and unconscious bias. The Contractor shall incorporate in policies, administration and service practice the values of the following: recognizing the Enrollee's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Enrollee's cultural background. The Contractor shall

communicate such policies to Subcontractors and include requirements in Subcontracts to ensure Subcontractor implementation of such policies. (p. 91, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

22.5 Outreach to Homeless Persons The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence. The plan shall include: A. Utilizing existing community resources such as shelters and clinics; and B. Face-to-face encounters. The Contractor shall not differentiate services for Enrollees who are homeless. Victims of domestic violence and Former Foster Care Youth should be targeted for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable. (p. 91, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

27.5 Provider Orientation and Education. The Contractor shall ensure that Provider education includes:... M. Cultural sensitivity (p. 110, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

28.5 Provider Network Plan. ...The Provider Network Plan shall address the following at a minimum:... Methods to support and sustain Network Providers, including hospitals, in Non-urban and other traditionally underserved areas. (p. 123, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

41.11.3 Cultural Consideration and Competency. The SKY Contractor shall comply with the requirements set forth in Section 22.4."Cultural Consideration and Competency." In addition, the SKY Contractor shall ensure that staff and Providers are educated on Trauma-informed Care, the impact of ACEs, NAS, and SEI. (p. 200, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX C. REQUIRED STANDARD PROVISIONS FOR NETWORK PROVIDER CONTRACTS. ...D. Enrollee Services... 3. Require Contract Providers to comply with applicable cultural competency requirements. (p. 227, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁵⁶ 34.2 Conditions and Populations The Department has identified the below conditions and populations as priority for the Population Health Management Program. The Contractor shall implement interventions that focus on Enrollees who have a priority condition identified by the Department, but should also identify additional conditions or populations of focus based on the Contractor's Enrollee population. The Department may also adjust this listing as needs are addressed or as additional needs are identified. A. Population health condition priorities, include:...7. Infant mortality; 8. Low birth weight... B. Population priorities, include:... 2. High-risk pregnant women as determined by providers. (p. 154, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁵⁷ 19.6 Performance Improvement Projects (PIPs). ...The Contractor's PIPs shall include the following elements: The Contractor shall be committed to ongoing collaboration for service and clinical care improvements through efforts such as development of best practices, use of Encounter data-driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection. The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community-based health and social agencies and health care delivery systems to achieve improvements in priority areas. Linkages with local public health agencies is essential for achievement of public health objectives. Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and implementation of PIP activities. (pp. 75-76, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

22.3 Enrollee Education and Outreach. Creative methods should be used to reach Contractor's Enrollees and community partners. These must include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites. (p. 91, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

30.7 Interface with State Behavioral Health Agency A. The Contractor's Behavioral Health Director or designee shall meet with the Department and DBHDID no less than quarterly to discuss State Mental Health Authority and Single State Agency (SSA) for Substance Abuse Services protocols, rules and regulations including but not limited to: 1. Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) operating definitions; 2. Other priority populations; 3. Targeted Case Management, Community Support Associate, and Peer Support provider certification training and process; 4. Satisfaction survey requirements; 5. Priority training topics (e.g., trauma-informed care, suicide prevention, co-occurring disorders, evidence-based practices); 6. Behavioral health Services hotline; and 7. Behavioral health crisis services (referrals; emergency, urgent and routine care). B. The Contractor shall coordinate: 1. Enrollee education process for individuals with Serious Mental Illnesses (SMI) and children and youth with serious emotional disturbances (SED) with the Department. Contractor will provide the Department and DBHDID with proposed materials and protocols. 2. With the Department, DBHDID and CMHCs a process for integrating Behavioral Health Services' hotlines with processes planned by the Contractor to meet system requirements. 3. With the Department on establishing collaborative agreements with state operated or state contracted psychiatric hospitals, as well as with other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. (p. 135, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

34.5 Coordination with Women, Infants and Children (WIC) The Contractor shall comply with Section 1902(a)(11)(C) of the Social Security Act which requires coordination between Medicaid MCOs and WIC. This coordination includes the referral of potentially eligible women, infants and children to the WIC program and the provision of medical information by providers working within Medicaid managed Care Plans to the WIC program if requested by WIC agencies and if permitted by applicable law. Typical types of medical information requested by WIC agencies include information on nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of mothers with a SUD or other drug addiction, developmental disabilities or intellectual disabilities, AIDS, allergy or intolerance that affects nutritional status and anemia. (p. 157, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

3.6.2.4 Education and Training for Law Enforcement Officials and Judges The SKY Contractor shall provide one (1) training per quarter for law enforcement officials, judges, district and county attorneys, including the Kentucky Administrative Office of the Courts and the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy about the following: A. An understanding of the SKY Program and the roles and responsibilities of the Department, DCBS, DJJ, and DBHDID, and how these agencies will coordinate and collaborate with the SKY Contractor; B. Role and responsibilities of the SKY Contractor; C. Needs of the SKY populations; D. High Fidelity Wraparound approach; E. Family First Prevention Services Act; F. Trauma-informed Care; G. Impact of ACEs; and H. Aging out process and support from the SKY Contractor. The Department, DCBS, DJJ and other sister agencies may also participate in these education and training sessions. The SKY Contractor shall provide multiple methods of training to engender the most participation, including face-to-face meeting, webinars, or other tutorials. (pp. 192-193, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

41.6.4 SKY Implementation Plan The SKY Contractor's shall submit an Implementation Plan to the Department by 1-1-2020. The proposed Implementation Plan must comply with all due dates established by the Department, specific requirements set forth in the Contract, and address at a minimum the following SKY Contractor activities: ...O, Detailed plans for coordinating with other sister agencies, such as DBHDID, Department of Public Health and Department of Education, as needed. Page 194 41.14.1 Education and Training of Network Providers. The educational and training approach for Providers must address at a minimum the following: ... C. An understanding of the SKY Program and the roles and responsibilities of the Department, DCBS, DJJ, and DBHDID, and how these agencies will coordinate and collaborate with the SKY Contractor...E. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from Medicaid coverage and processes, such as coordinating with Foster Parents, Caregivers, Fictive Kin, DCBS and DJJ professional personnel, Adoptive Parents, CASAs, judges, law enforcement officials, and other Cabinet sister agencies. (p. 207, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁵⁸ 6.4.5. Permanent Supportive Housing 6.4.5.1. LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana

PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid Managed Care members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH <http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388>. Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. (pp. 72-73, Effective ~~December-October~~ 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

12.25. Web and Mobile-Based Member Applications. 12.25.1. No later than February 1, 2019, the MCO shall provide a web - or mobile – based member/patient portal that includes the following information and features: ...12.25.1.2. Social services information and resources, such as housing supports, food programs, etc. (p. 232, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁵⁹ 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: ... *Emergency and Non-Emergency Medical Transportation. (p. 60, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.23. Medical Transportation Services 6.23.1. The MCO shall provide emergency and non-emergency medical transportation for its members. 6.23.2. The MCO or the MCO's Transportation Broker shall establish and maintain a call center. The call center shall be responsible for scheduling all Non-Emergency Medical Transportation (NEMT)/Non-Emergency Ambulance Transportation (NEAT) reservations and dispatching of trips during the business hours of 7:00 am to 7:00 pm Monday through Friday, with the exception of recognized state holidays. The call center shall adhere to the call center performance standards specified in Section 12. 6.23.3. NEMT/NEAT shall be provided to and from all medically necessary Medicaid state plan services (including carved out services) for those members who lack viable alternate means of transportation. NEMT/NEAT to non-Medicaid covered services is not a core benefit; it may be considered a cost-effective alternative service if so approved by LDH per Section 6.27. 6.23.3.1. NEMT/NEAT transportation includes the following, when necessary to ensure the delivery of necessary medical services: • Transportation for the member and one attendant, by any means permitted by law, including but not limited to the requirements of La. R.S. 40:1203.1 et seq.; • The use of any service that utilizes drivers that have not met the requirements of La. R.S. 40:1203.1 et seq. is strictly prohibited; and • For trips requiring long distance travel, in accordance with Section 6.23.2.3, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member. 6.23.3.2. The MCO must have an established process for coordinating medically necessary long distance travel for members who require covered Medicaid state plan services out of state. This may include air travel, lodging, and reimbursement for meals, as supported by medical necessity. 6.23.3.2.1. Coverage and reimbursement for meals and lodging for both the member and one attendant, shall be included when treatment requires more than twelve (12) hours of total travel. "Total travel" includes the duration of the health care appointment and travel to and from that appointment. 6.23.3.2.2. MCO must allow for meals and lodging, for each trip that are not otherwise covered in the inpatient per diem, primary insurance, or other payer source. 6.23.3.2.3. If the MCO denies meals and lodging services to a member who requests these services, the member must receive a written notice of denial explaining the reason for denial and the member's right to an appeal. 6.23.3.3. Other primary private insurance coverage must not impede a member's ability to receive transportation benefits to and from services covered by Medicaid as a secondary payer. If the private insurer has approved out-of-state services that are covered by Medicaid, the MCO must provide transportation, meals and lodging as specified in this section. 6.23.3.4. The MCO may require prior authorization and/or scheduling of NEMT and may require documentation to verify coverage of medical services by the primary insurer prior to approval. 6.23.3.4.1. For all NEMT services requiring scheduling and/or prior authorization, the MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of the request for services. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service or no less than 24 hours prior to the date of service, unless the request is received less than 48 hours prior to service. 6.23.3.4.2. In cases where the request is made less than 48 hours in advance of needed transportation, the MCO shall make reasonable efforts to schedule transportation and provide notice in advance of the scheduled appointment. 6.23.3.4.3. Expedited service authorizations for services that are deemed urgent but not emergent, shall be determined as expeditiously as the member's health condition requires. For ambulance services the timeframe for approval must allow ambulance providers to comply with any local ordinances governing their response times. 6.23.4. The MCO may establish its own policy for medical transportation services as long as the MCO ensures members' access to care and the MCO's policy is in accordance with current Louisiana Medicaid guidelines for non-emergency and emergency medical transportation (such as whether the member owns a vehicle or can

access transportation by friends, relatives or public transit). (pp. 87-89, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.9. Non-Emergency Medical Transportation and Non-Emergency Ambulance Transportation 7.8.9.1. MCO shall have sufficient NEMT/NEAT providers, including wheelchair lift equipped vans, to transport members to/from medically necessary services when notified 48 hours in advance. 7.8.9.2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall schedule the transportation and require its NEMT/NEAT provider to arrive and provide services with sufficient time to ensure that the member arrives at least fifteen (15) minutes, but no more than one (1) hour, before the appointment; does not have to wait more than one hour after the conclusion of the treatment for transportation; is not picked up prior to the completion of treatment; and is not in the vehicle for more than one (1) hour in excess of the estimated travel time, as calculated by a mapping application, for each leg of the trip. 7.8.9.3. If a member requests an MCO provider who is located beyond access standards, and the MCO has an appropriate provider within the MCO who accepts new patients, it shall not be considered a violation of the access requirements for the MCO to grant the member's request. However, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this selected provider, and the MCO shall notify the member in writing as to whether or not the MCO will provide transportation to seek care from the requested provider. (p. 131, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

12.12. MCO Member Handbook 12.12.1. The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10(g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.1.24. How to obtain emergency and non-emergency medical transportation. (p. 219, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁶⁰ 7.1.9. The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: ...Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments. (pp. 113-114, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.15.1.1.3.32. A requirement that the providers assess the cultural and linguistic needs of the service area, and deliver services that address these needs to the extent resources are available.

7.15.1.1.3.33. A requirement that the providers attend trainings on cultural competence. The MCO shall include a cultural competency component in each training topic. (p. 150, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

12.1.13. The MCO shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following url: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees. (p. 202, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁶¹ 6.11.3. The MCO shall perform or require health providers to perform a risk assessment on all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO shall provide case management for high-

risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth. (p. 80, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.11.5.2. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection to maternity case managers or other public health resources. (p. 80, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁶² 4.3.12 Behavioral Health Liaisons and Coordination with Partner Agencies — the MCO shall have staff identified to provide liaison activities for the following entities. The liaison shall be available for response to inquiries within one business day of inquiry. Any change in liaison personnel shall be sent to respective entity within 48 hours of notice to the MCO. 4.3.12.1 A liaison dedicated solely to LDOE, DCFS and OJJ. This liaison shall also be responsible for outreach, education and community involvement for the court systems, education systems and law enforcement. This staff position must be located in Louisiana. The designated liaison must attend all CSoC Governance Board meetings. The liaison shall have experience in child welfare and delinquency. The liaison shall also outreach to local school systems to educate on the services available. The liaison shall be knowledgeable and provide education on the entire behavioral health service array including, CSoC, crisis services and process for obtaining services and out of home placements and process for placement. 4.3.12.2 A single point of contact dedicated to liaising with the judicial system. Functions include serving as a point of contact for judges, court personnel and appearing in court when requested by the court system or LDH. This contact shall also serve as a point of contact for LDH legal and staff working with LDH custody cases. This person shall have familiarity with drug court, juvenile court, family court and criminal court processes and issues. This person shall provide continuous outreach and education to the judicial system on access to services. This staff person may also serve the function listed above as the DCFS/OJJ point of contact, however, if LDH determines the case load to be too voluminous, LDH may request an additional staff person be hired. 4.3.12.3 LGE liaison who shall serve as a point of contact for inquiries, barriers and resolution for LGEs. The liaison shall have experience with the LGE structure, services provided, members served and responsibilities. This liaison may be required to attend Human Services Interagency Council (HSIC) meetings if requested by LDH. The liaison shall have knowledge of the non-Medicaid uninsured system. 4.3.12.4 Tribal liaison that is the single point of contact regarding delivery of covered services to Native Americans; 4.3.12.5 Behavioral health consumer and family organizations liaison for children, youth and adults. This person shall be a peer, former consumer of services and/or in recovery. This liaison shall be engaged with the advocacy community. 4.3.12.6 A Permanent Supportive Housing (PSH) program liaison, to be approved by LDH, to work with LDH PSH program staff to assure effective implementation of PSH program deliverables as outlined in Section 6.4.5. 4.3.12.7 An Intellectual/Developmental Disability (I/DD) liaison to work with OCDD staff regarding I/DD medical and behavioral health issues. (pp. 31-32, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development. ... 6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc. (p. 75, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.30.2.14. Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the imitations, and participating in cross-agency staffing. (pp. 96-97, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

16.1.16 The contractor must have: 16.1.16.1 Capabilities of interagency electronic transfer to and from the participating state agencies (LDH-OBH, DCFS, and OJJ) as needed to support the operations as determined by LDH; 16.1.16.4 A secure online web-based portal that allows providers and state agencies (DCFS, LDOE, LDH, and OJJ) to submit and receive responses to referrals and prior authorizations for services. (pp. 275-276, Effective ~~December-October~~ 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁶³ B. Care Needs Screening and Appropriate Follow-Up... h. As further directed by EOHHS, evaluate Enrollees' health-related social needs, including whether the Enrollee would benefit from receiving community services to address health-related social needs. Such services shall include but not be limited to: ... * Housing stabilization and support services; * Housing search and placement. (p. 72, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Social Innovation Financing for Chronic Homelessness Program The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this Section. 1. The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with such SIF Program providers to provide Community Support Program (CSP) services as set forth in Appendix C and below; provided, however, that such providers must meet all applicable Contract, statutory, and regulatory requirements. The Contractor shall pay its contracted SIF Program providers a case rate consistent with the current market rate for the services in Section 2.7.F.3 below for each day an Enrollee is a SIF Program participant. 2. SIF Program participants shall be those Enrollees who the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Enrollees, including veterans, who are SIF Program participants. Such referrals shall only be for Enrollees who either: a. Meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, i.e. is an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or b. Are identified by SIF Program providers and approved by the SIF Intermediary as an individual who is homeless and a high-cost user of emergency services. The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Enrollees to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants. 3. Subject to Medical Necessity requirements, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide to Enrollees who are SIF Program participants Community Support Program (CSP) services as set forth in Appendix C in a manner consistent with the goals of the SIF Program. Such CSP services shall consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include: a. Assisting SIF Program participants in enhancing daily living skills; b. Providing service coordination and linkages; c. Assisting SIF Program participants with obtaining benefits, housing and healthcare; d. Developing a crisis plan; e. Providing prevention and intervention; and f. Fostering empowerment and recovery, including linkages to peer support and self-help groups. 4. The Contractor shall work with EOHHS to take all steps and perform all activities necessary to implement the above requirements consistent with SIF Program goals, policies and procedures as communicated by EOHHS, including but not limited to participating in meetings with the SIF Intermediary. G. Community Support Program (CSP) Services for Chronically Homeless Individuals Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP services as set forth in Appendix C to chronically homeless individuals as described in this Section. 1. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in Appendix C to Enrollees who are Chronically Homeless that consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include: a. Assisting in enhancing daily living skills; b. Providing service coordination and linkages; c. Assisting with obtaining benefits, housing and healthcare; d. Developing a crisis plan; e. Providing prevention and intervention; and f. Fostering empowerment and recovery, including linkages to peer support and self-help groups. 2. For the purposes of this Section 2.7.G, Chronically Homeless Enrollees shall be those Enrollees who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years. (pp. 165-167, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁶⁴ MCO Covered Services: Transportation (non-emergent, to out-of-state location) – ambulance and other common carriers that generally are pre-arranged to transport an Enrollee to a service that is located outside a 50-mile radius of the Massachusetts border. (pp. 7-8, Appendix C, Exhibit 1, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

Section 2.4 Enrollment and Education Activities... f. Enrollee Information, shall include, but not be limited to, a description of the following: ... 2) How to access Non-MCO Covered Services, including any cost sharing, if applicable, and how transportation to such services may be requested. The Contractor shall also inform Enrollees of the availability of assistance through the MassHealth Customer Service Center for help with determining where to access such services. (p. 52, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Section 2.5 Care Delivery, Care Coordination, and Care Management... A. General Care Delivery Requirements.... 3. Coordinate transportation to medical appointments where Medically Necessary for the Enrollee to access medical care. (p. 67, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁶⁵ B. Contract Management and Responsiveness to EOHHS. ... As directed by EOHHS, the Contractor shall participate in any: a. Efforts to promote the delivery of services in a Culturally and Linguistically Appropriate manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity. (p. 38, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

3.10.6 Provider Directory. The MCO must make available:... 3.10.6.2 The directory shall indicate the Network Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the provider has completed cultural competence training. (p. 47, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Section 2.5 Care Delivery, Care Coordination, and Care Management. ... 1. Ensure that all Enrollees may access: ...d. Care that is Linguistically and Culturally Competent. The Contractor shall regularly evaluate the population of Enrollees to identify language needs, including needs experienced by Enrollees who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in Section 2.5.B). The Contractor shall identify opportunities to improve the availability of fluent staff or skilled translation services in Enrollees' preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care. (pp. 66-67, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

6.1.4 Care Management Services. The MCO shall be responsible for the Care Management of all Enrollees. The MCO's Care Management system must be designed to coordinate the provision of primary care and all other Covered Services to its Enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery including... the provision of culturally appropriate care... At a minimum, the MCO's Care Management system must incorporate the following elements: 6.1.4.1 Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment for acute and long-term services, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's Enrollees. (pp. 90-91, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Section 2.7 Provider Network, Provider Contracts, and Related Responsibilities... A. Provider Network. 1. General requirements for the Provider Network... k. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, Enrollees with Special Health Care Needs, including individuals with disabilities, or other special populations served by the Contractor, by, at a minimum, having the capacity to, when necessary, communicate with Enrollees in languages other than English, communicate with individuals who are deaf, hard-of-hearing, or deaf blind, and making materials and information available in Alternative Formats as specified in this Contract (p. 137, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Section 2.8 Network Management. ... G. Cultural and Linguistic Competence The Contractor shall ensure that: 1. Multilingual Network Providers and, to the extent that such capacity exists throughout the Contractor's Regions, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations; 2. Network Providers and interpreters/transliterators are available for those who are Deaf or hearing-impaired, to the extent that such capacity exists throughout the Contractor's Regions; 3. Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under the Contract; 4. It identifies opportunities to improve the availability of fluent staff or skilled translation

services in Enrollees preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care ((p. 184, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

D. Access for Non-English Speaking Enrollees The Contractor shall ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language in the Regions provided that such provider capacity exists throughout the Region. (p. 205, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁶⁶ J. Provider Education. The Contractor shall establish ongoing Provider education, including but not limited to, the following issues: ... f. Issues concerning other special populations including the homeless, high-risk pregnant women, and children in the care or custody DCF and youth affiliated with DYS (either detained or committed). (p. 194, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

F. Enrollee Outreach, Orientation, and Education The Contractor shall: ...2. The Contractor must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall: ... Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in Section 2.5. Condition and disease specific information must be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to: ... 9) Pregnant individuals with substance use disorders (p. 65, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁶⁷ F. Services for Specific Populations...In addition, the Contractor shall: 1. At the direction of EOHHS, actively participate in initiatives, processes and activities of EOHHS agencies with which Enrollees have an affiliation. Such agencies include, but are not limited to: a. The Department of Mental Health (DMH); b. The Department of Children and Families (DCF); c. The Department of Youth Services (DYS); d. The Department of Public Health and DPH's Bureau of Substance Abuse Services (DPH/BSAS); e. The Department of Developmental Disabilities (DDS); f. The Massachusetts Rehabilitation Commission (MRC); g. The Massachusetts Commission for the Blind (MCB); and h. The Massachusetts Commission on the Deaf and Hard of Hearing. (pp. 127-128, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

Section 2.5 Care Delivery, Care Coordination, and Care Management... The Contractor shall: 11. Establish such affiliations with providers (including Community Service Agencies (CSAs) in the Contractor's geographic area, as determined by EOHHS) and organizations as necessary to fulfil the requirements of this Section, including affiliations with Community Partners and other community-based organizations and social services organizations. (p. 69, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

C. Care Coordination, Transitional Care Management, and Clinical Advice and Support Line. 1. The Contractor shall perform care coordination activities for Enrollees as follows. The Contractor shall: ... b. Coordinate care for all Enrollees, including but not limited to: ... 4) Coordinating with staff in other state agencies, or community service organizations, if the agency/organization is already involved in serving the Enrollee, or providing information and referral if the agency/organization may be helpful in meeting such Needs (pp. 75-76, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

⁶⁸ .09 Special Needs Populations — Homeless Individuals. An MCO's initial health screen shall attempt to identify homeless individuals and link them to the appropriate provider of services. (p. 126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁶⁹ .07 Access Standards: Clinical and Pharmacy Access. (3) Appointment Guidelines. ... (a) An MCO shall develop specific guidelines that define how requests for appointments are arranged, which shall include a policy that: ... (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. (p. 199, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁷⁰ N. Network Providers... 13. To ensure services are delivered in a culturally competent manner to all Enrollees, including: a. Enrollees with limited English proficiency; b. Enrollees with diverse cultural and ethnic backgrounds; and c. Enrollees of all genders, sexual orientations, and gender identities. (p. 26, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.10 Special Needs Populations. An MCO applicant shall include in its application the following information or descriptions: A. A narrative description of the clinical expertise and experience of the MCO's network for special needs populations in a format specified by the Department; B. Written evidence of the applicant's ability to comply with specific quality access, data, and performance measurements to satisfy the general requirements for all special needs populations specified in COMAR 10.67.04.04; C. Written evidence, including treatment protocols, of the applicant's ability to provide the range of clinical and support services specified in COMAR 10.67.04.05—.10 and .13, to ensure appropriate and coordinated services to the following special populations: (1) Children with special health care needs; (2) Individuals with a physical disability; (3) Individuals with a developmental disability; (4) Pregnant and postpartum women; (5) Individuals who are homeless; and (6) Individuals with HIV/AIDS. (p. 99, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁷¹ MATERNAL OPIOID MISUSE (MOM) MODEL AGREEMENT... B. In the Transition Period (January 2022 – June 2022) and Implementation Period (July 2022 – December 2022) of Model Year 3 of the MOM model, the MCO agrees to: 1. Confirm that they comply with Medicaid Program integrity rules at 42 CFR Part 455. 2. Participate in CMMI- and Department-led MOM model activities, such as monthly meetings, collaboratives, and technical exchanges. 3. If active in designated MOM model target jurisdictions: a. Proactively identify and serve as a referral hub for potential MOM model participants and confirm eligibility prior to intake. b. Receive the per member, per month reimbursement of \$208 in accordance with Section A(6), to provide the following services, at a minimum, on a monthly basis to MOM model participants: i. Ensure MOM model participants access at least one physical or behavioral health care services billable to Medicaid, including: 1. Physical health care: Maternity care and relevant primary care services, including medication for opioid use disorder (MOUD); and 2. Behavioral health care: Mental health and other appropriate substance use disorder services beyond MOUD. ii. Coordinate care, engage participants and provide referrals for community and other support services to complement the current set of Medicaid-covered services to meet MOM model participants' comprehensive needs, including screening and referral for health-related social needs, measurement of patient activation and to satisfy at least one of the following model components per month: 1. Comprehensive care management; 2. Care coordination; 3. Health promotion; 4. Individual and family support; and 5. Referral to community/support services. (pp. 79-80, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.08 Special Needs Populations — Pregnant and Postpartum Women. E. An MCO shall refer pregnant and postpartum women with a substance use disorder to the behavioral health ASO for substance use treatment within 24 hours of request. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: (1) Comprehensive prenatal, perinatal, and postpartum care, including high-risk specialty care when appropriate... (3) Enriched maternity services, including: ... (c) Substance abuse treatment, as provided in Regulation .10 of this chapter. (pp. 218-219, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

⁷² X. Population Health Management... 2. Data Analysis to Support Population Health Management... a. Contractor must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including: ... i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. (p. 69, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

X. Population Health Management... 3. Services Provided by Community-Based Organizations. ... b. Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include but are not limited to: ... viii. Arrange for social services (such as housing and heating assistance) and surrounding support services (pp. 71-72, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

C. Health Promotion and Disease Prevention... 2. Health Promotion and Disease Prevention Services... d. Contractor must collaborate with community-based organizations to facilitate the provision of Enrollee physical and oral health education services to ensure the entire spectrum of psycho-Social Determinants of Health are addressed (e.g. housing, healthy diet and physical activity, behavioral health)... D. Providing Care Management Services and Other Targeted Interventions... d. Contractor must refer Enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments. (pp. 73-75, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁷³ B. Services Covered Under this Contract. ... w. Non-emergent medical transportation (NEMT) to medically-necessary, Covered Services (p. 49, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

E. Emergency Services... 5. Contractor must provide emergency transportation for Enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, the emergency transportation provider must submit a properly completed and coded claim form for emergency transport, which includes an appropriate diagnosis code as described in Medicaid Policy. (p. 58, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

H. Transportation 1. Contractor must provide non-emergent medical transportation (NEMT), including travel expenses, to authorized, Covered Services. 2. Contractor must provide NEMT for CSHCS Enrollees with PCPs outside the MDHHS network adequacy travel standards in Appendix 14. The time and distance must be calculated from the Enrollee's home. 3. Contractor must submit to MDHHS policies and procedures for the coverage of NEMT, including travel expenses, updated at least annually. a. Contractor must submit equivalent policies and procedures for transportation Subcontractors. b. Contractor must provide procedures and documentation for purposes of monitoring Subcontractors to ensure compliance with these provisions including, but not limited to, Beneficiary Complaint resolution, mileage reimbursement and vehicle inspections. 4. Contractor/Subcontractor policies must include provisions for the following: a. Determination of the

most appropriate mode of transportation to meet the Enrollee's medical needs, including special transport requirements for Enrollees who are medically fragile or Enrollees with physical/mental challenges, pregnancy status, infancy, need for Enrollee to keep appointments confidential (such as when it is not appropriate for Enrollees to ask neighbors or family members for transportation), additional riders and/or car seats, housing status that affects pick up and drop off locations b. Prevention of excessive multi-loading of vehicles such that Enrollees are not unduly burdened or forced to travel for significantly longer periods of time than is necessary c. Contractor must have ability to schedule and provide Enrollee transportation services for: i. On-going prescheduled appointments for at least thirty Days, such as, but not limited to, dialysis, chemotherapy or physical therapy ii. Regularly scheduled appointments; plans may require reasonable advance notice (e.g. 48 – 72 hours) of the need for transportation iii. Urgently scheduled appointments for which the Enrollee requires transportation on the same day as the request or the following day d. Method for reimbursing mileage to individuals when it is appropriate for the Enrollee to drive or be driven to an Urgent Care facility or emergency department 5. Contractor may require prior authorization for overnight travel expenses (including meals and lodging) if the travel distance is less than 50 miles; prior authorization may not be denied based on distance alone. 6. Contractor must make appropriate accommodations for Enrollees with special transportation needs, including but not limited to, CSHCS Enrollees. 7. MDHHS will monitor transportation services provided by the Contractor including. a. Contractor must submit an annual NEMT evaluation report. The report must include any findings of NEMT Subcontractor non-compliance and any corrective action plan and/or measures taken by the contractor to bring the Subcontractor into compliance. b. Grievances and Appeals (p. 60-61, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

X. Population Health Management... 2. Data Analysis to Support Population Health Management... a. Contractor must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including: ... i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. (p. 69, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

C. Health Promotion and Disease Prevention... 2. Health Promotion and Disease Prevention Services... d. Contractor must collaborate with community-based organizations to facilitate the provision of Enrollee physical and oral health education services to ensure the entire spectrum of psycho-Social Determinants of Health are addressed (e.g. housing, healthy diet and physical activity, behavioral health)... D. Providing Care Management Services and Other Targeted Interventions... d. Contractor must refer Enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments. (pp. 73-75, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

2. Member Handbook... i. 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:... xxi. How to obtain emergency transportation xxii. How to obtain non-emergent transportation covered under this Contract (p. 95, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁷⁴ H. Transportation... 4. Contractor/Subcontractor policies must include provisions for the following: a. Determination of the most appropriate mode of transportation to meet the Enrollee's medical needs, including special transport requirements for Enrollees who are medically fragile or Enrollees with physical/mental challenges, pregnancy status, infancy, need for Enrollee to keep appointments confidential (such as when it is not appropriate for Enrollees to ask neighbors or family members for transportation), additional riders and/or car seats, housing status that affects pick up and drop off locations. (pp. 60-61, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁷⁵ V. Access and Availability of Providers and Services... 11. Contractor must participate in MDHHS initiatives (e.g. HHS CLAS), to promote the delivery of services in a culturally responsive manner to all Enrollees including those with limited proficiency in English, deaf and hard of hearing (DHOH), diverse cultural and ethnic backgrounds, disabilities, and regardless of gender or other factors in accordance with 438.206(c)(2). ... 16. Contractor must attest to and demonstrate compliance with contractual network adequacy and timeliness to care requirements on at least an annual basis... b. Contractor's Network Access Plan at a minimum must contain the following: ... (iii)vii Contractor's efforts to ensure that its Provider Network addresses the needs of Enrollees, including but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex, medical conditions. (pp. 36-38, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

D. Providing Care Management Services and Other Targeted Interventions... 2. Targeted Interventions for Subpopulations Experiencing Health Disparities: a. Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who qualify for those services. b. Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions. To the extent that CHIRs are functioning within the Contractor's service area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions. c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe. d. Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level, number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a community-based organization, and changes in Enrollee biometrics and self-reported health status. (p. 76, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

⁷⁶ 6.1.22 Housing Stabilization Services Housing stabilization services are covered under the Medical Assistance program, effective for dates of service beginning July 20, 2020. HSS is a set of services designed to support people with disabilities and seniors experiencing housing instability to find and retain housing in the community. HSS includes: • Housing consultation services (HSS-Consultation), • Housing transition services (HSS-Transition), and • Housing sustaining services (HSS-Sustaining). [Minnesota Statutes, §256B.051] 6.1.22.1 Eligibility for HSS is determined by the STATE. [Minnesota Statutes, §256B.051, subd. 3]... 6.1.22.3 The MCO shall comply with the following HSS program requirements: ... (2) Implement processes to assure that HSS-Transition services and HSS-Sustaining services are allowed up to 150 hours (600 units) total, for each Enrollee annually... (pp. 103-104, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁷⁷ 6.1.28 Medical Transportation Services. Medical transportation for obtaining emergency or nonemergency covered services is covered for Medical Assistance, MinnesotaCare Child Enrollees who are younger than nineteen (19) years of age, and pregnant women enrolled in MinnesotaCare. The most appropriate and cost-effective forms of transportation are covered. [Minnesota Statutes, §256B.0625, subd. 18] Medical transportation services include: 6.1.28.1 Ambulance services required for Medical Emergency care, as defined in Minnesota Statutes, §144E.001, subd. 2, and ambulance transportation with treatment as defined in Minnesota Statutes, §144E.001, subd. 3. The MCO shall require that providers bill ambulance services according to Medicare criteria. Non-emergency ambulance services shall not be paid as emergencies. [Minnesota Statutes §256B.0625, subd. 17a] 6.1.28.2 Non-emergency ambulance transfers from a facility to another facility for the purposes of facility capacity, during the PE or until notice by the STATE, are covered until August 31, 2021. 6.1.28.3 Non-emergency transportation (NEMT) services include the following modes of transportation. [Minnesota Statutes, §256B.0625, subd. 17, (i)] See section 6.1.29 for transportation services covered by Local Agencies. (1) Enrollee reimbursement, including mileage reimbursement provided to Enrollees who have their own transportation, or mileage reimbursement to family or an acquaintance who provides transportation. See section 6.1.29; (2) Volunteer transport by volunteers using their own vehicle; (3) Unassisted transport when provided by a taxicab or public transit. If a taxicab or public transit is not available, the Enrollee may receive transportation from another NEMT provider; (4) Assisted transport for an Enrollee who requires assistance from the NEMT provider; (5) Lift-equipped/ramp transport for an Enrollee who is dependent on a mobility device and requires an NEMT provider with a vehicle containing a lift or ramp; (6) Protected transport for an Enrollee who has received prescreening that determines other

forms of transportation inappropriate, and who requires a provider with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (7) Stretcher transport for an Enrollee who must be transported in a prone or supine position. (pp. 107-108, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁷⁸ 6.1.28 Medical Transportation Services. Medical transportation for obtaining emergency or nonemergency covered services is covered for Medical Assistance, MinnesotaCare Child Enrollees who are younger than nineteen (19) years of age, and pregnant women enrolled in MinnesotaCare. The most appropriate and cost-effective forms of transportation are covered. [Minnesota Statutes, §256B.0625, subd. 18] Medical transportation services include: 6.1.28.1 Ambulance services required for Medical Emergency care, as defined in Minnesota Statutes, §144E.001, subd. 2, and ambulance transportation with treatment as defined in Minnesota Statutes, §144E.001, subd. 3. The MCO shall require that providers bill ambulance services according to Medicare criteria. Non-emergency ambulance services shall not be paid as emergencies. [Minnesota Statutes §256B.0625, subd. 17a] 6.1.28.2 Non-emergency ambulance transfers from a facility to another facility for the purposes of facility capacity, during the PE or until notice by the STATE, are covered until August 31, 2021. 6.1.28.3 Non-emergency transportation (NEMT) services include the following modes of transportation. [Minnesota Statutes, §256B.0625, subd. 17, (i)] See section 6.1.29 for transportation services covered by Local Agencies. (1) Enrollee reimbursement, including mileage reimbursement provided to Enrollees who have their own transportation, or mileage reimbursement to family or an acquaintance who provides transportation. See section 6.1.29; (2) Volunteer transport by volunteers using their own vehicle; (3) Unassisted transport when provided by a taxicab or public transit. If a taxicab or public transit is not available, the Enrollee may receive transportation from another NEMT provider; (4) Assisted transport for an Enrollee who requires assistance from the NEMT provider; (5) Lift-equipped/ramp transport for an Enrollee who is dependent on a mobility device and requires an NEMT provider with a vehicle containing a lift or ramp; (6) Protected transport for an Enrollee who has received prescreening that determines other forms of transportation inappropriate, and who requires a provider with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (7) Stretcher transport for an Enrollee who must be transported in a prone or supine position. (pp. 107-108, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁷⁹ 6.1.18.2 Certified Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, Parts 4764.0010 through 4764.0070. (1) Health Care Home services include pediatric care coordination for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness and who are not receiving care coordination services through another service. (2) Care coordination services must be provided in accordance with Minnesota Statutes, §256B.0751, subd. 9. (p. 100, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

6.13.9 Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article. 6.13.9.1 Persons with Serious and Persistent Mental Illness (SPMI). Services for this group include ongoing medications review and monitoring, day treatment, and other community-based alternatives to conventional therapy, and coordination with the Enrollee's case management service Provider to assure appropriate utilization of all needed psychosocial services. 6.13.9.2 Persons with a Physical Disability or Chronic Illness. Services for this group include inhome services and neurological assessments. 6.13.9.3 Abused Children and Adults, Abusive Individuals. Services for this group include comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, or emotional). 6.13.9.4 Enrollees with Language Barriers. Services for this group include interpreter services, bilingual staff, culturally appropriate assessment and treatment. (1) When an individual is enrolled in PMAP, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language she or he speaks. (2) Upon receipt of enrollment information indicating interpreter services are needed, the MCO shall contact the Enrollee by phone or mail in the appropriate language to inform the Enrollee how to obtain Primary Care services. (3) In addition, whenever an Enrollee requests an interpreter in order to obtain services under this Contract the MCO must provide the Enrollee with access to an interpreter in accordance with section 6.1.24 of this Contract. 6.13.9.5 Cultural and Racial Minorities. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various cultural and racial minority groups. 6.13.9.6 Persons with Dual MH/DD or

MH/SUD Diagnoses. Services for this group include comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs. 6.13.9.7 Lesbians, Gay Men, Bisexual and Transgender Persons. Services for this group include sensitivity to critical social and family issues unique to these Enrollees. 6.13.9.8 Persons with a Hearing Impairment. Services for this group include access to TDD and hearing impaired interpreter services. 6.13.9.9 Enrollees in Need of Gender Specific MH and/or SUD Treatment. The MCO must provide its Enrollees with an opportunity to receive mental health and/or substance use disorder services from a therapist of the same gender and the option of participating in an all-male or all-female group therapy program. 6.13.9.10 Children and Adolescents, including Children with SED and Children involved in the Child Protection System. Services for these groups include services specific to the needs of these groups, such as day treatment, home-based mental health services, and inpatient services. The services which the MCO delivers must be: 1) provided in the least restrictive setting; 2) individualized to meet the specific needs of each child; and 3) designed to provide early identification and treatment of mental illness. The MCO must coordinate services with the Child's Local Agency case management service Provider(s), children's mental health collaborative service coordination and family services collaborative service coordination, and must arrange for participation in the Child's wraparound services planning, upon request. 6.13.9.11 Persons with a Developmental Disability (DD). Services for this group include specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance services that are designed to maintain or increase function and prevent further deterioration or dependency and that are coordinated with available community resources and support systems, including the Enrollee's Local Agency DD case management service Provider, families, guardians and residential care Providers. Continuity of care should be a major consideration in the treatment planning process. Referrals to specialists and subspecialists must be made when medically indicated. 6.13.9.12 American Indians. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various tribes. (pp. 142-143, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

7.3 POPULATION HEALTH MANAGEMENT (PHM)... The PHM Strategy shall include the following areas of focus:... (2) Managing Enrollees with emerging risk... 7.3.4 The MCO shall continue to offer case management services to the most complex, highest risk Enrollees. (pp. 155-156, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁸⁰ 6.1.35.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (2) Women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit. (p. 20, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁸¹ 6.1.31 Adult Mental Health Services. Mental health services should be directed at rehabilitation of the Enrollee in the least restrictive clinically appropriate setting. Services include [Minnesota Statutes, §§256B.0622, 256B.0623, 256B.0624, and 245.462]:... (8) Forensic Assertive Community Treatment. although similar to traditional ACT teams, includes the additional following elements: a) a goal of preventing arrest; b) receiving referrals from criminal justice providers (for example, Department of Corrections transition release planners, local jails and mental health courts); and c) integration of probation personnel in treatment (for example, Ramsey County corrections supervisors and supervising agents); (pp. 110-111, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁸² 2.11.1 Member Care Management:... e. Care Plans:... 3) In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women... Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment... (p. 75, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸³ z. Transportation Services: The health plan shall provide emergency transportation (ground and air) for its members. 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. (p. 58, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸⁴ 2.11.1 Member Care Management:... e. Care Plans:... 3)... In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women... Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care;... (p. 75, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸⁵ 2.3 Cultural Competency: 2.3.1 The health plan shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. The health plan shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations. The health plan shall adhere to the following standards: a. The health plan shall ensure that members receive from all providers and staff effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. b. The health plan shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of regions covered by the contract. c. The health plan shall ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery. d. The health plan shall provide to members, in their preferred language, both verbal offers and written notices, when required, informing them of their right to receive language assistance services. e. The health plan shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in regions covered by the contract. f. The health plan shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. g. The health plan shall ensure that data on the individual member's race, ethnicity, and spoken and written language are collected in health records, integrated into the health plan's management information systems, and periodically updated. h. The health plan shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of regions covered by the contract. i. The health plan shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services in health care. j. The health plan shall ensure that the grievance and appeal resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural grievance and appeals by the member. k. The health plan shall regularly make information available to the public about the health plan's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information. (pp. 25-26, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

The health plan shall perform an assessment for care management within thirty (30) calendar days of enrollment for new members who present with a diagnosis listed below and who are not enrolled in the State health home program. The health plan shall perform an assessment for care management within thirty (30) calendar days of diagnosis for existing members who receive a

new diagnosis listed below and who are not enrolled in the State health home program: · Diabetes; · Asthma; · COPD; · Congestive heart failure; · Cancer; · Chronic pain with opioid dependence; · Hepatitis C in active treatment; · HIV/AIDS; · Organ failure requiring supportive treatment and potentially requiring transplant (e.g., ESRD and dialysis requirement or pancreatic/hepatic failure); · Individuals with special health care needs including those with Autism Spectrum Disorder. Individuals with special health care needs are those individuals who without services such as private duty nursing, home health, durable medical equipment/supplies, and/or care management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need: Ø Individuals with Autism Spectrum Disorder; Ø Individuals eligible for Supplemental Security Income (SSI); Ø The health plan shall offer care management to individuals in foster care, receiving foster care or an adoption subsidy or other out-of-home placement. The health plan shall work with the guardian/foster parents to ensure that the child receives all required examinations and healthcare visits/interventions within the time specified by the state and determined by the child's needs. Ø Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs. · Sickle Cell Anemia; and · Serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, recurrent major depression, and moderate to severe substance use disorder). (p. 72, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸⁶ e. The health plan shall participate in the Show Me ECHO project that focuses on the health care needs of MO HealthNet Managed Care members and aligns with the state's health priorities... 2) Beginning July 1, 2018, the health plan will participate in Show Me ECHO projects that address the management of high-risk obstetrics cases, the reduction in the occurrence of neonatal abstinence syndrome, the management of opioid use disorder and the management of chronic pain. (p. 19, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸⁷ 2.19 Community Health Initiatives: 2.19.1 The health plan shall participate in community health improvement initiatives along with the Missouri Department of Health and Senior Services and local public health agencies to include the following: a. Initiatives that align with the Maternal Child Health Program (MCH), Department of Health and Senior Services (DHSS) strategic priorities. DHSS will provide their strategic priorities and a list of corresponding best practices for MCH health improvement initiatives to the health plan. DHSS, MCH/Center for Local Public Health Services shall provide technical assistance to link the health plan to health improvement initiatives being conducted at a local level. The health plan shall participate in health improvement initiatives by, at a minimum: 1) Becoming a member of a regional and/or community-wide MCH planning coalition. Community means a geographic entity (usually a county (ies) with broad based representation from local public health agencies, community providers, businesses, local organizations, schools, etc. DHSS will provide information to the health plan about DHSS/MCH strategic priorities. The health plan shall not be required to be the lead agency in establishing a coalition. 2) Being actively involved in the development and implementation of the community strategic plan to implement health improvement programs. 3) Providing feedback on the community strategic plan and its effectiveness. b. Upon request by the state agency, initiatives addressing identified public health challenges, including increasing immunization rates, asthma education and mitigation, increasing smoking cessation rates, injury prevention, chronic disease prevention and management (in particular diabetes, heart attack, and stroke), breast feeding promotion, oral health promotion, sexually transmitted infection prevention, and lead exposure prevention and management and other member education. This includes providing support to the local agencies, state agency, and DHSS in gathering data to support outcome reporting. (p. 133, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

A Special Programs Coordinator who is either (1) a Missouri-licensed social worker; (2) a Missouri-licensed registered nurse including advanced practice nurse, physician, or physician's assistant; or (3) has a Master's degree in health services, public health, or health care administration. In addition, the Special Programs Coordinator should be familiar with the variety of services available through the Missouri human services agencies that interface with health care. The duties of the Special Programs Coordinator shall include care coordination with all stakeholders and providers involved in the care of members. These stakeholders and providers may include, but not be limited to, the state agency, the Department of Health and Senior Services (DHSS), local public health agencies, the Department of Mental Health (DMH), the Department of Elementary and Secondary Education (DESE), the Family Support Division (FSD), Children's Division (CD), hospitals, the judicial system, schools, and Community Mental Health Centers (CMHCs). The Special Programs Coordinator shall provide timely and comprehensive facilitation of the identification of medically necessary services and implementation of such when included in a member's Individualized Education Program/Individual Family Service Plan. The Special Programs Coordinator is the main point of contact for members, their representatives, providers, the state agencies, and local public health agencies. (p. 21, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁸⁸ A. Care Management Responsibilities... 1. Assignment of Risk Levels... The detailed health risk assessment must be reviewed by a qualified health professional appropriate for the Member's health condition. The detailed health risk assessment shall address the following, at a minimum:... c. Demographic information (including... living situation/housing...) (p. 118, [Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract](#))

6. Care Management The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. The Contractor will develop and implement a Care Management system to ensure and promote:... e. Coordination with appropriate resources to reduce socioeconomic disparities, including housing... programs. (p. 151, [Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract](#))

⁸⁹ G. Non-Emergency Transportation The Contractor shall provide Non-Emergency Transportation for its Members to access Medically Necessary Services, in compliance with minimum Federal requirements for the provision of transportation services and according to Division policies, which are outlined in Mississippi Administrative Code, Title 23, Part 201. Non-Emergency Transportation shall be provided to Members who require transportation to and from medically necessary Medicaid covered non-Emergency Services. See Exhibit E, Non-Emergency Transportation, of this Contract for additional requirements of the Contractor. (p. 246, [Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract](#))

⁹⁰ A. NET Service Requests... Because scheduling issues will occasionally occur, the Contractor must develop processes for handling urgent trips, high risk trips, last minute requests from Members, their family members, guardians or representatives and Mississippi Medicaid Providers, scheduling changes and NET Providers who do not arrive for scheduled pick-ups. Trips considered "high risk" include but are not limited to the following types of requests:... high risk pregnancy, newborn check, prenatal appointment... (p. 246, Effective July 2017, Exhibit E, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁹¹ O. Cultural Competency The Contractor must demonstrate cultural competency in its communications, both written and verbal, with Members and must ensure that cultural differences between the Provider and the Member do not present barriers to access and quality health care. Both the Contractor and its Providers must demonstrate the ability and commitment to provide and deliver quality health care across a variety of cultures. The Contractor must promote access and delivery of services, in a culturally competent manner to all Medicaid beneficiaries and Members including, but not limited, to those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of race, color, religion, national origin, sex, sexual orientation, gender, or gender identity. The Contractor must ensure that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs. (p. 25, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

7. Targeted Interventions The Contractor will offer evidence-based interventions to address subpopulations experiencing unique health risks. Subpopulations may include Members with disabilities, specific chronic conditions or comorbidities, those with specific environmental risk factors or those with a history of high or inappropriate service utilization. (p. 151, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

Assignment of Risk Levels The Contractor shall develop a Care Management program that addresses the varying needs and differing levels of Care Management needs for Members. Based on the Health Risk Screening, the Contractor's Care Management program must provide for the completion of a detailed health risk assessment for Members, which includes an assessment of and assignment to risk stratification levels (e.g., low, medium, rising, high) which determine the intensity of interventions and follow-up care that is required for each Member. The Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need. Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to Members with persistent and/or preventable inpatient readmissions, pregnant women under twenty-one (21), high risk pregnancies, serious and persistent behavioral health conditions, Substance Use Disorder, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level and receive Care Management

services. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to high risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and shall have access to Care Management teams. ((p. 118, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

The Contractor shall provide Members assigned to the high risk level all the services included in the low risk and medium risk levels and the following services, at a minimum: a. As appropriate, form inter-disciplinary treatment teams to assist with development and implementation of individual medical treatment plans; b. Provide list of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.; c. Identify Providers with special accommodations (e.g., sedation dentistry); d. Educate staff about barriers Members experience in making and keeping appointments; e. Facilitate group visits to encourage self-management of various physical, substance use disorder, and behavioral health conditions/diagnoses such as pregnancy, diabetes and tobacco use; and f. Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP. (p. 122, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁹² 3. Perinatal High Risk Management/Infant Services System The Contractor shall coordinate with the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will provide case management services to those Members, and the Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. Should the Members have additional needs; the Contractor will provide additional case management and coordinate with the MSDH case managers to create an individual medical treatment plan for the Members. Members shall have freedom of choice regarding PHRM/ISS services provided by MSDH or the Contractor. Should the Member choose PHRM/ISS services through the MSDH, the Contractor will conduct health care assessments for pregnant women and offer the women the option of case management by either the Contractor or the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. The Contractor will coordinate with the MSDH, as specified by the Division. (p. 122, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

The Contractor shall coordinate with the Mississippi Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS) Program. The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will MississippiCAN Program Office of the Governor – Division of Medicaid Page 152 of 286 provide Case Management services to those Members, and the Contractor will coordinate with MSDH to confirm the Case Management will support all of the Members health care needs. ((pp. 151-152, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

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

⁹³ The Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services:....f. Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA),the Special Supplemental Food Program

for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; Developing, planning and assisting Members with information about community-based, free care initiatives and support groups (pp. 119-120, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

The Contractor will develop and implement a Care Management system to ensure and promote:... Coordination with appropriate resources to reduce socioeconomic disparities, including housing, employment, and nutrition programs. (p. 151, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁹⁴ 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. (p. 37, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁹⁵ 5.3 MCO's Selection of Network Providers 5.3.1 Network Provider Selection, Generally... (B) Pursuant to 42 CFR § 438.206(c)(2)(3), MCO shall participate in STATE's effort to promote the delivery of services in culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. MCO will also ensure Contracted Providers and Network Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollee's with physical or mental disabilities. (p. 51, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

10.2.2. Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers, and Physical Disability (A) MCO shall minimize, with a goal to eliminate, the Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities. (B) MCO shall provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. (C) MCO shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, TTY phone lines, and other auxiliary aids to all Enrollees as needed. (D) MCO shall accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990, as amended (42 U.S.C. § 126). (E) MCO will provide an annual plan, approved by STATE, for identifying non-English languages spoken by Enrollees. STATE will monitor how the Health Plan is striving to improve the quality of health care for multicultural populations by ensuring that services are available, accessible, and provided in a culturally and linguistically appropriate manner. (F) MCO will ensure that translation services are provided for written Marketing and Enrollee Education Materials for the top 15 non-English languages spoken by individuals with LEP in North Dakota, in accordance with guidance issued under Section 1557, CMS, HHS, and HHS OCR. STATE requires that MCO and any Subcontractors have oral interpretive services for those who speak any foreign language. (G) MCO must: (1) Meet Section 1932(a)(5) of the Social Security Act (42 U.S.C. § 1396u-2(a)(5)) and 42 CFR § 438.10, in so far as these regulations are applicable. (2) Provide Potential Enrollee and Enrollee materials translated into Prevalent non-English languages and meet the criteria listed below: (a) MCO must meet all requirements in accordance with 42 CFR § 438.10. (b) MCO must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the Prevalent non-English languages in the Service Area at no cost to Enrollees [42 CFR § 438.10(d)(3)]. (c) MCO must ensure the capacity to meet the needs of Prevalent Non-English Language groups within the Service Area. This includes notifying Enrollees [42 CFR § 438.10(d)(5)(i) - (iii)]: (i) Oral interpretation is available for any language, and how Enrollees access this service (ii) Written translation is available in Prevalent languages, and how Enrollees access this service (iii) Auxiliary aids and services are available upon request at no cost for Enrollees with disabilities, and how Enrollees access these services (d) MCO must make available materials in alternative formats, upon request and at no cost to Enrollees. (e) MCO must include taglines in the Prevalent Non-English Languages in the state of North Dakota, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of MCO's member/customer service unit. (f) Prevalent non-English languages are defined by guidance issued under Section 1557, CMS, HHS; and HHS OCR lists the top 15 non-English languages spoken by individuals with LEP in North Dakota. (3) Provide interpretive services, including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL) to Potential Enrollees and Enrollees relative to: (a) MCO must provide interpretive services for languages on an as-needed basis at no cost to an Enrollee [42 CFR § 438.10(d)(4)]. These requirements must extend to both in-person and telephone communications to ensure that an Enrollee is able to communicate with MCO and Providers. (b) MCO must promote the delivery of services in a culturally competent manner to all Enrollees, including those with LEP and diverse cultural or ethnic backgrounds. (4) Provide a mechanism to help Enrollees

and Potential Enrollees understand the managed care program: a) Potential Enrollees will receive a brochure developed by STATE along with the affirmative enrollment letter that details: MCO options, services covered, contact information of the plan(s), etc. (b) Once individuals are enrolled with the plan and defined as Enrollees, they will receive information from the managed care plan, such as an Enrollee handbook. 10.2.3 Interpretive Services (A) MCO shall provide oral interpretive services available free of charge for all non-English languages, not just those that STATE identifies as Prevalent, on an as-needed basis. These requirements shall extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with Network and Out-of-Network Providers and receive Covered Services. (B) Qualified interpreters shall be provided when needed, including where technical, medical, or treatment information is to be discussed. Pursuant to 45 CFR § 92.201, an adult family member or friend may be used as an interpreter if this method is requested by the patient, the adult family member or friend agrees to provide such assistance, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality. The Enrollee must be advised that a qualified interpreter is available at no charge to the Enrollee and should be advised that they are in no way required to provide a family member or friend as an interpreter. (C) MCO shall ensure that its Network Providers have interpretative services available. (D) Nothing in this Attachment, as part of MCO contract, shall be construed to relieve Providers of their obligations to provide interpretive services under federal laws and regulations. 10.2.4 Cultural Competence Requirements (A) MCO shall ensure the delivery of services in a culturally competent manner to all Enrollees, including those with LEP and diverse cultural and ethnic backgrounds. (B) MCO shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs, being sensitive to cultural diversity, and promoting attitudes and interpersonal communication styles with staff and Network Providers, which respect Enrollee's cultural backgrounds. (C) MCO shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background, and beliefs. (D) MCO shall strive to ensure its Network Providers provide culturally sensitive services to Enrollees. These services shall include, but are not limited to, providing training to Network Providers regarding how to promote the benefits of Health Care Services as well as training about health care attitudes, beliefs, and practices that affect access to Health Care Services. (pp. 91-93, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

⁹⁶ Covered Services and Benefits ...Non-emergency medical transportation (pp. 122-123, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

The MCO must provide emergency and non-emergency medical transportation (NMET) for its members... (p. 124; 2377, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁹⁷ CM [care management] Staff Training Modules to Promote Member Engagement...Poverty Competency...Trauma-Informed Care...Training will also address biopsychosocial factors that affect member willingness and ability to engage, such as health literacy and the impacts of domestic violence and drug abuse (pp. 1402-1403, no date, Nebraska Total Care Inc. Medicaid Managed Care Contract RFP)

⁹⁸ 4.10.5.10 The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:... 4.10.5.10.4 Housing;(p. 198, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.10.3 The MCO's Care Management shall include help for Members in addressing unmet resource needs through strategies including, at a minimum:... 4.10.10.3.3 Having a housing specialist on staff or on contract who can assist Members who are homeless in securing housing;... 4.10.10.4 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing... (p. 212, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.1.3.5.3 DHHS has authorized...assistance in finding and keeping housing (not including rent), as In Lieu Of Services. (p. 84, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

11.5.7 Services for the Homeless 4.11.5.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services. 4.11.5.7.2 The MCO shall have one (1) or more Housing Coordinator(s) on staff or under contract to provide in-person housing assistance to Members who are homeless, as described in Section 3.15.1 (Key Personnel). 4.11.5.7.2.1. [Amendment #8:1 [Amendment #6:1 [Amendment #5:1 For the period January 1, 2021 through Juno 30December 31, 2022 2024. the Housing Coordinator position is not required. 4.11.5.7.3 The Housing Coordinator(s) shall coordinate with housing case managers at the CMH Programs, New Hampshire Hospital, the Bureau of Mental Health Services, the Bureau of Housing Supports and other CMH Providers to coordinate referrals. 4.11.5.7.4 In coordination with CMH Programs/CMH Providers, the MOO shall ensure that ACT teams and/or Housing Coordinator(s) also provide ongoing mental health and tenancy support services to Members. 4.11.5.7.5 In Its contract with CMH Programs/CMH Providers, the MCO shall describe how it shall provide appropriate oversight of CMH Program/CMH Provider responsibilities, including: 4.11.5.7.5.1. Identifying housing options for Members at risk of experiencing homelessness; 4.11.5.7.5.2. Assisting Members in filing applications for housing and gathering necessary documentation; 4.11.5.7.5.3. Coordinating the provision of supportive housing; and 4.11.5.7.5.4. Coordinating housing-related services amongst CMH Programs/CMH Providers, the MCO and NH's Housing Bridge Subsidy Program. 4.11.5.7.6 The contract with CMH Programs/CMH Providers shall require quarterly assessments and documentation of housing status and homelessness for all Members. 4.11.5.7.7 The MCO shall ensure that any Member discharged into homelessness Is connected to Care Management as described in Section 4.10.10 (Coordination and Integration with Social Services and Continuity of Care) within twenty-four (24) hours upon release. (pp. 232-233, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

Services MCO Covered...Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports (p. 83, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

⁹⁹ 1.9 Non-Emergency Medical Transportation (NEMT) 4.1.9.1 The MCO shall arrange for the NEMT of its Members to 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. 4.1.9.1.1 For the federal COVID-19 Public Health Emergency period beginning March 18, 2020. the MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility. 4.1.9.2 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. 4.1.9.3 The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family member with a car, who can drive them to their Medically Necessary service. A Member with a car who does not want to enroll in the Family and Friends Program shall meet one (1) of the following criteria to qualify for transportation services: 4.1.9.3.1 Does not have a valid driver's license; 4.1.9.3.2 Does not have a working vehicle available in the household; 4.1.9.3.3 Is unable to travel or wait for services alone; or 4.1.9.3.4 Has a physical, cognitive, mental or developmental limitation. 4.1.9.4 The MCO shall make good faith effort to achieve a fifty percent (50%) rate of total NEMT one-way rides provided by the MCO through the Family and Friends Mileage Reimbursement Program. (p. 94, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

Services MCO Covered...Non-Emergency Medical Transportation (p. 82, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁰⁰ 4.1.9.5 If no car is owned or available, the Member shall use public transportation if: 4.1.9.5.1 The Member lives less than one half mile from a bus route; 4.1.9.5.2 The Provider is less than one half mile from the bus route; and 4.1.9.5.3 The Member is an adult under the age of sixty-five (65)...4.1.9.6 Exceptions the above public transportation requirement are;... 4.1.9.6.3 The Member has at least one (1) of the following conditions: 4.1.9.6.3.1. Pregnant or up to six (6) weeks postpartum, (pp. 94-95, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁰¹ 4.10.3 Priority Populations 4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs: 4.10.3.1.1 Adults with Special Health Care Needs, meaning those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age. 4.10.3.1.1.1. This Includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; 4.10.3.1.2 Children with Special Health Care Needs meaning those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. 4.10.3.1.2.1. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with MAS; in high stress social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with an SED, I/DD or Substance Use Disorder diagnosis; 4.10.3.1.3 Members receiving services under HCBS waivers; 4.10.3.1.4 Members identified as those with rising risk. The MCO shall establish criteria that define Members at rising risk for approval by DHHS as part of the Readiness Review process and reviewed and approved annually; 4.10.3.1.5 Individuals with high unmet resources needs meaning MCM Members who are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 {Coordination and Integration with Social Services and Community Care); 4.10.3.1.5.1. Recently incarcerated; 4.10.3.1.5.2. Mothers of babies born with MAS; . 4.10.3.1.5.3. Pregnant women with Substance Use Disorders; 4.10.3.1.5.4. IV Drug Users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use; 4.10.3.1.5.5. Members who have been in the ED for an overdose event in the last twelve (12) months; 4.10.3.1.5.6. Members who have a suicide attempt in the last twelve (12) months; 4.10.3.1.5.7. Members with an I/DD diagnosis: and/or 4.10.3.1.5.8. Other Priority Populations as determined by the MCO and/or by DHHS. (pp. 194-195, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.6 Care Management for High Risk and High Need Members 4.10.6.1 The MCO shall provide Care Management for Members identified as "high-risk-high-need" through the Comprehensive Assessment. Every high-risk/high-need Member identified as needing Care Management shall be assigned a designated Care Manager. 4.10.6.2 [Amendment #5:1 Beginning January 1. 2021. Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members. [Amendment #5:] For the period January 1, 2021 through Juno 30, 2021, Core Managomont for high risk/high nood 4.10.6.2.1 [Amendment #6:1 Beginning March 1. 2021. Care Management for shall be conducted for at least three percent (3%) of the total membership....4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum: 4.10.6.4.1 Coordination of physical, mental health. Substance Use Disorder and social services; 4.10.6.4.2 Quarterly medication reconciliation; 4.10.6.4.3 Monthly telephonic contact with the Member; 4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants; 4.10.6.4.5 Referral follow-up monthly; 4.10.6.4.6 Peer support; 4.10.6.4.7 Support for unmet resource needs; 4.10.6.4.8 Training on disease self-management, as relevant; and 4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management). 4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to, the Member, caretaker(s), PCP, behavioral health Provider(s), specialist(s), HCBS case managers, school personnel as needed, nutritionist(s), and/or pharmacist(s). 4.10.6.6 The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships. 4.10.6.7 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective healthcare including how the Care Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports. 4.10.6.8 The MCO shall develop a care plan, within 30 calendar days of the completed Comprehensive Assessment, for each high-risk/high need Member identified through a Comprehensive Assessment who ls in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)] 4.10.6.9 The MCO's care plan shall be regularly updated and incorporate input from the local community based care team participants and the Member. (pp. 200-202, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.10.4.2 Risk Scoring and Stratification by Member Level of Need: The MCO shall identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, shall ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and

transportation. 4.10.10.4.3 High Risk/High-Need Members: The MCO shall ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment shall include questions regarding social determinants of health. 4.10.10.4.4 The MCO shall provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services shall include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community. (pp. 212-213, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.4.7 Cultural and Accessibility Considerations... 4.4.7.3 Cultural Competency Plan 4.4.7.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit 0. 4.4.7.3.2 The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity. 4.4.7.3.3 The MCO shall work with the DHHS Office of Health Equity to address cultural and linguistic considerations. (p. 136, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁰² 4.10.3 Priority Populations 4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs: 4.... Mothers of babies born with MAS; . 4.10.3.1.5.3. Pregnant women with Substance Use Disorders; (pp. 194-195, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁰³ 4.10.1.8 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including... social service resources; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care. (p. 191, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum: 4.10.6.4.1 Coordination of...social services; (p. 201, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.10.10 Coordination and Integration with Social Services and Community Care 4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)] 4.10.10.2 The MCO shall utilize 2-1-1 NH, which is New Hampshire's statewide, comprehensive, information and referral service. The MCO shall leverage and partner with 2-1-1 NH to ensure warm transfers and the ability to report on closed loop referrals. 4.10.10.3 The MCO's Care Management shall include help for Members in addressing unmet resource needs through strategies including, at a minimum: 4.10.10.3.1 How the MCO identifies available community support services and facilitates referrals to those entities for Members with identified needs;... 4.10.10.3.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers. 4.10.10.4 In addressing unmet resource needs for Members, the MCO shall promote access to... interpersonal safety, and job support. [\(p. 212, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract\)](#)

¹⁰⁴ W. X. In Lieu of Services (ILOS) 1. The Contractor may cover the services or settings that are in lieu of the services or settings included in the New Jersey's Medicaid State Plan that the Contractor is responsible to provide as part of any benefit package provided by the Contractor under this contract... f. Assistance with finding or keeping housing (not to include rent) (p. 8, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

9.6.3 CARE PLANNING: NEEDS ASSESSMENT AND OPTIONS COUNSELING A. The Contractor's Care Managers shall use a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. Care Managers shall:... 11. Assist Members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing... (p. 36, Article 9, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁰⁵ 4.1.2 BENEFIT PACKAGE A. 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...25. Transportation Services – Emergency ground and air transportation. (p. 11, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁰⁶ 4.5.4 PERSONS WITH HIV/AIDS ...B. Prevention. The Contractor shall address the HIV/AIDS prevention needs of uninfected enrollees, as well as the special needs of HIV+ enrollees. The Contractor shall establish: 1. Methods for promoting HIV prevention to all enrollees in the Contractor's plan. HIV prevention information shall be consistent with the enrollee's age, sex, and risk factors as well as culturally and linguistically appropriate. 2. Methods for accommodating self-referral and early treatment. 3. A process to facilitate access to specialists and/or include HIV/AIDS specialists as PCPs. 4. Methods for education concerning HIV/AIDS risk reduction. 5. A process for HIV/AIDS testing and counseling. C. Traditional Providers. The Contractor shall include traditional HIV/AIDS providers in its networks, including HIV/AIDS Specialty Centers (Centers of Excellence), and shall establish linkages with AIDS clinical educational programs to keep current on up-to-date treatment guidelines and standards. D. Current Protocols. The Contractor shall establish policies and procedures for its providers to assure the use of the most current diagnosis and treatment protocols and standards established by the DOH and the medical community. E. Care Management. The Contractor shall develop and implement an HIV/AIDS Care Management program with adequate capacity to provide services to all enrollees who would benefit from HIV/AIDS Care Management services. Contractors shall establish linkage with Ryan White CARE Act grantees for these services either through a contract, MOA, or other cooperative working agreement approved by the Department. F. ADDP. The Contractor shall have policies and procedures for supplying DOH application forms and referring qualified NJ FamilyCare enrollees to the AIDS Drug Distribution Program (ADDP). Qualified individuals, described in Article 8.5.5, receive protease inhibitors and certain antiretrovirals solely through the ADDP. The Contractor shall ensure timely referral for registration with the program to assure these individuals receive appropriate and timely treatment. G. MLTSS. The Contractor shall have policies and procedures for identifying and evaluating individuals for potential eligibility for long term services and supports. Additional services and Contractor requirements, for individuals who are found to be eligible, can be found in Article 9. (pp. 71-72, Effective 2021, Article 4, New Jersey Medicaid Managed Care HMO Model Contract)

4.2.9 HEALTH PROMOTION AND EDUCATION PROGRAMS The Contractor shall identify relevant community issues (such as TB outbreaks, violence, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include: 1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs.... (pp. 49-50, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

F. Community Advisory Committee. Contractor shall implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers (with representatives of each Medicaid/NJ FamilyCare eligibility category- See Article 5.2), community advocates, and traditional and safety net providers. The Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency. (p. 31, Article 5, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

B. Ongoing Training. The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor. (p. 3, Article 6, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁰⁷ 4.5.4 PERSONS WITH HIV/AIDS A. Pregnant Persons. The Contractor shall implement a program to educate, test and treat people who are pregnant with HIV/AIDS to reduce perinatal transmission of HIV from the person who is pregnant to infant. All pregnant persons shall receive HIV education and counseling and HIV testing with their consent as part of their regular prenatal care. A refusal of testing shall be documented in the patient's medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (the use of Zidovudine [AZT] or most current treatment accepted by the medical community for treating this disease) for the mother and newborn infant should be made available during pregnancy and/or to the infant within the first months of life. (pp. 71-72, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁰⁸ 4.3 COORDINATION WITH ESSENTIAL COMMUNITY PROGRAMS A. The Contractor shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social service organizations, consumer organizations, and civic/community groups. (p. 57, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁰⁹ 4.4.1.7 Supportive Housing The CONTRACTOR shall have a full-time Supportive Housing Specialist dedicated to this Agreement to work with Members to assess housing needs and identify appropriate resources in order to help them attain and maintain housing. 4.4.1.7.1 The Support Housing Specialist shall serve as the internal resource to provide training and technical assistance to the CONTRACTOR's care coordinators. 4.4.1.7.2 Supportive Housing specifically targets the following populations: · Individuals who are chronically homeless individuals, as defined by the U.S. Department of Housing and Urban Development (HUD) or precariously housed; · Individuals with frequent or lengthy institutional care; · Individuals with frequent or lengthy adult residential care or treatment stays; · Individuals with LTSS and frequent turnover of in-home caregivers or providers; and · Individuals at highest levels of risk for expensive care and negative outcomes, defined by a Predictive Risk Intelligence System (PRISM) risk score of 1.5 or higher or similar risk measures. (pp. 48-49, no date, New Mexico Amended Version Sample RFP)

4.4.9.6.11 Other services that will be provided to the Member, including Covered physical and Behavioral Health Services that will be provided by the CONTRACTOR to help the Member maintain or improve his or her physical or Behavioral Health status or functional abilities and maximize independence, as well as other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, and any non-Covered Services including services provided by other community resources, including plans to link the Member to financial assistance programs including but not limited to housing, utilities and food as needed; (p. 59, no date, New Mexico Amended Version Sample RFP)

¹¹⁰ 4.3.5 Care Coordination Level 2 and Level 3. For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:... 4.4.3.5.5 Is identified as having a high risk pregnancy; 4.4.3.5.5.1 Pregnant members 18 years of age and younger (p. 50, New Mexico Amended Version Sample RFP, 2022).

4.4.5 Comprehensive Needs Assessment for Care Coordination Level 2 and Level 3...4.4.5.5 At a minimum, the CNA shall: ... 4.4.5.5.5 Determine a social profile including but not limited to: living arrangements;... living environment (related to health and safety)...(pp. 51-52, no date, New Mexico Amended Version Sample RFP)

¹¹¹ Non-Community Benefit Services Included Under Centennial Care...Transportation Services (medical) (p. 299, no date, New Mexico Amended Version Sample RFP)

Adult Benefit Plan Services Included Under Centennial Care... Non-emergency transportation when necessary to secure covered medical services (p. 315, no date, New Mexico Amended Version Sample RFP)

¹¹² 3.5 Cultural and Linguistic Competence 3.5.1 The CONTRACTOR shall develop and implement a Cultural Competence/Sensitivity Plan, through which the CONTRACTOR shall ensure that it provides culturally competent services to its Members, both directly and through its Contract Providers, Major Subcontractors and Subcontractors. The CONTRACTOR shall participate in HSD's efforts to promote the delivery of Covered Services in a culturally competent manner to all Members, regardless of gender, sexual orientation, or gender identity, and including Members who have: a hearing impairment, Limited English Proficiency, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, and diverse cultural and ethnic backgrounds. The CONTRACTOR shall: 3.5.1.1 Develop a Cultural Competence/Sensitivity Plan that shall be submitted to HSD for approval, describing how the CONTRACTOR shall ensure that Covered Services provided to Members are culturally competent and including provisions for monitoring and evaluating disparities in membership, especially as related to historically and socially disadvantaged Members; 3.5.1.2 Develop written policies and procedures ensuring that Covered Services provided to Members, both directly and through its Contract Providers and Major Subcontractors are Culturally Competent; 3.5.1.3 Target Cultural Competence training to Member services staff and Contract Providers, including PCPs, care coordinators, case managers, home health care MCO staff, and ensure that staff at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery; 3.5.1.4 Develop and implement a plan for interpretive services and written materials, consistent with Section 4.14 to meet the needs of Members and their decision-makers whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member-oriented materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area; 3.5.1.5 Identify community advocates and agencies that could assist Limited-English Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral; 3.5.1.6 Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment; 3.5.1.7 Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups; 3.5.1.8 Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State; and 3.5.1.9 Ensure that new Member assessment forms contain questions related to primary language preference and cultural expectations, and that information received is maintained in the Member's file. 3.5.2 The CONTRACTOR shall conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and shall integrate cultural and linguistic competence-related measures into its internal audits, performance improvement programs, Member Satisfaction Surveys and outcomes-based evaluations. (pp. 38-39, no date, New Mexico Amended Version Sample RFP)

¹¹³ 4.13.4 Home Visiting Pilot Program 4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care members. The CONTRACTOR shall include methods to incentivize participation...4.13.4.5.2 Targeted Case Management: These services include activities such as conducting a comprehensive history and assessment (in place of CNA), developing an individualized care plan, providing referrals and scheduling treatment services, linking members to necessary community resources, monitoring, and follow-up activities. (pp. 160-161, no date, New Mexico Amended Version Sample RFP)

¹¹⁴ 4.8.15 Shared Responsibility Between the CONTRACTOR and Public Health Offices... 4.8.15.1.8 Participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as driving while intoxicated (DWI) councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others. (pp. 119-120, no date, New Mexico Amended Version Sample RFP)

4.4.15.5 The CONTRACTOR is required to participate in care coordination efforts for justice-involved individuals to facilitate the transition of Members from prisons, jails, and detention facilities into the community, to include tribal communities and reservations for Native American members transitioning from incarceration. Care coordination should occur prior to release, including when release from the facility occurs after business hours or on non-work days. The CONTRACTOR shall collaborate with criminal justice partners to identify Justice-Involved Members with physical and/or Behavioral Health chronic and/or complex care needs prior to the Member's release. (p. 74, no date, New Mexico Amended Version Sample RFP)

4.5.16.17 The CONTRACTOR is required to designate a liaison for Justice-Involved care coordination and transitions of care. The designated liaison is to be the single point-of-contact to communicate with the prisons, jails, and detention facilities, and who can facilitate the care coordination process for Justice-Involved members, to include Native American members transitioning from incarceration and minor members transitioning from juvenile detention facilities. (pp. 92-93, no date, New Mexico Amended Version Sample RFP)

4.12.13.2 The CONTRACTOR shall coordinate services with the CYFD Protective Services ("PS"), Family Services ("FS"), and Juvenile Justice Services ("JJS") divisions, including discharge planning. (p. 153, no date, New Mexico Amended Version Sample RFP)

¹¹⁵ 7.4.8.2. The Contractor's Case Managers will be responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. This coordination includes referral of eligible Members to appropriate community resources and social service programs, including supportive housing. (p. 132, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹¹⁶ 7.4.6.2. Non-Emergency Transportation (NET) The State contracts with a NET Broker who authorizes and arranges for all covered Medically Necessary non-emergency transportation. The Contractor and its Subcontractors shall coordinate with the NET Broker, if necessary, to ensure NET services are secured on behalf of Members. The Contractor and its Subcontractors must also verify medical appointments upon request by the State or the NET Broker. 7.4.6.3. Non-Emergency Secure Behavioral Health Transport Non-Emergency Secure Behavioral Health Transport is available to Members; however, the services are reimbursed under FFS pursuant to MSM Chapter 1903 and are outside the scope of transportation services provided by the State's NET Broker. Providers of this service are accredited and licensed by the DPBH. The Contractor is responsible for Managed Care Organization ensuring referral and coordination of care for Non-Emergency Secure Behavioral Health Transport services. Furthermore, the Contractor is responsible for educating Providers and Members, as appropriate, about the availability of this service. (p. 121, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹¹⁷ 7.3.8. Contractor's Responsibility for Members Upon Enrollment 7.3.8.1. The Contractor will be responsible for Members as soon as they are enrolled and the Contractor is aware of the Member in treatment. The Contractor must have policies and procedures including, without limitation, the following to ensure a Member's smooth transition from FFS to the Contractor: 7.3.8.1.1. Members with medical conditions such as: Pregnancy (especially if high risk); (p. 91, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

The priority list is not exhaustive and Case Management should be offered to Members whose health conditions warrant Case Management services. Congestive Heart Failure (CHF); Coronary Arterial Disease (CAD); Hypertension (excluding Mild Hypertension); Diabetes; Chronic Obstructive Pulmonary Disease (COPD); Asthma; High-Risk or High-Cost Substance Abuse Disorders; including Opioid Use Disorders; Members with Co-Morbid (PH and BH) Conditions; Children with SED and Adults with SMI; Children with Special Health Care Needs; High Risk Pregnancy including Members who are pregnant and have a SUD or history of a SUD; Severe Cognitive and/or Developmental Limitation; HIV; Members with Complex Conditions such as cystic fibrosis, cerebral palsy, sickle cell anemia, etc.; Justice involved populations; Members in Supportive Housing; and Homeless/Transient status (p. 159, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.1.3. The Contractor's Population Health program must align the efforts and resources of the Contractor's Care Management programs (i.e., disease management, Care Coordination, Case Management, and programs that address social determinants of health and racial and ethnic disparities in health care), Quality Management, and the Contractor's value based contracting strategies to achieve population health improvements. (p. 136, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.3.2. Cultural Competency Plan 7.5.3.2.1. The Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner. 7.5.3.2.2. The CCP must identify the goals and objectives of the Contractor's cultural competency program and encompass the goals and objectives described in the State's Quality Strategy. 7.5.3.2.3. The CCP must be reviewed and updated annually and submitted to the State in the second quarter of each calendar year. 7.5.3.2.4. The Contractor must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the State. 7.5.3.2.5. The Contractor must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the Contractor's membership and cultural competence must be included as part of job descriptions. 7.5.3.2.6. The CCP must include a process to obtain Member and stakeholder feedback that will be used to improve the cultural competency program and cultural support provided by clinical and member services programs. 7.5.3.2.7. The Contractor must describe in the CCP the method for the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the Contractor's Members. A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the Contractor's membership. 7.5.3.2.8. Culturally competent care requires that the Contractor regularly evaluate its Network, outreach services and other programs to improve accessibility and quality of care for its membership. The CCP must also describe the provision and coordination needed for linguistic and disability-related services. 7.5.3.3. Cultural Competency Education and Training 7.5.3.3.1. The training program must include the methods the Contractor will use to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to Members of all cultures. The Contractor must regularly assesses the training needs of the staff and update the training programs, when appropriate. 7.5.3.3.2. Training must be customized to staff based on the nature of the contacts they have with Providers and/or Members.

7.5.3.3.3. The education program must include methods the Contractor will use for Providers and other Subcontractors with direct Member contact. The education program must be designed to make Providers and Subcontractors aware of the importance of providing services in a culturally competent manner. The Contractor must make sufficient efforts to train Providers and Subcontractors or assist Providers and Subcontractors in receiving training on how to provide culturally competent services. 7.5.3.4. Culturally Competent Services and Translation/Interpretation Services The Contractor must demonstrate that they use a quality review mechanism to ensure that translated materials convey intended meaning in a culturally appropriate manner. The Contractor must provide translations in the following manner: 7.5.3.4.1. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's Members who also have Limited English Proficiency (LEP) in that language. 7.5.3.4.1. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's Members who also have Limited English Proficiency (LEP) in that language. 7.5.3.4.2. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's Members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, and vital information from the Member Handbook. 7.5.3.4.3. All written notices informing Members of their right to interpretation and translation services must be translated into the appropriate language when the Contractor's caseload consists of 1,000 Members that speak that language and have LEP. (pp. 139-141, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹¹⁸ 7.4.8.3. In addition to routine Care Coordination with other vendors or entities, the Contractor is responsible for designating a specific clinician or case manager to ensure continuity of services for Members with special needs. These Members may include, but are not limited to...women with high-risk pregnancies). Care Coordination must address critical issues such as out-of-home placement, specialized mental health services and therapies, and needs that may typically be filled by community resources and social service programs. (p.132, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.5. Health Needs Assessment The Contractor must conduct a Health Needs Assessment Screening for all new Members with the following timeframes from the date of enrollment with the Contractor: 7.5.5.1. The Contractor must arrange for or conduct an initial screening assessment of new Members, to confirm the results of a positive identification and to determine the need for Care Coordination and/or Case Management services within sixty (60) Calendar Days of enrollment. Screening assessment for pregnant women...~~children with special health care needs, adults with special health care needs~~ must be conducted within thirty (30) Calendar Days (p. 143, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

5.6. Care Management 7.5.6.1. Care Management comprises the Contractor's clinical programs that must include, at a minimum, Level 1 Care Coordination and Level 2 Case Management as described in this section. 7.5.6.2. The Contractor must put a system in place that promotes continuity of care and Care Management. The Contractor must take a comprehensive and collaborative approach to coordinate care for the populations and conditions as specified by the State through effective Care Coordination and Case Management programs, partnerships with PCPs and Specialists, other Providers, Members, Member/family outreach and education, and the ability to holistically address Member health care needs. Care Coordination or Case Management must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including Behavioral Health and related issues, such as lack of social or family support. 7.5.6.3. The Contractor will have a geographically based Case Manager for inperson assistance. Upon request of the State, Case Managers must be available to conduct home visits of Members within forty-eight (48) hours of identification as high-risk for serious health, safety and welfare issues. (p.144, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.6. Level 1 – Lower Risk: Care Coordination 7.5.6.6.1. Level 1- Care Coordination is designed to assist Members with social determinant of health needs, challenges in accessing health and community resources, or other Member needs that fragment the Member's care or lead to poor health outcomes. The Contractor must offer and provide Care Coordination to reduce fragmentation, improve Member's access to necessary services and address social determinant of health needs for eligible Members. 7.5.6.6.2. The Contractor's Care Coordination services are provided to Members who have short-term or intermittent needs for coordination of care, to limit Member and Provider confusion, the State requires Contractors to use the title "Care Coordinator" for staff who perform Care Coordination supports for Members as defined in this Contract. 7.5.6.6.3. A Care Coordinator for purposes of this Contract is a para-professional, whose background is most frequently anchored in the disciplines of social work or community health systems to improve health outcomes. Care Coordination services may be provided by non-licensed staff, including Community Health Workers, Promotores or Peer Support Specialists, and Doulas for Contractors who may offer this service as a Value Added Service. 7.5.6.6.4. The type of interventions provided to Members under the Care Coordination program may include, but are not limited to: Coordinating the authorization of needed services such as timely approval of durable medical equipment, pharmacy, and medical supplies; Ensuring access to Medically Necessary physical health or Behavioral Health through assisting with appointments and transportation services; Providing coaching and social support; Providing coordination of Member's care with treating Providers such as primary care and Behavioral Health Services; Ensuring access to community based services and resources to address identified social or economic factors impacting the Member's health outcomes; Ensuring appropriate referrals are made and services are delivered, including any follow-up action; Providing Member education and resources to support Member shared decision-making; Screening for and addressing social determinants of health, including identification of community resources and actively linking Members to those resources; Following up after an emergency department visit to assist the Member in reengagement with primary care treating Providers; Providing culturally appropriate health education and information; and Provision of face-to-face Care Coordination and in the communities where Members reside... (pp. 148-149, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.2. The Contractor must offer a Case Management program for all Members identified as eligible within the Nevada Medicaid population that includes Case Management support for Members identified as high-risk. These populations include...Members experiencing a high-risk pregnancy. (p. 150, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.5.6.7.10. High Risk Maternal Case Management 7.5.6.7.10.1 The Contractor will make a good faith effort to screen Medicaid and CHIP pregnant Members for maternal high risk factors. 7.5.6.7.10.2. Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, Personal Care Services or Home Health care, substance abuse services, and Care Coordination services, in addition to maternity care. 7.5.6.7.10.3. All Case Management

requirements and standards outlined within Section 7.5.6.7 apply to the Contractor's High Risk Maternal Care Management program. 7.5.6.7.10.4. Any identification of high-risk factors will require the PCP, OB/GYN Provider, Case Manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Contractor's High Risk Maternal Case Management Program 7.5.6.7.10.5. The Contractor must demonstrate ongoing and active efforts to educate Providers on how to make referrals to the Contractor's High Risk Maternal Case Management Program for Members identified as pregnant for screening. 7.5.6.7.10.6. As appropriate, the Contractor must assist the Member in contacting appropriate agencies for Care Coordination of noncovered/carved-out plan services or community health information. The Contractor's Case Manager will begin medical Case Management services for those risk factors identified. 7.5.6.7.10.7. The State and/or the External Quality Review Organization (EQRO) will conduct on-site reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies. (pp.152-153, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹¹⁹ 7.4.8.2. The Contractor's Case Managers will be responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. This coordination includes referral of eligible Members to appropriate community resources and social service programs, including supportive housing. (p. 132, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.6.3.8.2. The Contractor is required to negotiate in good faith with all of the following Essential Community Providers who are located in the Contractor's geographic service area(s).... Southern Nevada Adult Mental Health Services (SNAMHS) and Northern Nevada Adult Mental Health Services (NNAMHS); School Health Services; Aging and Disability Services Division (ADSD); Division of Public and Behavioral Health (DPBH); Substance Abuse Prevention and Treatment Agency (SAPTA); Division of Child and Family Services (DCFS); County Child Welfare Agencies, there may be times when DCFS and County Child Welfare Providers have provided services to a FFS Recipient who then moves into managed care. Contracting with these Providers will help ensure continuity of care for these Members; Crisis Stabilization Centers; Public Mobile Crisis Teams operated by public agencies; Nurse Midwives; Certified Community Behavioral Health Centers (CCBHCs); Free Standing Birth Centers (FBCs)/Obstetric Centers; Indian Health Care Providers (see Attachment J – Essential Community Providers); Any health provider designated by the State as an Essential Community Provider. The State will notify the Contractor of Providers designated by the State as Essential Community Providers. At the States option, the Contractor may be required to contract with other agencies within the DHHS, the Juvenile Justice system, Disproportionate Share Hospitals (DSH), or various County entities in providing Medically Necessary services, including Behavioral Health. If this option is exercised and there is any resulting additional expense incurred by the Contractor, the State will adjust the Capitation Rate so that it remains Actuarially Sound. (pp. 178-180, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹²⁰ 16.14. HARP Behavioral Health Education for Staff [Applicable to the HARP and HIV SNP Programs]. 16.14.a. The Contractor shall provide behavioral health training programs for its clinical, member services and case management staff. The training objectives shall be to strengthen the knowledge, skills, expertise and coordination efforts within the respective outreach, utilization management, care management, pharmacy and provider relations workforce. The training shall incorporate New York State's vision, mission, and operating principles for behavioral health managed care programs and services. The Contractor shall submit all staff training plans to DOH, OMH and OASAS for review as directed by the State. DOH, OMH and OASAS will facilitate Contractor access to training resources. 16.14.b. Training topics shall include, as appropriate to job function, the following: . . . 16.14.b.vi. Supportive housing and related services and supports. (pp. 16-13-to-16-14, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²¹ App'x K. 23. Non-Emergency Transportation. K.23.e. Non-emergency transportation is covered for FHPlus Enrollees that are nineteen (19) or twenty (20) years old and are receiving C/THP services. Subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s). K.23.f. For MMC Enrollees with disabilities, the

method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability. (pp. K-34, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

App'x K. 24. Emergency Transportation. K.24.e. For MMC plans that cover emergency transportation only, according to a county-by-county phase in schedule to be determined by SDOH, and concomitantly with the assumption of the MMC non-emergency benefit by a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be removed from the Contractor's benefit package. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s). (pp. K-35, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²² 15.10. Cultural and Linguistic Competence. 15.10.a. The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse sexual orientations, gender identities and member of diverse faith communities. For the purpose of this Agreement, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor's organization. (pp. 15-7, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²³ 10.34. Additional Requirements for the HIV SNP Program Only. b. HIV Primary and Secondary Prevention and Risk Reduction Services. ii) The Contractor will be responsible for ensuring that its Participating Providers provide to Enrollees the following HIV Primary Prevention, HIV Secondary Prevention and Risk Reduction Education services: A) Education and counseling regarding reduction of perinatal transmission. (pp. 10-41-to-10-42, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²⁴ 12. MEMBER SERVICES. 12.1. General Functions. 12.1.a. The Contractor shall operate a Member Services Department during regular business hours, which must be accessible to Enrollees via a toll-free telephone line. 12.1.c. Member Services staff must be responsible for the following: . . . 12.1.c.x. Directing Enrollees to appropriate member-serving systems including, but not limited to, social services, State or federally funded non-Medicaid behavioral health services, the Office for People with Developmental Disabilities, the NYS Justice Center, law enforcement and community-based organizations providing services to criminal justice-involved Enrollees. Contractor shall ensure other appropriately-trained staff are available to provide such information or direction. (pp. 12-2, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²⁵ 10. Specialized Services for High Risk Populations. The MCP may provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community, including home visiting, centering, community hub, community workers, etc., as appropriate, for high risk populations identified by the MCP or ODM . . . n.1: Qualified community hub means a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria: (a) demonstrates to the director of health that it uses an evidenced-based, pay-for performance community care coordination model (endorsed by the federal agency for health research and quality, the national institutes for health, and the centers for Medicare and Medicaid services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to . . . housing . . . services (pp. 163, [Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan](#))

¹²⁶ 19. Provision of Transportation Services. The MCP shall ensure transportation pick-up is completed not more than 15 minutes before or 15 minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment. Following a scheduled appointment, transportation pick-up shall be completed no more than 30 minutes after a request for pick-up following

a scheduled appointment. The vendor shall attempt to contact the member if he/she does not respond at pick-up. a. The transportation vendor shall not leave the pick-up location prior to the pre-scheduled pick-up time. b. The MCP shall identify and accommodate any special transportation assistance needs of their members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs shall be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs shall be documented in the member's care plan. c. The MCP shall submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The plan shall specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCP shall notify the Contract Administrator immediately when transportation is canceled in accordance with the plan. (pp. 25-26, Appendix C, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

10. Specialized Services for High Risk Populations . . . [T]he MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub . . . n.1: Qualified community hub means a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria: (a) demonstrates to the director of health that it uses an evidenced-based, pay-for performance community care coordination model (endorsed by the federal agency for health research and quality, the national institutes for health, and the centers for Medicare and Medicaid services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to . . . transportation . . . services (pp. 163, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

9. Non-Emergency Medical Transportation Services. The MCP must arrange and provide transportation for members who are enrolled with the OhioRISE Plan in a manner that ensures that children, youth, and their families served by the OhioRISE Plan do not face transportation barriers to receive services regardless of Medicaid payer. a. The MCP is responsible for arranging for transportation, regardless of whether the transportation is covered by the county or MCP. Members and their families must be able to contact the MCP within reasonable timeframes to arrange for transportation, including same day appointments. The MCP must work with the OhioRISE Plan care management resources, including CMEs, to ensure transportation services are well-coordinated with the services the OhioRISE Plan member or family is receiving. b. The MCP must provide additional transportation benefits for members under the age of 21. This medically necessary service cannot be a value-added service or have annual limitations. c. The MCP must ensure appropriate transportation for members who have cognitive or behavioral challenges that require different transportation providers or supports than available from counties or standard Medicaid provider network. (p. 257, Appendix T, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹²⁷ 21. Cultural Competency and Communication Needs. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as defined by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (<https://www.thinkculturalhealth.hhs.gov/clas>), to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. The MCP shall comply with applicable federal and state laws regarding persons with LEP and persons with disabilities, including Title VI of the Civil Rights Act of 1964, Titles II and III of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Patient Protection and Affordable Care Act. At minimum, the MCP shall do the following: a. The MCP shall develop and implement a written plan or policy governing accessibility and accommodations for persons with LEP and persons with disabilities. The plan shall require routine training of pertinent staff on the process. The plan must be made available for review by ODM at ODM's request. b. The MCP shall provide written notice of nondiscrimination (i.e. that the MCP may not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, ancestry, genetic information, health status, or need for health services in the receipt of health services) to members. c. The MCP shall provide written information to members describing how to request language or disability accommodations and how to file a grievance with both the MCP and the HHS Office of Civil Rights. d. The MCP shall make oral interpreter services for all languages, alternative formats, and auxiliary aids and services available free of charge to all members and eligible individuals pursuant to 42 CFR 438.10. e. The MCP shall comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05, and 5160-26-05.1 for providing assistance to LEP members and eligible individuals. f. The MCP must include taglines on all materials which are critical to obtaining services. These include, at a minimum, direct member contact marketing materials, HIPAA privacy notices, provider directories, member handbooks, care coordination materials provided to the member, grievance and appeal notices, denial and termination notices,

member letters, solicitation brochures, and any other materials as identified by ODM. g. If ODM identifies prevalent non-English languages in the MCP's service area, the MCP, as specified by ODM, shall translate marketing and member materials, including but not limited to HIPAA privacy notices, into the primary languages of those groups. The MCP shall make these marketing and member materials available to eligible individuals free of charge. h. The MCP shall utilize a centralized database which records the special communication needs of all MCP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment, etc.) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, sign language services, and other auxiliary aids and services). This database shall include all MCP member primary language information (PLI), as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODM, the SPBM, the OhioRISE Plan, the Hotline, MCP staff, providers, and members. This centralized database shall be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available. i. Unless otherwise specified by a member, the MCP shall ensure that the special communication needs identified by a member (for example, large print) are applied to subsequent communications with the member so that a member does not have to repeatedly request the accommodation. j. The MCP shall share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third-Party Administrators (TPAs)], as applicable. k. The MCP shall submit to ODM, upon request, information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider). l. The MCP is responsible for ensuring that all member materials use easily understood language and format. The determination of whether materials comply with this requirement is in the sole discretion of ODM. m. The MCP shall participate in ODM's cultural competency initiatives. n. The MCP will use person-centered language in all communication with eligible individuals and members. (pp. 26-27, Appendix C, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

10. Specialized Services for High Risk Populations . . . [T]he MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub . . . n.1: Qualified community hub means a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria: (a) demonstrates to the director of health that it uses an evidenced-based, pay-for performance community care coordination model (endorsed by the federal agency for health research and quality, the national institutes for health, and the centers for Medicare and Medicaid services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to . . . social services (pp. 163, [Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan](#))

128 This appendix establishes program requirements and expectations related to MCP responsibilities for developing and implementing a population health management program, inclusive of a care coordination program; ensuring health, safety, and welfare for members; partnering with Care Coordination Entities (CCE), the OhioRISE Plan, and OhioRISE Plan-contracted care management entities (CMEs) to improve population health; coordinating activities for justice-involved individuals; developing and implementing a Population Health and Management Strategy and a Quality Assessment and Performance Improvement (QAPI) program; and participating in external quality review activities. These program requirements support the priorities and goals set forth in Ohio Medicaid's Quality Strategy. (p.135, [Appendix K, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan](#)) *See Appendix K for more information.*

¹²⁹ 8. Social Determinants of Health and Equity Spending Programs: SHARE Initiative. 8.b. The SDOH-E SRSA shall identify how Contractor plans to implement the requirements for the SHARE Initiative as such Program is described below in this Sec. 8, Ex. K. 8.b.2. The SDOH-E SRSA must include, at a minimum, all of the following. 8.b.2.b. At least one spending priority that aligns with the OHA-designated statewide priority for SDOH-E spending in housing-related services and supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities as set by OHA (p. 256, [Effective October 2019, Exhibit K, Social Determinants of Health and Equity, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health](#))

6. Screening Members Contractor shall require Providers to do the following: . . . b. Screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy...) (p. 282, [Effective October 2019, Exhibit M Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health](#))

7. Substance Use Disorders Contractor shall:... g. Provide to Members receiving SUD services, to the extent of available Community resources and as Medically Appropriate, information and referral to community services which may include but are not limited to:... housing... (p. 284, Effective October 2019, Exhibit M Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹³⁰ 4. Covered Service Component: Crisis, Urgent and Emergency Services... a. Crisis, Urgent and Emergency Services... 12. In accordance with OAR 410-141-3460 and 410-120-0000(91) Contractor shall pay for emergency Ambulance transportation for Members, including Ambulance services dispatched through 911 when a Member's medical condition requires Emergency Services. 5. Covered Service Component: Non-Emergency Medical Transportation (NEMT) a. Contractor is responsible for ensuring Members have access to safe, timely, appropriate Non-Emergent Medical Transportation services... (pp. 56-57, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹³¹ See Exhibit K on the state's and MCO's social determinants of health and equity initiatives, which includes health equity plan, implicit bias training, cultural competence, etc.

¹³² Exhibit M. 3. Integration, Transition, and Collaboration with Partners. Contractor shall do all of the following. M.3.f. Engage with local law enforcement, jail staff and courts to improve outcomes and mitigate additional health and safety impacts for Members who have criminal justice involvement related to their Behavioral Health conditions. Key outcomes include reductions in Member arrests, jail admissions, lengths of jail stay and recidivism along with improvements in stability of employment and housing. (pp. 280-281, Effective October 2019, Exhibit M Behavioral Health, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹³³ 9. Value Based purchasing... c. Financial Goals... In addition, the MCOs must incorporate CBOs into VBP arrangements with Network Providers to address SDOH as follows:... \$2.5 million of the \$10 million could incorporate CBOs that address... housing insecurity... The MCO must require the CBO to address at least one of the following SDOH domains, which are included in the statewide resource and referral tool:... Housing instability/homelessness (pp. 156-157, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Exhibit NN. SPECIAL NEEDS UNIT. A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services. Examples of members with Special Needs will include but not be limited to: Children with Special Health Care Needs including those requiring skilled or unskilled home shift care, Children in Substitute Care, those with limited English Proficiency, or special communication needs due to sensory deficits those with Physical and/or Intellectual/ Developmental Disabilities, those with HIV/AIDS, those with significant behavioral challenges, or members requiring transportation assistance. Examples of factors in the determination of a member with Special Need(s) include but are not limited to the following: . . . Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers including, but not limited to, housing, food, and employment challenges . . . Special Needs Unit Functions and Requirements. The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member including behavioral health and substance use disorder services, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services to support housing, food and employment needs. (pp. NN-1, NN-3, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

Patient Centered Medical Home (PCMH) Program... B. The PH-MCO will ensure the PCMH provider meets the following requirements:... 4. Will deploy a community-based management team as described below... The CBCM team will also connect individuals as needed to community resources and social support services through "warm hand off" referrals for assistance with problems

such as... housing instability... 11. Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains... housing... (pp. DDD-1 to DDD-2, Effective January 2022, Exhibit G, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁴ 15. Transportation The PH-MCO must provide for all Medically Necessary emergency ambulance transportation and all Medically Necessary non-emergency 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, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁵ I. Home Visiting Program Requirements and Goals A. The PH-MCO must implement a Home Visiting Program that is available to all first-time parents and parents/caregivers of children who have been identified as having additional risk factors which may include social, clinical, racial, economic or environmental factors. The Home Visiting Program must also be available to any infant and the infant's parent/caregiver who requests Home Visiting services. Services must be available from the prenatal period through the child's first 18 months of life... C. Home Visiting activities must be primarily be focused on:... 6. Increasing screenings and referrals to community resources for SDOH (...transportation...)... T. The Maternal Needs and Risk Assessment must include at a minimum the following:... social determinants of health (...transportation...) (p. B(5a)-1, 4, Effective January 2022, , Pennsylvania HealthChoices Physical Health Agreement)

¹³⁶ 2. Cultural Competency Both the PH-MCO and Network Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Member cannot be permitted to present barriers to accessing and receiving quality health care; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or nontraditional treatment methods that are consistent with the Member's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Member; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Member of a particular culture than to another of a differing culture. (p. 122, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁷ The Special Needs Unit will perform the following functions... • Ensure coordination between the PH-MCO and other health, education, and human services systems including County Children and Youth Services Offices, County Office of Intellectual Disability Services Offices and Juvenile Justice Offices. For a more inclusive list see Exhibit OO. • The coordination between the PH-MCO and other health education, and human services systems may include coordination with the state level offices for these agencies as well. For example, the PH-MCOs would be expected to work with the Office of Developmental Programs (ODP) state office and the Family Facilitator on efforts to discharge children in a pediatric residential setting. (pp. NN-3-to NN-4, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁸ 5. Assertive Community Treatment (ACT) and IHH Requirements. . . . The ACT and IHH Teams provide[] or coordinate[] the following services . . . Housing Assistance, Tenancy Supports and Activities of Daily Living Supports. (pp. 353–354, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹³⁹ 2.07.02. Non-Emergency Transportation. The Contractor will coordinate and collaborate with the EOHHS-selected transportation broker to assist members in accessing non-emergency transportation. Requirements will include but will not be limited to supplying provider directories to the broker on a annually basis and complying with all EOHHS-established referral policies. (pp. 89, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

Emergency Room Service and Emergency Transportation Services [] Covered both in-and out-of-State,for Emergency Services (2.10.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service. (pp. 274, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁴⁰ 2.10.04 Cultural Competency As required by 42 CFR 438.206xvi, the Contractor will participate in EOHHS's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, diverse cultural and ethnic backgrounds, and disabilities regardless of gender, sexual orientation or gender identity. The Contractor must ensure that services are provided in a culturally competent manner to all members. Culturally competency is the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural and linguistic needs of members. Specifically, the Contractor will: 1. Develop policies and procedures for the provision of language assistance services which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats. 2. Will provide language and cultural competence training to all employees, subcontractors and providers. Training should include the potential impact of linguistically and cultural barriers on members obtaining services. 3. Must give the concerns of members related to their racial and ethnic minority status full attention beginning with the first contact with a member, continuing throughout the care process, and extending to evaluation of care; 4. Must make interpreter/translation services available when language barriers exist and are made known to the Contractor, including the use of sign interpreters for members with hearing impairments and the use of Braille for members with vision impairments; and 5. As appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its member population. (pp. 123-124, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV . . . SCOPE OF BENEFIT (ANNUAL)[,] Including but not limited to: This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. (pp. 279, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹⁴¹ 4.3.Additional Services. The CONTRACTOR may offer Additional Services to enrolled Medicaid Managed Care Members. These Additional Services are health care services that are not covered by the South Carolina State Plan for Medical Assistance and/or are in excess of the amount, duration, and scope of those listed in the Managed Care Policy and Procedure Guide and handbooks. The Department will not provide any additional reimbursement for these Additional Services. The CONTRACTOR shall: 4.3.1. Ensure transportation for these Additional Services is the responsibility of the Medicaid Managed Care Member and/or CONTRACTOR. (p. 74, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹⁴² 3.14.4. Cultural Competency As required by 42 CFR §438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (p. 49, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

5.4. Member Risk and Care Management Activity Requirements. The CONTRACTOR shall provide Care Management activities based on the Member's risk stratification. 5.4.1.General Care Management Activities for All Members. The CONTRACTOR shall: 5.4.1.8. Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e. absence of appropriate treatment setting availability, high demand for appropriate

treatment setting, high-risk members and members with multiple agency involvement). (p. 82, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

6.1.12. Cultural Considerations The CONTRACTOR shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (p. 90, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹⁴³ 2.11.7.7. The CONTRACTOR, in collaboration with TENNCARE, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders to develop and implement strategies for the identification of resources to assist in transitioning CHOICES, ECF CHOICES, and 1915(c) waiver members to affordable housing. To demonstrate this strategy, the CONTRACTOR shall report annually to TENNCARE on the status of any affordable housing development and networking strategies it elects to implement (See Section A.2.30.6). (p. 88, no date, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹⁴⁴ Amend. 14. Non-emergency Medical Transportation (including Non-Emergency 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). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to HCBS provided through the CHOICES program or an I/DD MLTSS Program. However, as specified in Section A.2.11.1.8.1 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. The CONTRACTOR shall be responsible for providing NEMT to dental services for I/DD MLTSS Programs members, including facility or other medical services related to such dental services. (pp. 20–21, no date, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹⁴⁵ A.2.18.3 Cultural Competency As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities. (p. 46, no date, Amendment 11, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹⁴⁶ 2.8.4.6. High Risk Maternity Program. The CONTRACTOR shall provide a High Risk Maternity Program for eligible members identified as described in Sections A.2.8.2.2 and A.2.8.2.2.1 of this Contract. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. (p. 13, no date, Amendment 11, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹⁴⁷ 8.1.34.4 Referral to Community Organizations The MCO must provide information about and referral to community organizations that may not be providing Covered Services, but are otherwise important to the health and wellbeing of Members. These organizations include, but are not limited to:... 2. Social service agencies (e.g., Area Agencies on Aging, residential support agencies, independent living centers...); 3. City and county agencies (e.g., ...housing programs, etc.) (p. 205, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

¹⁴⁸ 8.1.22.14 NEMT Services NEMT Services should be part of the MCO's overall strategy to affect positive Member outcomes. The MCO must assess, approve, arrange, coordinate, and ensure delivery of NEMT Services in accordance with the Contract and Chapter 16 of the UMCM. NEMT Services include the following: 1. Demand response transportation services, including Nonmedical Transportation (NMT) Services, and public transportation services; 2. Mass transit; 3. Individual transportation participant (ITP) mileage reimbursement; 4. Meals; 5. Lodging; 6. Advanced funds; and 7. Commercial airline transportation services. (p. 169, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

¹⁴⁹ 8.1.5.8 Cultural Competency Plan The MCO must have a comprehensive written Cultural Competency plan describing how the MCO will ensure culturally competent services and provide Linguistic Access and Disability-related Access. The Cultural Competency plan must be developed in adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as described in UMCM Chapter 16 in the format as required by HHSC. The Cultural Competency plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 28 C.F.R. §36.303, 42 C.F.R. § 438.206(c)(2), and 1 Tex. Admin. § 353.411. Additionally, the Cultural Competency plan must describe how the MCO will implement each component of the National CLAS Standards as described in UMCM Chapter 16. The Cultural Competency plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, languages, communication needs, and religions, as well as those with disabilities, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The MCO must submit the Cultural Competency plan to HHSC for Readiness Review. During Readiness Review, the Cultural Competency plan will be assessed to determine the extent to which it aligns with the National CLAS Standards as described in UMCM Chapter 16.1. The Cultural Competency plan must detail how the MCO implements each component of the National CLAS Standards 2 through 15. By implementing Standards 2 through 15, MCOs are working toward CLAS Standard 1, the Principal Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (pp. 107–108, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

¹⁵⁰ 8.1.22.4. Perinatal Services. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services: . . . 7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services. (pp. 163–164, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

¹⁵¹ 8.1.34.4 Referral to Community Organizations The MCO must provide information about and referral to community organizations that may not be providing Covered Services, but are otherwise important to the health and wellbeing of Members. These organizations include, but are not limited to: 1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance use disorder, mental health, intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.); 2. Social service agencies (e.g., Area Agencies on Aging, residential support agencies, independent living centers, supported employment agencies, etc.); 3. City and county agencies (e.g., welfare departments, housing

programs, etc.); 4. Civic and religious organizations; 5. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.); and 6. Affordable housing programs (e.g., Section 811, local housing authorities, agencies that operate affordable housing, homeless service agencies). (P. 205, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & ConditionS)

¹⁵² 10.2.4 Cultural Competence Requirements (A) The Contractor shall have methods to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Enrollees have access to Covered Services that are delivered in a manner that meets their unique needs. (B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and Network Providers which respect Enrollees' cultural backgrounds. (C) The Contractor shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background and beliefs. (D) The Contractor shall strive to ensure its Network Providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to Network Providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services. (p. 106, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹⁵³ 1.3.25 High-Risk Prenatal Services (A) The Contractor shall ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility. (p. 10, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization) *See 1.3.25 for more information on high-risk prenatal services.*

¹⁵⁴ 4.13.4 Collaboration with Other Programs (C) The Contractor shall coordinate health care needs for Enrollees with Special Health Care Needs with the services of other entities such as mental health and substance use disorder providers, public health departments, transportation providers, home and community based service providers, developmental disabilities service providers, Title V, local schools, Individuals with Disabilities Education Act programs, and child welfare, and with families, caregivers, and advocates. (p. 47, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹⁵⁵ 7.16.A Outreach to Homeless Population The Contractor shall collaborate with the Department to develop referral and assistance policies and procedures that identify homeless members enrolled in the Contractor's managed care program and provide them with information on community services. (p. 127, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.6.B Health Risk Assessment Development The Contractor shall work with the Department to develop a standard Health Risk Assessment tool that all managed care plans will use. This assessment will assist case managers in identifying member physical and behavioral health status and risk factors along with their social, economic and housing needs. The HRA will be used to create a plan of service that will encompass member goals for their health outcomes, strengths and community resources. The goal of both the HRA and service plan shall be to develop member centered care strategies and ultimately aid in the improvement of member health outcomes and overall social and economic independence. The Contractor shall annually submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as housing referrals, etc.). (p. 229, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.8 SOCIAL DETERMINANTS OF HEALTH The Contractor shall collaborate with the Department to continually develop programs and/or establish partnerships to address social factors that affect health outcomes, also called social determinants of health (SDOH), which contribute significantly to the cost of care and the member's health care experience. The Contractor shall provide care coordination efforts that identify and address member access to employment, food security, housing stability, education, social cohesion or resources that support Member connection to social supports, health and health care, as well as environmental needs identified by the member. These social determinants are encompassed under five key areas: Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment. (p. 241, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹⁵⁶ 8.2.MM Transportation Services The Contractor shall cover emergency, urgent, and non-emergency medical transportation (NEMT) to ensure that members have necessary access to and from providers of covered medical services, per 42 CFR § 440.170(a) and 12 VAC 30-50-530 in a manner that seeks to ensure the member's health, safety, and welfare. (p. 203, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract) *See 8.2.MM for full details of transportation services benefit.*

¹⁵⁷ 7.14 CULTURAL COMPETENCY The Contractor must demonstrate cultural competency in its dealings, both written and verbal, with members and providers. Under 42 CFR § 438.206(c)(2), the Contractor must promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (p. 125, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹⁵⁸ 8.2 W 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 screenings for SUD for both high risk and non high risk mothers (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2 X d The Contractor shall have methods in place to monitor high-risk maternity programs and track members who are deemed by the Contractor as being "high-risk." The Contractor shall also continue to monitor, as deemed appropriate, the risk status of pregnant members not originally considered "high-risk" for potential enrollment in the Contractors high-risk maternity programs. The Contractor shall report monthly to the Department information outlined on the Managed Care Technical Manual on the status of both their high-risk maternity programs and services rendered for all other pregnant and postpartum women. (p. 192, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

159 7.16.B Services for Justice-Involved Members The Contractor shall collaborate with the Department to develop policies and procedures for the screening and provision of care for Medicaid members who have been identified as recently released from a correctional facility or local/regional jail. These policies and procedures should address the following: 1) assisting the member with accessing care and/or community supports as needed, 2) partnering with community resources to facilitate referral networks, and 3) developing reports that include methods for identifying and removing barriers to care and addressing additional needs expressed by the member. Plans, policies, and procedures will be submitted annually to DMAS for approval according to specifications in the MCTM. (p. 127, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹⁶⁰ 6.3 Service Delivery Network In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following (42 C.F.R. § 438.206(b)): 6.3.10 With respect to a behavioral health network, the anticipated needs of special populations including, but not limited to: 6.3.10.13 Individuals in permanent supported housing or other types of community housing (p. 132, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

11.1.25 The Contractor shall establish protocols to perform concurrent review which identify and actively refer Enrollees needing discharge planning who require assistance in transitioning from inpatient care, or administrative days to the next lower level of care, including home. Protocols must address response to discharge planning requests for Enrollee care in which UM review is not applicable, such as observation level of care or non-skilled nursing facility care. Protocols shall address the following: 11.1.25.1 Treatment availability and community supports necessary for recovery including, but not limited to: housing, financial support, medical care, transportation, employment and/or educational concerns, and social supports. (p. 212, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.21.2.2.8 Assist the Enrollee to access the following services: 14.21.2.2.8.3 Housing and employment assistance (p. 288, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁶¹ 5.21.3.6 In addition to the services required in the Transitional Services section of this Contract, the Contractor shall: 5.21.3.6.3 Educate the Enrollee about the importance of attending the follow-up appointment, and provide assistance to the Enrollee in getting to the appointment, including helping with transportation arrangements. (p. 108, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.11 Coordination Between the Contractor and External Entities 14.11.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to: 14.11.1.20 Non-Emergency Medicaid Transportation services (p. 271, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.17.5.2 Warm Hand-off: When an Enrollee completes or is discharged from an Inpatient Behavioral Health Agency, the subcontracting agency will have policies and practices in place to: 14.17.5.2.1 Provide scheduled immediate appointments with community health care providers, to include, but not be limited to the following: 14.17.5.2.1.5 Transportation- Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing. (p. 284, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁶² 3.3 Equal Access for Enrollees and Potential Enrollees with Communication Barriers The Contractor shall assure equal access for all Enrollees and Potential Enrollees when oral or written language communications creates a barrier to such access. (42 C.F.R. § 438.10 and 45 C.F.R. § 92.8). 3.3.1 Oral Information 3.3.1.1 The Contractor shall ensure interpreter services are provided free of charge for Enrollees and Potential Enrollees with a primary language other than English or those who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. § 438.10(d)(4)). (p. 79, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

3.3.2 Written Information 3.3.2.1 The Contractor shall provide all generally available and Enrolleespecific written materials through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and Potential Enrollees (42 C.F.R. § 438.10(d)(1) and 438.10(d)(6)(iii)). For the purposes of this subsection, the Enrollee's preferred language may not be the same as their primary language. The Contractor must translate materials into the Enrollee's preferred language. (p. 79, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

10.2.3.2 the contractor shall Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (CLAS Standard 5) (p. 202, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.17.2.1.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals. (p. 280, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁶³ 14.11.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, ...Juvenile Justice and Rehabilitation Administration (JJ&RA)... Criminal Justice Systems, Children's Long-term Inpatient facilities, Department of Children, Youth and Families: Early childhood and family support services including home visiting, ESIT, ECLIPSE, ECEAP/Head Start (courts, jails, law enforcement, public defenders); (p. 269, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁶⁴ 1. Care Management Elements... 3) Drivers of Health Screening and Referral a. HMOs shall include drivers of health in their screening process for adult members. HMOs are required to develop a screening plan to include written policy and procedure and screening questions to capture the following categories of drivers of health: housing... (p. 48, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

1. Care Management Model Characteristics c. Social Determinants Approach to Care: Addressing member social determinants is a critical consideration for SSI members. While the HMO is not required to provide "wrap around" social services, the HMO must establish partnerships and maintain effective working relationships with key social service and community-based agencies to ensure the social determinants of health (e.g., housing...) (p. 50, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁶⁵Non-Emergency Medical Transportation (NEMT) (BadgerCare Plus and Medicaid SSI) Most non-emergency Medical Transportation (NEMT) is coordinated by the Department of Health Services' NEMT manager. The NEMT manager arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include public transportation such as a city bus, non-emergency ground ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical transportation needs, as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and Medicaid SSI covered services. Non-emergency medical transportation also includes coverage of meals and lodging in accordance with the ForwardHealth policy. Members needing non-emergency medical transportation services should be directed to the DHS NEMT manager. Members may visit the Wisconsin Medicaid and BadgerCare Plus Non-emergency Medical Transportation webpage for more information. (p. 69, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁶⁶ d. Comprehensive Care Plan... 4) Care Plan Characteristics... The Comprehensive Care plan must have the following characteristics:... b) Incorporate health literacy and cultural competency attributes based on the individual member needs. (p. 57, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

e. HMO Responsibilities... 3) OB Medical Home Sites... h. Demonstrate cultural competency among provider and officer staff. (p. 101, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁶⁷ D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women The OB Medical Home for high-risk pregnant women is a care delivery model that is patientcentered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services. (p. 95, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

See OB MH initiative for more details.

¹⁶⁸ HMO should Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin Per Art. III, section C, the HMO must have a system in place to coordinate the services it provides to member with services a member receives through community and social support providers. (p. 187, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁶⁹ 3.11.1.1 Assessment of SDoH Needs The MCO shall screen enrollees for Social Determinants of Health (SDoH) risk factors and properly refer enrollees to community-based resources based on assessed need. Enrollees must be screened during the initial health risk assessment and then annually to reassess SDoH needs past initial enrollment. Care coordination and care management assessments and reassessments must also address SDoH and any needs shall be documented in care plans. The SDoH screening and referral process shall include, but not be limited to aspects such as enrollee housing and utilities status, food insecurity, transportation availability, and employment status. (p. 116, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹⁷⁰ The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed in Contract Appendix A and assume financial responsibility for the provision of these services. The MCO is responsible for determining whether services are Medically Necessary and whether the MCO will require prior approval for services. Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on-call, licensed practical nurses, and registered nurses. The MCO is also responsible for providing emergency transportation as outlined in Article III, Section 1.2.2 and in Appendix A. (p. 53, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

1.3.1 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. (p. 63, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹⁷¹ 2.1.2.3 Provider Cultural Competency Requirements In accordance with 42 CFR §438.206(c), the MCO must ensure that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. The MCO must also ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (p. 68, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹⁷² 4. MEDICAID ADMINISTRATOR/CONTRACT LIAISON FUNCTIONS The MCO must employ a West Virginia Medicaid Administrator/Contract Liaison. The MCO's Medicaid Administrator(s) may also fulfill the duties of the Contract liaison, as outlined in Article II, Section 5.9 of the Contract. The Medicaid Administrator(s) must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered. The Administrator(s) will: 1. Investigate and resolve access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations and beneficiaries; 2. Monitor MCO grievances with the grievance personnel to look at trends or major areas of concern and discuss these reports with community advocates, if requested; 3. Coordinate with schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees (p. 117, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

Table 4. Obligations related to access, networks, performance, payment and member rights

This table allows readers to view the extent to which any single state addresses any one of the major domains of managed care and maternity care services within its state purchasing agreements, as well as the actual language used by the state in addressing any maternity care domain.*

Accessibility of Care

State	Perinatal-specific travel time and distance	Perinatal-specific appointment wait times	Special access rules or network composition requirements for perinatal persons with high medical or social risk	Telehealth rules related to prenatal care and postpartum visits
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N
AZ	Y ¹	Y ²	N	N
CA	N	N	N	N
CO	Y ³	N	N	N
DC	Y ⁴	Y ⁵	N	N
DE	Y ⁶	Y ⁷	N	N
FL	Y ⁸	N	N	N
GA	Y ⁹	Y ¹⁰	Y ¹¹	N
HI	Y ¹²	N	Y ¹³	N
IA	Y ¹⁴	Y ¹⁵	N	N
IL	Y ¹⁶	Y ¹⁷	Y ¹⁸	N
IN	N	N	N	N
KS	N	N	Y ¹⁹	N
KY	N	N	N	N
LA	N	Y ²⁰	Y ²¹	N
MA	Y ²²	N	N	N
MD	Y ²³	Y ²⁴	Y ²⁵	N
MI	N	N	N	N
MN	N	N	N	Y ²⁶
MO	Y ²⁷	Y ²⁸	Y ²⁹	N

* Note: All language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of July 2022, unless otherwise noted.

State	Perinatal-specific travel time and distance	Perinatal-specific appointment wait times	Special access rules or network composition requirements for perinatal persons with high medical or social risk	Telehealth rules related to prenatal care and postpartum visits
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N
MS	Y ³⁰	N	N	N
ND	N	Y ³¹	N	N
NE	N	N	N	N
NH	Y ³²	N	Y ³³	N
NJ	Y ³⁴	Y ³⁵	N	N
NM	N	N	N	N
NV	Y ³⁶	Y ³⁷	N	N
NY	N	N	Y ³⁸	N
OH	N	N	N	N
OR	N	N	N	N
PA	Y ³⁹	Y ⁴⁰	Y ⁴¹	Y ⁴²
RI	Y ⁴³	N	N	N
SC	N	N	N	N
TN	N	N	N	N
TX	N	Y ⁴⁴	Y ⁴⁵	N
UT	Y ⁴⁶	N	N	N
VA	Y ⁴⁷	Y ⁴⁸	N	N
WA	Y ⁴⁹	N	N	N
WI	Y ⁵⁰	Y ⁵¹	N	Y ⁵²
WV	Y ⁵³	N	Y ⁵⁴	N
Total	Y= 23 N= 16	Y= 16 N= 23	Y= 12 N= 27	Y= 3 N= 36

Network Composition, Competencies, and Payment Reform

State	Perinatal payment reform initiatives	Inclusion of free-standing birth centers in provider network
	Incl. in contract [†]	Incl. in contract
	Y/N	Y/N
AZ	Y ⁵⁵	N
CA	N	Y ⁵⁶
CO	N	N
DC	N	N
DE	Y ⁵⁷	N
FL	Y ⁵⁸	Y ⁵⁹
GA	Y ⁶⁰	N
HI	N	N
IA	N	N
IL	N	N
IN	Y ⁶¹	N
KS	Y ⁶²	Y ⁶³
KY	Y ⁶⁴	Y ⁶⁵
LA	Y ⁶⁶	N
MA	N	N
MD	N	N
MI	N	N
MN	Y ⁶⁷	Y ⁶⁸
MO	N	Y ⁶⁹
MS	Y ⁷⁰	N
ND	N	N

[†] This includes bundled payments (e.g., what is in bundle, what period of care covered, who are providers), value-based payments (e.g., linked to performance measures), and in-lieu-of and value-added services (i.e., covered under the contract and unrelated to the contract).

State	Perinatal payment reform initiatives	Inclusion of free-standing birth centers in provider network
	Incl. in contract [†]	Incl. in contract
	Y/N	Y/N
NE	Y ⁷¹	Y ⁷²
NH	Y ⁷³	Y ⁷⁴
NJ	Y ⁷⁵	N
NM	N	N
NV	Y ⁷⁶	Y ⁷⁷
NY	N	N
OH	Y ⁷⁸	Y ⁷⁹
OR	Y ⁸⁰	N
PA	Y ⁸¹	N
RI	N	N
SC	N	N
TN	N	N
TX	N	N
UT	N	Y ⁸²
VA	Y ⁸³	N
WA	N	Y ⁸⁴
WI	N	N
WV	N	Y ⁸⁵
Total	Y= 18 N= 21	Y= 13 N= 26

State	Midwifery services	Doula Services	Community health worker services	Maternal-fetal medicine services
	Incl. in contract [‡]	Incl. in contract [§]	Incl. in contract ^{**}	Incl. in contract ^{††}
	Y/N	Y/N	Y/N	Y/N
AZ	Y ⁸⁶	N	N	N
CA	Y ⁸⁷	N	N	N
CO	Y ⁸⁸	N	N	N
DC	Y ⁸⁹	N	N	N
DE	Y ⁹⁰	N	Y ⁹¹	N
FL	Y ⁹²	Y ⁹³	N	N
GA	Y ⁹⁴	N	Y ⁹⁵	N
HI	Y ⁹⁶	N	Y ⁹⁷	Y ⁹⁸
IA	Y ⁹⁹	N	N	N
IL	N	N	N	Y ¹⁰⁰
IN	N	N	N	N
KS	Y ¹⁰¹	N	N	N
KY	Y ¹⁰²	N	N	Y ¹⁰³
LA	Y ¹⁰⁴	N	N	Y ¹⁰⁵
MA	Y ¹⁰⁶	N	N	N
MD	Y ¹⁰⁷	Y ¹⁰⁸	N	N
MI	Y ¹⁰⁹	N	Y ¹¹⁰	N
MN	Y ¹¹¹	Y ¹¹²	Y ¹¹³	N
MO	Y ¹¹⁴	N	N	N
MS	Y ¹¹⁵	N	N	N
ND	N	N	N	N
NE	Y ¹¹⁶	N	N	N
NH	Y ¹¹⁷	N	N	Y ¹¹⁸
NJ	Y ¹¹⁹	Y ¹²⁰	N	Y ¹²¹

[‡] This includes requirements for inclusion in networks and other practice-related provisions.

[§] This includes requirements for inclusion in networks and other practice-related provisions.

^{**} This includes requirements for inclusion in networks and other practice-related provisions.

^{††} This includes requirements for inclusion in networks and other practice-related provisions (e.g., referral without UM).

State	Midwifery services	Doula Services	Community health worker services	Maternal-fetal medicine services
	Incl. in contract [‡]	Incl. in contract [§]	Incl. in contract ^{**}	Incl. in contract ^{††}
	Y/N	Y/N	Y/N	Y/N
NM	Y ¹²²	N	Y ¹²³	N
NV	Y ¹²⁴	Y ¹²⁵	Y ¹²⁶	N
NY	Y ¹²⁷	N	N	N
OH	Y ¹²⁸	N	Y ¹²⁹	N
OR	N	Y ¹³⁰	Y ¹³¹	N
PA	Y ¹³²	Y ¹³³	Y ¹³⁴	N
RI	Y ¹³⁵	Y ¹³⁶	N	N
SC	Y ¹³⁷	N	N	N
TN	Y ¹³⁸	N	N	N
TX	Y ¹³⁹	N	N	N
UT	Y ¹⁴⁰	N	N	N
VA	Y ¹⁴¹	Y ¹⁴²	N	N
WA	Y ¹⁴³	N	Y ¹⁴⁴	N
WI	Y ¹⁴⁵	N	Y ¹⁴⁶	Y ¹⁴⁷
WV	Y ¹⁴⁸	N	N	N
Total	Y= 35 N= 4	Y= 9 N= 30	Y= 12 N= 27	Y= 7 N= 32

Quality improvement/performance measurement

State	Required MCO reporting or state EQR reporting of perinatal performance measures (via the CMS Core Set or HEDIS measures)	Required reporting of perinatal performance measures by stewards other than CMS and NCQA	Linkage to perinatal quality collaboratives	Use of maternal health safety bundles (in-hospital or community)	Quality ratings or auto-enrollment tied to perinatal-related performance	Performance improvement activities/plans related to perinatal care
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
AZ	Y ¹⁴⁹	N	N	N	N	Y ¹⁵⁰
CA	Y ¹⁵¹	N	N	N	N	Y ¹⁵²
CO	Y ¹⁵³	N	N	N	N	N
DC	Y ¹⁵⁴	N	N	N	N	Y ¹⁵⁵
DE	Y ¹⁵⁶	N	N	N	N	N
FL	Y ¹⁵⁷	N	N	N	N	N
GA	Y ¹⁵⁸	N	N	N	N	Y ¹⁵⁹
HI	Y ¹⁶⁰	N	N	N	N	N
IA	Y ¹⁶¹	N	N	N	N	Y ¹⁶²
IL	Y ¹⁶³	N	N	N	N	Y ¹⁶⁴
IN	Y ¹⁶⁵	N	N	N	N	Y
KS	N	N	N	N	N	Y ¹⁶⁶
KY	N	Y ¹⁶⁷	N	N	N	N
LA	Y ¹⁶⁸	Y ¹⁶⁹	N	N	N	N
MA	N	N	N	N	N	N
MD	Y ¹⁷⁰	N	N	N	N	N
MI	Y ¹⁷¹	Y ¹⁷²	N	N	N	Y ¹⁷³
MN	Y ¹⁷⁴	N	N	N	N	Y ¹⁷⁵
MO	Y ¹⁷⁶	N	N	N	N	N
MS	Y ¹⁷⁷	Y ¹⁷⁸	N	N	N	Y ¹⁷⁹
ND	N	N	N	N	N	N
NE	Y ¹⁸⁰	N	N	N	N	N
NH	Y ¹⁸¹	N	N	N	N	N
NJ	Y ¹⁸²	N	N	N	N	N
NM	Y ¹⁸³	N	N	N	N	Y ¹⁸⁴

State	Required MCO reporting or state EQR reporting of perinatal performance measures (via the CMS Core Set or HEDIS measures)	Required reporting of perinatal performance measures by stewards other than CMS and NCQA	Linkage to perinatal quality collaboratives	Use of maternal health safety bundles (in-hospital or community)	Quality ratings or auto-enrollment tied to perinatal-related performance	Performance improvement activities/plans related to perinatal care
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
NV	Y ¹⁸⁵	N	Y ¹⁸⁶	N	N	Y ¹⁸⁷
NY	Y ¹⁸⁸	N	N	N	N	N
OH	Y ¹⁸⁹	N	Y ¹⁹⁰	N	N	N
OR	N	N	N	N	N	Y ¹⁹¹
PA	Y ¹⁹²	Y ¹⁹³	N	N	N	N
RI	Y ¹⁹⁴	N	N	N	N	Y ¹⁹⁵
SC	Y ¹⁹⁶	N	N	N	N	N
TN	Y ¹⁹⁷	N	N	N	N	N
TX	N	N	N	N	N	Y ¹⁹⁸
UT	Y ¹⁹⁹	N	N	N	N	N
VA	Y ²⁰⁰	Y ²⁰¹	N	N	N	Y ²⁰²
WA	Y ²⁰³	Y ²⁰⁴	N	N	N	Y ²⁰⁵
WI	Y ²⁰⁶	N	N	N	N	Y ²⁰⁷
WV	Y ²⁰⁸	N	N	N	N	N
Total	Y= 33 N= 8	Y= 7 N= 30	Y= 2 N= 37	Y= 0 N= 39	Y= 0 N= 39	Y= 19 N= 20

Member Rights

State	Right to select participating provider	Ability to obtain care from an out-of-network provider under certain conditions ^{##}	Special protections for members who began care prior to enrollment with an out-of-network provider	Special plan safeguards to protect against coverage interruptions during the perinatal period ²⁰⁹
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N
AZ	Y ²¹⁰	Y ²¹¹	Y ²¹²	Y ²¹³
CA	Y ²¹⁴	Y ²¹⁵	Y ²¹⁶	N
CO	Y ²¹⁷	Y ²¹⁸	Y ²¹⁹	N
DC	Y ²²⁰	Y ²²¹	N	N
DE	Y ²²²	N	Y ²²³	Y ²²⁴
FL	Y ²²⁵	N	Y ²²⁶	Y ²²⁷
GA	Y ²²⁸	Y ²²⁹	N	Y ²³⁰
HI	Y ²³¹	Y ²³²	Y ²³³	Y ²³⁴
IA	Y ²³⁵	Y ²³⁶	Y ²³⁷	Y ²³⁸
IL	Y ²³⁹	Y ²⁴⁰	Y ²⁴¹	Y ²⁴²
IN	Y	Y ²⁴³	Y ²⁴⁴	N
KS	Y ²⁴⁵	Y ²⁴⁶	Y ²⁴⁷	Y ²⁴⁸
KY	Y ²⁴⁹	Y ²⁵⁰	Y ²⁵¹	N
LA	Y ²⁵²	Y ²⁵³	Y ²⁵⁴	Y ²⁵⁵
MA	Y ²⁵⁶	Y ²⁵⁷	Y ²⁵⁸	Y ²⁵⁹
MD	Y ²⁶⁰	Y ²⁶¹	N	N
MI	Y ²⁶²	Y ²⁶³	Y ²⁶⁴	Y ²⁶⁵
MN	Y ²⁶⁶	Y ²⁶⁷	Y ²⁶⁸	Y ²⁶⁹
MO	Y ²⁷⁰	Y ²⁷¹	Y ²⁷²	Y ²⁷³
MS	Y ²⁷⁴	Y ²⁷⁵	N	Y ²⁷⁶
ND	Y ²⁷⁷	Y ²⁷⁸	Y ²⁷⁹	N
NE	Y ²⁸⁰	N	N	N

^{##} See “Family Planning” column in Table 1, in part, for out-of-network language pertaining to family planning services.

State	Right to select participating provider	Ability to obtain care from an out-of-network provider under certain conditions ^{##}	Special protections for members who began care prior to enrollment with an out-of-network provider	Special plan safeguards to protect against coverage interruptions during the perinatal period ²⁰⁹
	Incl. in contract	Incl. in contract	Incl. in contract	Incl. in contract
	Y/N	Y/N	Y/N	Y/N
NH	Y ²⁸¹	Y ²⁸²	Y ²⁸³	Y ²⁸⁴
NJ	Y ²⁸⁵	Y ²⁸⁶	Y ²⁸⁷	N
NM	Y ²⁸⁸	Y ²⁸⁹	Y ²⁹⁰	Y ²⁹¹
NV	Y ²⁹²	Y ²⁹³	Y ²⁹⁴	Y ²⁹⁵
NY	Y ²⁹⁶	Y	Y	N
OH	Y	Y ²⁹⁷	Y ²⁹⁸	Y ²⁹⁹
OR	Y ³⁰⁰	Y ³⁰¹	N	N
PA	Y ³⁰²	Y ³⁰³	Y ³⁰⁴	Y ³⁰⁵
RI	Y ³⁰⁶	Y ³⁰⁷	Y ³⁰⁸	N
SC	Y	Y ³⁰⁹	Y ³¹⁰	Y ³¹¹
TN	Y	Y ³¹²	N	N
TX	Y	Y ³¹³	Y ³¹⁴	Y ³¹⁵
UT	Y	N	N	N
VA	Y	Y ³¹⁶	Y ³¹⁷	Y ³¹⁸
WA	Y	Y ³¹⁹	N	N
WI	Y ³²⁰	Y ³²¹	N	N
WV	Y	Y ³²²	N	N
Total	Y= 39 N= 0	Y= 35 N= 4	Y= 28 N= 11	Y= 22 N= 17

¹ Network Development and Management Plan: The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 457.1230(b), 42 CFR 438.207(b)(1)-(2)]. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The NDMP must include the requirements specified in ACOM Policy 415. The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances,

appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible [42 CFR 438.604(a)(5), 42 CFR 438.606, 42 CFR 438.207(b)-(c), 42 CFR 438.206].

The Contractor shall maintain a sufficient network in accordance with the requirements specified in ACOM Policy 436, 42 CFR 457.1218, 42 CFR 438.68, 42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c). In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area [42 CFR 457.1218, 42 CFR 438.68]. AHCCCS may impose Administrative Actions for material deficiencies in the Contractor's provider network. (pp. 165-166, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

III. POLICY... B. STATEWIDE TIME AND DISTANCE NETWORK CALCULATION DEFINITIONS AND STANDARDS For each county in the Contractor's assigned service area, the Contractor shall have a network in place to meet time and distance standards specified below. If the Contractor delegates network activities, it shall ensure subcontractor compliance with applicable network standards. For the purposes of this policy, the Contractors shall use its network of the following provider types and specialties to calculate compliance with this policy's time and distance standards: PROVIDER CATEGORY: OBSTETRICIAN/GYNECOLOGIST (OB/GYN); APPLIES TO: All; MEMBER POPULATION: 15 to 45 years old; COUNTY: Maricopa, Prima; STANDARD (90% of membership does not need to travel more than): 45 minutes or 30 miles from their residence; COUNTY: All Other; STANDARD (90% of membership does not need to travel more than): 90 minutes or 75 miles from their residence. (p. 5, 7, Effective October 1, 2022, [ACOM Policy 436, AHCCS Contractor Operations Manual Chapter 400 – Operations](#))

² 32. APPOINTMENT STANDARDS The Contractor shall actively monitor and track provider compliance with appointment availability standards as required in ACOM Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that providers offer a range of appointment availability, per appointment timeliness standards, for intakes, initial services, and ongoing services based upon the clinical need of the member. The exclusive use of same-day only appointment scheduling and/or open access is prohibited within the Contractor's network. The Contractor is required to conduct regular reviews of the availability of providers and report this information as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 174, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

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

³ 9.3. Access to Care Standards... 9.3.8. The Contractor shall ensure that its network complies with the time and distance standards... Required Providers: 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. (p. 64, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

⁴ C.5.29.2 Network Composition C.5.29.2.1 The Contractor shall ensure that its Provider Network is sufficient in number, geographic distribution, and type of Providers to ensure that all Covered Services, including an appropriate range of preventive, primary care, and specialty services, are accessible to meet the needs of the anticipated number of Enrollees within 90 days of the Start Date. C.5.29.2.1.2 The Contractor shall meet relevant District network adequacy standards, in accordance with 42 C.F.R. § 438.68, in all geographic areas in which the Contractor operates, as well as, adhere to the time and distance standards developed by the District for the following Provider types:... C.5.29.2.1.2.3 OB/GYN Providers (p. 111, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

⁵ C.5.29.18 Appointment Time Standards for Services... C.5.29.18.9 The Contractor shall ensure that initial appointments for pregnant women or Enrollees desiring family planning services are provided within ten (10) calendar days of the Enrollee's request. (p. 125, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

⁶ 3.9.17.2 Time and Distance Requirements 3.9.17.2.1 The Contractor shall contract with sufficient providers to enable members to receive Covered Services from the following providers within 30 miles or 45 minutes from the member's primary residence for the following services:... 3.9.17.2.1.7 Obstetrics and gynecology. (p. 200, Effective 2020, Addendum 1, MCO MSA, Delaware)

⁷ 3.9.17.3.9 Maternity Care 3.9.17.3.9.1 For maternity care, the Contractor shall provide prenatal care appointments for pregnant members as specified in the QMS, including: 3.9.17.3.9.1.1 First trimester within three weeks of member request. 3.9.17.3.9.1.2 Second trimester within seven calendar days of member request. 3.9.17.3.9.1.3 Third trimester within three calendar days of member request. 3.9.17.3.9.1.4 High-risk pregnancies within three calendar days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists. (p. 202, Effective 2020, Addendum 1, MCO MSA, Delaware)

⁸ Section VIII. Provider Services A. Network Adequacy Standards... Table 4. Managed Medical Assistance Provider Network Standards Table Required Providers: Obstetrics/Gynecology; Urban County: Maximum Time (min) - 50, Maximum Distance (miles) - 35; Rural County: Maximum Time (min) - 75, Maximum Distance (miles) - 60; Regional Provider Ratios: 1:1, 500 enrollees (p. 47, Updated February 2022, AHCA Contract No. FPOXX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

⁹ 4.8.17 Geographic Access Requirements 4.8.17.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the following geographic access standards for all Members as outlined in Figure 1. The Contractor shall utilize the most recent Geo Access program versions available and update periodically as appropriate. The Contractor shall use GeoCoder software along with the Geo Access application package.

Figure 1. Geographic Access Standards by Provider Type... Provider Type: 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 (pp. 112-114, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

¹⁰ 4.8.19 Waiting Maximums and Appointment Requirements... 4.8.19.2 The Contractor shall have in its network the capacity to ensure that waiting times for appointments do not exceed those outlined in Figure 2.

Figure 2. Waiting Times by Provider Type Provider Type: Maternity Care; Waiting Time: First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not to exceed seven (7) Third Trimester – Not to exceed three (3) Business Days (p. 116, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

¹¹ 4.6.9 Perinatal Services 4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members... The Contractor shall have in place a system that provides, at a minimum, the following services:... 4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care; 4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and 4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems... (p. 93, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

¹² Table 6: 8.1.D: Geographic Driving Time Provider Type: OB/GYN; Honolulu Metropolitan Statistical Area (MSA): 30 minute driving time; Rural: 60 minute driving time (p. 329, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

¹³ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services:... 2) Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary; 3) Availability and accessibility of: a) Appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating women with complex perinatal diagnoses; and b) Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses. (p. 157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

¹⁴ Exhibit B General Access Standards... 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. The Contractor shall also have a system to refer members to, and pay for, non-network providers when medically necessary. The Contractor shall also pay for non-network providers when a member has medical needs that would be adversely affected by a change in service providers. All non-network providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At 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.... (pp. 211-212, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

¹⁵ Exhibit B General Access Standards... 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. The Contractor shall also have a system to refer members to, and pay for, non-network providers when medically necessary. The Contractor shall also pay for non-network providers when a member has medical needs that would be adversely affected by a change in service providers. All non-network providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At 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. (pp. 211-212, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

¹⁶ 5.8.1.1.3 OB/GYN access. Contractor shall ensure an Enrollee has access to at least two (2) OB/GYN Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) OB/GYN Provider within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence. (p. 81, Effective 2018, State of IL Model Contract)

¹⁷ 5.8.3. Appointments... Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to Persons who are not Enrollees. (p. 82, Effective 2018, State of IL Model Contract)

¹⁸ 5.14. Interdisciplinary Care Team. 5.14.1. Contractor shall support an ICT for all Enrollees stratified as high-risk (Level 3), Dual-Eligible Adult Enrollees, and Enrollees who receive Covered Services under an HCBS Waiver. The ICT will ensure the integration of the Enrollee's medical and Behavioral Health services, and, if appropriate, Service Package II services. Duties of the ICT are separate from utilization management duties. 5.14.2 Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and support one another in the oversight of each Enrollee's needs. 5.14.3. ICT functions shall include: 5.14.3.1 providing Care Management for Enrollees; assisting in the development,

implementation, and monitoring of IPoCs, including HCBS service plans where applicable; and, assisting in assuring integration of services and coordination of care across the spectrum of the healthcare system; 5.14.3.2 ensuring a primary Care Coordinator is responsible for coordination of all benefits and services the Enrollee may need (Care Coordinators will have prescribed caseload limits as set forth in section 5.17.2); 5.14.3.3 assigning a Care Coordinator who has the experience most appropriate to support the Enrollee; 5.14.3.4 using motivational interviewing techniques; 5.14.3.5 explaining alternative care options to the Enrollee; and 5.14.3.6 maintaining frequent contact with the Enrollee through various methods including face-to-face visits, e-mail, and telephone, as appropriate to the Enrollee's needs and risk level or upon the Enrollee's request. 5.15. Individualized Plans of Care and Service Plans. 5.15.1. Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as high-risk Level 3 (high risk) and Enrollees in a HCBS Waiver. The IPoC must be developed within ninety (90) days after enrollment. Contractor shall engage Enrollees in the development of the IPoC as much as possible. (p. 92, Effective 2018, State of IL Model Contract)

3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (pp. 311-312, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

¹⁹ Performance Guarantees. SUD Access to Care Standard: CONTRACTOR(S) must comply with the contract provisions regarding priority access to care for pregnant women. At minimum, pregnant women are to be placed in the urgent category. Members are assessed within 24 hours of initial contact and services delivered within 48 hours of initial contact. CONTRACTOR(S) must demonstrate performance at 100%. (Data source: KCPC.) Fine: \$10,000 for each non-compliant finding/pregnant woman not assigned at minimum to urgent category, not assessed within 24 hours of initial contact, or not delivered services within 48 hours of initial contact. Validation of metric will be completed by KDADS chart review prior to damages being assessed to the CONTRACTOR(S). (p. 9, no date, Attachment G, Liquidated Damages. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

²⁰ 7.2. Appointment Availability Access Standards... 7.2.1.7. Maternity Care Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy. •Within their first trimester within 14 days; •Within the second trimester within 7 days; •Within their third trimester within 3 days; •High risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists ((p. 115, Effective October_2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

²¹ 7.8.4.2.2. MCO must establish access to the following within their network of hospitals: Level III Obstetrical services... (p. 129, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

²² C. Availability. 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. When feasible, Enrollees shall have a choice of two Obstetrician/Gynecologists. The Contractor shall report to EOHHS annually in accordance with Appendix A, the following: 1) A specialist-to-Enrollee ratio report showing the number of each specialist by specialty type per the number of Enrollees; 2) As specified by EOHHS, a geographic access report for high volume specialty provider types based on utilization, demonstrating access by geography; and 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. c. For all other specialist providers, the Contractor must demonstrate to EOHHS that these specialist providers are available within 20 miles or 40 minutes travel time from the Enrollee's residence. (p. 203, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

²³ NETWORK ADEQUACY STANDARDS To comply with the requirements of 42 CFR 438.68, MDH is responsible for developing minimum time and distance standards for HealthChoice MCO provider networks. MDH developed these standards by adapting the Health Service Delivery (HSD) standards for Maryland Medicare Advantage plans and the current HealthChoice regional and distance network standards. For each provider type, MCOs must meet either the time or distance standard for each county in the MCO's service area. Prenatal Care Max Time Urban: 15 minutes, Max Distance Urban: 10 miles, Max Time Suburban: 30, Max Distance Suburban: 20, Max Time Rural: 90, Max Distance Rural: 75. (p. 70, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

²⁴ .08 Special Needs Populations — Pregnant and Postpartum Women. A. An MCO shall meet the standards set forth in this regulation for treating pregnant and postpartum women. B. An MCO shall ensure access to prenatal care for pregnant women and postpartum care for postpartum women by: (1) Scheduling an appointment for the first prenatal visit and seeing the woman within 10 days of request; (2) Scheduling an appointment for a postpartum woman and seeing the woman within 10 days of request; (3) Arranging for an adequate network of providers including obstetricians, gynecologists, perinatologists, neonatologists, anesthesiologists, and advanced practice nurses who are capable of addressing complex maternal and infant health issues; and (4) Linking a pregnant woman with a pediatric provider before delivery. C. An MCO shall ensure that prenatal providers: (1) Complete a prenatal risk assessment, using an instrument approved by the Department, at the first prenatal visit; and (2) Within 10 days of completing the prenatal risk assessment, forward this instrument to the local health department in the jurisdiction in which the pregnant enrollee lives. D. The Department may not include questions about a woman's HIV infection status on the prenatal risk assessment instrument. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

²⁵ .08 Special Needs Populations — Pregnant and Postpartum Women... E. An MCO shall refer pregnant and postpartum women with a substance use disorder to the behavioral health ASO for substance use treatment within 24 hours of request. (pp. 125-126, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

²⁶ 6.1.19.8 For this Contract, Home Health Services include: (1) Skilled Nursing visits provided by a Medicare certified Home Health Agency, up to the service limit described in Minnesota Statutes, §256B.0652, subd. 4, and §256B.0653, subd. 4, including telehomecare skilled nurse visits. A onetime perinatal visit does not require the face-to-face encounter described in section 6.1.19.1. (p. 102, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

²⁷ 2.5.2 Travel Distance: The health plan shall comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 as amended, and in Travel Distance Standards located on the MO HealthNet website at Bidder and Vendor Documents (<http://dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/>). For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure that members have access to those providers within thirty (30) miles, unless the health plan can demonstrate to the state agency that there is no such licensed provider within thirty (30) miles, in which case the health plan shall ensure members have access to those providers within sixty (60) miles. For those providers addressed under 20 CSR 4007.095 but not applicable to the MO HealthNet Managed Care Program, the health plan shall not be held accountable for the travel distance standards for those providers. (pp. 32-33, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

Provider Type: Obstetrics/Gynecology; Distance Standards: Urban County: 15; Basic County: 30; Rural County: 60 (MO Travel Distance Standards, Reviewed January 2016, available at <https://dss.mo.gov/business-processes/managed-care-2017/bidder-vendor-documents/2017-travel-distance-standards-20csr4007.pdf>)

²⁸ c. For maternity care, the health plan shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows: First trimester appointments must be available within seven (7) calendar days of first request. Second trimester appointments must be available within seven (7) calendar days of first request. Third trimester appointments must be available within

three (3) calendar days of first request. Appointments for high risk pregnancies must be available within three (3) calendar days of identification of high risk to the health plan or maternity care provider, or immediately if an emergency exists. (pp. 32-33, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

²⁹ 2.4.16 Tertiary Care: Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists. These services frequently require complex technological and support facilities. The health plan shall provide tertiary care services including trauma centers, burn centers, stroke centers, ST-Elevation Myocardial Infarction (STEMI) centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the regions covered by the contract. If the health plan does not have a full range of tertiary care services, the health plan shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers. (p. 32, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

³⁰OB/GYN [Urban] One (1) within thirty (30) minutes or thirty (30) miles [Rural] One within sixty (60) minutes or sixty (60) miles (pp. 92-93, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

³¹ 10.2.6 Waiting Time Benchmarks (A) MCO shall adopt benchmarks for waiting times as follows:... (3) Benchmarks for waiting times for maternity appointments: (a) Emergency Services - immediate (b) Initial prenatal care (first trimester) - within 28 calendar days of first request (c) Initial prenatal care (second trimester) - within seven (7) calendar days of first request (d) Initial prenatal care (third trimester) - within three (3) calendar days of first request (e) Initial high-risk pregnancy - within three (3) calendar days of identification of high-risk, or immediately if an emergency exists (p. 94, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

³² Geographic Access Standards... OB/GYN Providers One (1) within sixty (60) driving minutes or forty-five (45) driving miles (pp. 161-162, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

³³ 4.7.7 Access to Special Services 4.7.7.1 The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network. 4.7.7.2 The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable. 4.7.7.3 The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act] 4.7.7.4 The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available. The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable. (pp. 170-171, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

³⁴ D. Hospitals. The contractor shall include in its network at least one (1) licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in each county or in adjacent counties no greater than 15 miles or 30 minutes driving time, whichever is less, from 90 percent of Members within the county or in adjacent counties. (p. 111, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

³⁵ I. Prenatal Care. Enrollees shall be seen within the following timeframes: 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester (p. 29, Article 5, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

³⁶ Specialty Area Maximum Time and Distance Standards (Minutes/Miles) Primary Care (adult) 15/10 Pediatrics 15/10 Hospitals 45/30 Obstetrics/Gynecology 15/10 (p. 172, Nevada Attachment AA Anthem Blue Cross Blue Shield Contract, 2022).

³⁷ 7.6.3.9.4. Prenatal Care Appointments Initial prenatal care appointments must be provided for pregnant Members as follows: First trimester within seven (7) Calendar Days of the first request; Second trimester within seven (7) Calendar Days of the first request; Third trimester within three (3) Calendar Days of the first request; and High-risk pregnancies within three (3) Calendar Days of identification of high-risk by the Contractor or maternity care Provider, or immediately if an emergency exists. (pp. 181-182, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

³⁸ 21. PROVIDER NETWORK. 21.1. Network Requirements. a. The Contractor will establish and maintain a network of Participating Providers. 21.1.a.iii. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible (meeting time/distance standards) and being accessible for the disabled. For the HIV SNP Program, this includes the following requirements [Applicable to the HIV SNP Program only]: C. Maternal/Pediatric HIV Specialized Care Centers: Access availability for one hundred percent (100%) of HIV infected women enrollees with HIV infected and/or HIV-exposed children up to the age of 18 months. (pp. 21-1, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

³⁹ Exhibit AAA. PROVIDER NETWORK COMPOSITION/SERVICE ACCESS. 1. Network Composition . . . [T]he PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist: AAA.1.C. Specialists. AAA.1.C.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): . . . Obstetrics & Gynecology . . . 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): . . . Obstetrics & Gynecology (pp. AAA-2, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

⁴⁰ 2. Appointment Standards... e. Pregnant Women Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows: First trimester — within ten (10) Business Days of the Member being identified as being pregnant. Second trimester — within five (5) Business Days of the Member being identified as being pregnant. Third trimester — within four (4) Business Days of the Member being identified as being pregnant. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists. (pp. AAA-9 to AAA-10, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

⁴¹ S. Provider Network The PH-MCO must establish and maintain adequate Provider Networks to serve all of the eligible HealthChoices populations in each HealthChoices Zone covered by this Agreement. Provider Networks must include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, specialists, dentists, orthodontists, physicians, pharmacies, emergency transportation services, long-term care facilities, rehab facilities, home health agencies, certified hospice providers and DME suppliers in sufficient numbers to make available all services in a timely manner. Detailed requirements related to the composition of Provider Networks and members' access to services

from the providers in those networks are located in Exhibit AAA, Provider Network Composition/Service Access, as applicable. (p. 121, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

⁴² Exhibit B(7). MATERNITY CARE BUNDELED [sic] PAYMENT. 12. Quality measures that will be reported to DHS by PH-MCOs: This is the list of quality measures that PH-MCOs will report to the Department at the aggregate level for their Maternity Care Bundle population and non-Maternity Care Bundle population. The PH-MCO must track these quality measures for the Maternity Care Bundle population at the Practice level and report to the Department, as requested. c. Postpartum visit follow-up: The PH-MCO needs to provide the total number of postpartum visits completed between 7 and 84 days after delivery for their Maternity Care Bundle population and non-Maternity Care Bundle population. In addition, the PH-MCO must also include a breakout rate for the medical home visit and telehealth visits in the numerator. (pp. B(7)-5, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement).

⁴³ 2.09.02. Travel Time. The Contractor will develop, maintain and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State established provider-specific network adequacy standards. The Contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided in the table below. Members may, at their discretion, select a participating provider located farther from their home . . . OB/GYN specialty care . . . Forty-five (45) minutes or thirty (30) miles from the member's home. (pp. 115–16, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

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

⁴⁵ 8.1.22.4 Perinatal Services The MCO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M. The MCO must have a perinatal health care system in place that, at a minimum, provides the following services: . . . 4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary; 5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; 6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; (p. 163, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

⁴⁶ 5.1.2 Time and Distance Standards (A) The Contractor shall maintain provider network adequacy time and distance standards to ensure patient access. The standards will be different for Frontier, Rural and Urban areas of the State. Wasatch Front Urban, Rural and Frontier areas of Utah are listed in the following table... (B) The Contractor shall ensure that Enrollees have access to the following types of providers within the time and distance standards. Table 2 – Time and Distance Standards... Provider or facility type: OB/GYN; Urban Counties: 90% of members must have access within 10 miles or 15 minutes; Rural Counties: 90% of members must have access within 35 miles or 45 minutes; Frontier Counties: 90% of members must have access within 60 miles or 70 minutes (p. 56, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

⁴⁷ 4.7.B Member Travel Time and Distance Standards Member Travel Time and Distance Standards In accordance with 42 CFR 438.68(b)(1), the Contractor shall ensure that the travel time and distance standards described in this section are met. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The Contractor shall contract with a sufficient number of providers and facilities to ensure that at least 80 percent of its members within a county can access primary care within the time and distance standards described below. In addition, travel time and distance for all other providers in which the member travels to receive covered benefits shall not exceed the standards below for at least 75 percent of

its enrolled members. Member Time & Distance Standards: Standard: Urban – Other Providers including Specialists; Distance: 30 miles; Time: 45 minutes; Rural: Other Providers including Specialists; Distance: 60 miles; Time: 75 minutes (p. 78, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

8.2 X Prenatal Care Requirements: The Contractor shall ensure that the travel time and distance standards stated in Section 4.6 are met (p. 190, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

⁴⁸ 4.9 MATERNITY CARE APPOINTMENT STANDARDS For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant members as follows: First trimester Appointments shall be scheduled within seven (7) calendar days of request. Second trimester Appointments shall be scheduled within seven (7) calendar days of request. Third trimester Appointments shall be scheduled within three (3) business days of request. High Risk Pregnancies Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists. (p. 80, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

⁴⁹ 6.11 Provider Network – Distance and Drive Time Standards... 6.11.2 Distance Standards... 6.11.2.2 Obstetrics (including non-emergency birthing services) 6.11.2.2.1 Urban: 2 within 10 miles. 6.11.2.2.2 Non-urban: 1 within 25 miles. (p. 135, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

⁵⁰ 3. OB/GYN Network Adequacy Standards Counties: Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha Distance: The HMO must have an OB/GYN provider within 20 miles of any member residing in these counties. At least one OB/GYN provider must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member. Drive Time: An OB/GYN provider must be within a 30 minute drive time of any member residing in these counties. Counties Served: All other remaining counties. Distance: The HMO must have an OB/GYN provider within 30 miles of any member residing in all other counties. At least one OB/GYN provider must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member. Drive Time: An OB/GYN provider must be within a 60 minute drive time of any member residing in all other counties. (p. 119, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

⁵¹ 3. OB/GYN Network Adequacy Wait times for an appointment shall be no more than 30 days. High Risk Prenatal Care Services The HMO must provide medically necessary high risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific HMO provider, who is accepting new patients. (p. 119, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

⁵² Provide appropriate best practice medical care for high-risk pregnant women, which may include: ... 2. To the extent it is covered by ForwardHealth (such as through in person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. (p. 99, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

⁵³ Medical Provider Network Time and Travel Distance The MCO must contract with a sufficient number of active providers accepting new patients to meet the following standards for all adult and pediatric populations. For review purposes, medical providers are grouped into the following categories: PCP, OB/GYNs, frequently-used specialists, other specialists, and hospitals. The requirements for each specialty group are outlined below. Provider Category: OB/GYN; Provider Type: OB/GYN or certified nurse midwife; Adult standard: Two (2) providers within twenty-five (25) miles or thirty (30) minutes travel time (p. H-5, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

⁵⁴ See Appendix I: Provider Network Standards for details on required inclusion of certain network providers.

⁵⁵ Incentive Arrangements: This Contract provides for the following incentive arrangements between AHCCCS and the Contractor: 1. The Alternative Payment Model (APM) Initiative – Quality Measure Performance (QMP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for performance on select quality measures identified in [ACOM Policy 306](#). Payment is contingent on the Contractor meeting the minimum requirements of the percentage of payments that must be governed by APM strategies defined in [ACOM Policy 307](#). AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year and the computation of the quality measures. 2. The Alternative Payment Model (APM) Initiative – Performance Based Payments (PBP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at quality improvement, such as reducing costs, improving health outcomes, or improving access to care. In accordance with ACOM Policy 307, for those APM arrangements which result in performance-based payments to providers, AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year.

It is AHCCCS' intent beginning in CYE22, the Contractor shall align quality-based PBPs with the quality measures specified in ACOM Policy 306 to receive AHCCCS reimbursement.

It is AHCCCS' intent beginning CYE22, the Contractor shall allocate a specified percentage of planned PBP amounts to integrated practice providers and specialty behavioral health providers, as specified in ACOM Policy 307.

The Contractor shall not receive incentive payments in excess of 5% of the approved capitation payments attributable to the members or services covered by the incentive arrangements. These incentive arrangements: 1. Are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied, 2. Are not to be renewed automatically, 3. Are made available to both public and private contractors under the same terms of performance, 4. Do not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements, and 5. Are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at 42 CFR 438.340[42 CFR 438.6(b)(2)] (pp. 205-206, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

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

Differential Adjusted Payments: AHCCCS has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. Federal regulation mandates that these payments be prior-approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the Differential Adjusted Payments (DAPs). AHCCCS may amend the DAP components annually, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The Contractor will support the Rate Differential in accordance with 42 CFR 438.6(c)(1)(iii)(B). The DAPs effective October 1, 2020 require that the Contractor shall adjust payments for specific providers and provider types listed below, in addition to any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified providers. This DAP increase to rates should be included on all payments made to qualified providers (including sub-capitation and block payment arrangements). These DAP payments are specified in the Public Notices and Opportunities for Public Comment – Rates and Supplemental Payment... DAP rates apply to the following qualified providers:... 6. Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31)... AHCCCS will provide a reference file that will contain the qualified DAP providers, or a provider file for individual provider flags, for applicable DAP categories. In addition, AHCCCS will post listings of qualified providers by DAP category on the AHCCCS Fee-For-Service Fee Schedules - Differential Adjusted Payments - "Qualifying Provider" webpage on the AHCCCS website:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/qualifyingproviders.html> The Contractor shall utilize these files along with information specified in the DAP public notice on the AHCCCS website to increase the rates that the Contractor would otherwise pay by the appropriate percentage for contracted and non-contracted providers. For contracted providers, the DAP

category is reflected as an increase in the provider contracted rates. For noncontracted providers not reimbursed at a provider specific rate, the applicable AHCCCS MCO fee schedule (also supplied as a reference file extract) should be used as the default base rate to which the applicable increase or increase percentages should be applied for the qualified providers. For non-contracted providers reimbursed at a provider specific rate, the AHCCCS supplied rates are reflective of the % increase. (pp. 208-209, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

10. Physicians, Physician Assistants, and Registered Nurse Practitioners (Up to 3.5%) Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31) are eligible for DAP increases under the following criteria... c. Six-Week Postpartum Visits (1.0%) An obstetrician or gynecologist that meets the criteria for provision of six-week postpartum visits will qualify for a 1.0% DAP increase on all claims. A provider qualifies if they have delivered and discretely billed for six-week postpartum visit services for at least 25% of the members for whom it delivered in the CYE 2021 period. AHCCCS will review claims and encounters for the period of October 1, 2020 through September 30, 2021 to determine eligibility for the DAP in CYE 2023. Only approved and adjudicated AHCCCS claims and encounters as of April 1, 2022 will be utilized in determining providers that meet this criteria. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase. (p. 30, Revision posted August 1, 2022, [AHCCS Differential Adjusted Payment \(DAP\) Activity CYE 2023 Final Public Notice](#))

⁵⁶ 7. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) Services Contractor shall meet federal requirements for access to FQHC, RHC, and FBC services as a mandatory service and benefit, including those in 42 USC Section 1396 b(m). Contractor must include at least one (1) FQHC, one (1) RHC, and one (1) FBC in the Provider Network within Contractor's Service Area, to the extent that the FQHC, RHC and FBC Providers are licensed and recognized under State law and they are available within Contractor's Service Area. Contractor shall reimburse FQHCs, RHCs, and FBCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7. If FQHC, RHC, and FBC services are not available in the Provider Network, Contractor shall reimburse FQHCs, RHCs, and FBCs for services provided out-of-Network to Contractor's Members at a rate determined by DHCS. If FQHC, RHC, and FBC services are not available in Contractor's Provider Network, but are available within DHCS' time and distance standards for access to Primary Care for Contractor's Members in the Service Area, Contractor shall not be obligated to reimburse FQHCs, RHCs, or FBCs for services provided out-of-Network to Members (unless authorized by Contractor). (no pg #, Effective FY 17-18, Utilization Management, Exhibit A, Attachment 5, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

⁵⁷ 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/Masurement 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)... e. QPM Penalty: For each applicable QPM performance/measurement year, the Contractor will be assessed a financial penalty if Contractor does not achieve the performance levels specified in Section 3.g of this Appendix. i. For the CY 2019 QPM performance/measurement year, the penalty that can be assessed against the Contractor is a maximum of up to one percent (1.0%) of the Contractor's total net revenue received from the Department for all populations covered under this Agreement. If a penalty is applicable to the Contractor the Department may assess/collect the penalty either through a deduction in future payments to the Contractor or through a remittance paid by the Contractor to the Department. ii. To avoid a penalty, the Contractor must achieve at least a satisfactory performance level on each

QPM as specified in the Evaluating Performance Level section of this Appendix. . QPM Performance Weighting Factor: Each QPM will have a performance weighting factor as determined by the Department. This factor determines the proportion of the maximum penalty attributable to each QPM. The performance weighting factors for each QPM are shown below: i. For the CY 2019 performance/measurement year:... 6. QPM #6: A maximum of 1/5 of the total QPM penalty... ii. For the CY 2020 performance/measurement year:... 6. QPM #6: A maximum of 1/7 of the total QPM penalty... g. Satisfactory Performance Level: For purposes of evaluating the 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:... 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. 395-398, Effective 2020, Addendum 1, MCO MSA, Delaware)

⁵⁸ Section XIII. Sanctions... C. Performance Measure sanctions 1. The Agency may sanction the Managed Care Plan for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance. The Agency may impose monetary sanctions as described below in the event that the plan's performance is not consistent with the Agency's expected minimum standards, as specified in this subsection. 2. Performance measures shall be assigned a point value by the Agency that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to the HEDIS National Means and Percentiles for Medicaid Plans Table, Table 8 below. Individual performance measures will be grouped, and the scores averaged within each group. TABLE 8: HEDIS NATIONAL MEANS AND PERCENTILES FOR MEDICAID PLANS PM Ranking Score >= 90th percentile 6 75th – 89th percentile 5 60th – 74th percentile 4 50th – 59th percentile 3 25th-49th percentile 2 10th – 24th percentile 1 < 10th percentile 0 3. The Agency may require the Managed Care Plan to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance. 4. The Managed Care Plan may receive a monetary sanction of up to ten thousand dollars (\$10,000.00) for each performance measure group where the group score is below three (3). Performance measure groups are as follows:... d. Prenatal/Perinatal (1) Prenatal and Postpartum Care (includes two (2) measures) (p. 94, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

⁵⁹ C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1. Table 2A: Required MMA Services... (5) Birth Center and Licensed Midwife Services (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

⁶⁰ Attachment U – Value Based Purchasing Measures.... Performance Measures: Pregnancy-related Care: Prenatal and Postpartum Care – Postpartum Care (p. 1309, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

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

management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into the Portal within twelve (12) calendar days of receiving NOP data from the State's fiscal agent. (p. 144, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

2. Incentive Payment Potential. ... b. Additional Maternity Payments and Incentives. FSSA will reimburse Contractor \$60 for each Notification of Pregnancy (NOP) form completed and submitted to FSSA in accordance with the standards set forth by the State. This payment will be made on a monthly basis with capitation payments. The Contractor must distribute the entire \$60 payment to the physician that completed the NOP form on behalf of the pregnant member. For each NOP form completed and submitted to FSSA in accordance with the standards set forth by the State, FSSA shall deposit \$40 in a birth outcomes bonus pool. Contractors may be eligible to receive a bonus payment in the amount of some or all of the birth outcomes bonus pool funds based on its achievement of a high rate of ongoing prenatal care. The bonus payment will be calculated as set forth in Section B.4.c. NOP forms must be submitted in the form and manner set forth by FSSA. Reimbursement is limited to one NOP form per member, per pregnancy, regardless of whether the member receives pregnancy services through the HIP program. In order to qualify for reimbursement, the NOP form must meet standards set forth by FSSA. (p. 193, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

4. Performance Measures and Incentive Payment Structure. a. Incentive Payments, Withholds... vi. Timeliness of Ongoing Prenatal Care. Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within forty-two (42) days of enrollment in the organization. HEDIS measure (HEDIS PPC) using hybrid data. Amount of Performance Withhold at risk: 15% If Contractor's 2022 measurement year rate is at or above the 25th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred (100%) of the amount of the Performance Withhold at risk. v. Post-partum visits. Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty four (84) days after delivery. (Includes deliveries between Nov 6th of the year prior to the measurement year and Nov 5th of the measurement year.) HEDIS measure (HEDIS) PPC) using hybrid data. Amount of Performance Withhold at risk: 15% If Contractor's 2022 measurement year rate is at or above the 25th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. PPC) using hybrid data. vii. Prenatal Depression Screening and Follow-Up (PND-E). The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. HEDIS measure (PND-E) using hybrid data. Amount of Performance Withhold at risk: 5% If the Contractor timely and accurately reports this measure for the 2022 measurement year, in accordance with State expectations, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. (p. 196, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

⁶² Performance Guarantees. SUD Access to Care Standard: CONTRACTOR(S) must comply with the contract provisions regarding priority access to care for pregnant women. At minimum, pregnant women are to be placed in the urgent category. Members are assessed within 24 hours of initial contact and services delivered within 48 hours of initial contact. CONTRACTOR(S) must demonstrate performance at 100%. (Data source: KCPC.) Fine: \$10,000 for each non-compliant finding/pregnant woman not assigned at minimum to urgent category, not assessed within 24 hours of initial contact, or not delivered services within 48 hours of initial contact. Validation of metric will be completed by KDADS chart review prior to damages being assessed to the CONTRACTOR(S). (p. 9, no date, Attachment G, Liquidated Damages. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

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

⁶⁴ APPENDIX B. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE. 60. Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 32.5 "Maternity Care." Fine: \$500.00 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Contract. (p. 222, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁶⁵ 28.2 Network Providers to Be Contracted. The Contractor shall contract with providers who are willing to meet the terms and conditions for participation established by the Contractor, including, but not limited to the following provider types: ... C. Free standing birthing centers, primary care centers, local health departments, home health agencies, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and private duty nursing agencies. (p. 116, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

APPENDIX H. COVERED SERVICES. I. Contractor Covered Services. A. Alternative Birthing Center Services. (p. 264, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

⁶⁶ 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 ...6.13.1.3. Incentives for vaginal birth after cesarean (VBAC); ...6.13.1.4. Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery. ...6.13.1.5. Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and 6.13.1.6. Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age. (p. 81, Effective October 2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

⁶⁷ 4.13 Managed Care Withhold. The STATE shall withhold as follows: [Minnesota Statutes, §256B.69, subd. 5a] 4.13.1.1For PMAP the STATE shall withhold eight percent (8%) from the base rates. Of this total, 62.5% (5.0 /8.0 x 100) of the withheld funds (shown in section 4.13.5.2(1)) shall be returned only if, in the judgment of the STATE, performance targets in section 4.13.2 are achieved. 4.13.1.2For MinnesotaCare, eight percent (8%) of the MCO's payments will be withheld. Of this total, 62.5% (5.0/8.0 x 100) of the withheld funds (shown in section 4.13.6.2(1)) shall be returned only if, in the judgment of the STATE, performance targets in section 4.13.2 are achieved. 4.13.2 Withhold Return Scoring for the 2022 Contract Year. 4.13.2.1 The Performance-Based withheld funds will be returned to the MCO for the Contract Year based on the following performance targets and assigned points. All withhold return is contingent on improving each overall rate over the previous baseline.... (4) Prenatal and Postpartum Care, sixteen (16) points... 4.13.2.2 The percentage of the MCO's withheld funds to be returned shall be calculated by summing all earned points, dividing the sum by one hundred (100), and converting to a percentage. This percentage is referred to as the Withhold Score.

4.13.4 Administrative and Access/Clinical Performance Targets for PMAP and MinnesotaCare. Detailed descriptions of each withhold measure are provided in the most recent version of the STATE document titled "2022 Managed Care Withhold Technical Specifications." These specifications are posted on the DHS Partners and Providers, Managed Care Organizations web site at www.dhs.state.mn.us/dhs16_139763... 4.13.4.1Prenatal and Postpartum Care (1)MCO is required to achieve a five (5) percentage point improvement in its rate of women who receive prenatal and postpartum care. (2) Half of the total points will be awarded for the Timeliness of Prenatal Care sub-measure and the other half of the total points for the Postpartum Care sub-measure. (pp. 73-74, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁸ 6.1.35 Obstetrics and Gynecological Services. Such services include nurse-midwife services and prenatal care services as described below. MCO must comply with section 6.13.11, Direct Access to Obstetricians and Gynecologists... 6.1.35.4 Birth Centers. Services provided in a licensed birth center by a licensed health professional are covered if the service would otherwise be covered if provided in a hospital. [Minnesota Statutes §256B.0625, subd. 54] (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

⁶⁹ 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/>): a. Ambulatory surgical center, birthing center (p. 48, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

⁷⁰ III. Section 10, Quality Management, is amended to add the following: V. Quality Withhold Measurements and Targets. CCO MSCAN SFY 2023 Incentive/Withhold Targets. Quality Measure: Timeliness of Prenatal Care. Target: 84.92% (p. 4, Effective July 2017, Amendment #13, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

⁷¹ Attachment 14 Quality Performance Program Measure - Contract Year Five. Base Performance Requirement: Prenatal and Postpartum Care: Postpartum Care (PPC-AD): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. Payment Threshold: 74.36%. % of Payment Pool: 5%. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP. Payment Threshold: 87.59%. % of Payment Pool: 5%. (pp. 21-22, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁷² Covered Services and Benefits ...Free standing birth center services (pp. 122-123, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

⁷³ 4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters... 4.14.12.3 State Priorities in RSA 126-AA 4.14.12.3.1 [Amendment #5:1 The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:... 4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of MAS births; (p. 288, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

⁷⁴ Services MCO Covered... Freestanding Birth Centers (p. 81, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

⁷⁵ Performance payment pool - Criteria for earning the performance pool payments is achieving the benchmarks on the following five metrics: Pre-term birth rate: The percent of all singleton live births which are less than 37 weeks gestation, as recorded in the New Jersey Electronic Birth Certificate system (EBC), for members consecutively enrolled with the same Contractor for the 6 months prior to the birth. < 9.25% Pre-natal care timeliness: Score as reported by the Healthcare Effectiveness Data and Information Set (HEDIS see <https://www.ncqa.org/hedis/measures/>) ≥ NCQA 75th Percentile for HEDIS MY2020 Post-partum care timeliness: Score as reported by the HEDIS ≥ NCQA 75th Percentile for HEDIS MY2020 Each Eligible Contractor will receive a performance based incentive payment for each successfully attained benchmark. The payment will be equal to \$0.175 multiplied by the contractor's total member months for calendar year 2020. The member-month data source is the Department's Shared Data Warehouse report from the Monthly Eligibility Summary data universe with the following parameters illustrating the total member-month count for each participating Contractor: · Member-month dates between January 1, 2020 and December 31, 2020 · Run date = March 31, 2021 D. High Performance Bonus - Each eligible

Contractor who successfully meets three of the five benchmarks will qualify for incentive payments from the High Performance Bonus Pool. The \$3,000,000 high performance bonus pool will be divided equally amongst the qualifying Contractors. In the event that none of the participating Contractors qualify for the High Performance Bonus, no payments will be made. This amount will not be redistributed to participating Contractors in the current year or succeeding years. E. Data Sources and Timing - NCQA "Accreditation" and a 3.5 Star Rating for HEDIS/CAHPS must be received for HEDIS MY2020 scores (the scores that are based on the calendar year 2020 data which will be made available in June of 2021, and published through the NCQA in late summer/early fall of 2021. The performance payment pool and high performance incentives will be based on these same calendar year HEDIS MY2020 scores and the calendar year 2020 birth data. Star ratings are subject to change annually based on HEDIS/CAHPS performance. (pp. 10-11, Article 8, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

⁷⁶ 7.7.6. Value Based Purchasing 7.7.6.1. The Contractor must contract with Network Providers using alternative payment methodologies (APMs) as described in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Methodology framework, as appropriate and reasonable for the capacity of the Provider to participate in such APM arrangements. 7.7.6.2. The Contractor must focus its APM contracting strategies to support the Population Health goals and plan as provided in Section 7.5.2.9, in particular, the APM contracting strategies should focus on incentivizing Providers to address... improvements in maternal and child health outcomes...when appropriate. (pp. 199-200, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁷⁷ 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:... 7.4.2.1.16. Free Standing Birth Centers/Obstetric Centers; (p. 99, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada) 7.6.3.8.2. The Contractor is required to negotiate in good faith with all of the following Essential Community Providers who are located in the Contractor's geographic service area(s). Negotiating in good faith requires, at a minimum, offering Provider Contracts that are at least as beneficial to the Provider as contracts with other Providers in the same geographic area for similar services. Contracts with Providers who work through one of the Essential Community Providers must be negotiated in good faith.... Free Standing Birth Centers (FBCs)/Obstetric Centers; (pp 178-180, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

⁷⁸ 1. Quality Measures. For SFY 2020, SFY 2021, and SFY 2022 specific measures are designated for use in the Quality Based Assignment incentive program. For these measures, results will be used in determining the award of incentives for participating MCPs. For the measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty (see Appendix N)... Measures, Measurement Sets, Standards, and Measurement Years. The measures, accompanying Minimum Performance Standards, and measurement years for the SFY 2021, SFY 2022, and SFY 2023 contract periods are listed in Table 1 below. The measurement set associated with each measure is also provided. The measures used in the Quality Based Assignment Incentive Systems each year are denoted with a QBA in the respective Minimum Performance Standard columns. No standard will be established, or compliance assessed, for measures designated 'reporting only' for the corresponding year.

Table 1. SFY 2021, SFY 2022 and SFY 2023 Performance Measures, Measurements Sets, Standards, and Measurement Years. Measure: Prenatal and Postpartum Care – Timeliness of Prenatal Care; Prenatal and Postpartum Care – Postpartum Care; Percent of Live births Weighing Less Than 2,500 Grams (pp. 179-180, Appendix Q, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

⁷⁹ App'x G. 1. Basic Benefit Package. The MCP shall ensure members have timely access to all services outlined in OAC rule 5160-26-03 in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid and in accordance with 42 CFR 438.210, with limited exclusions, limitations, and clarifications (specified in this appendix), including emergency and post-stabilization services pursuant to 42 CFR 438.114. For information on Medicaid-covered services, the MCP shall refer to the Ohio

Department of Medicaid (ODM) website. Services covered by the MCP benefit package shall include: . . . m. Free-standing birth center services in free-standing birth centers as defined in OAC rule 5160-18-01. (pp. 89, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

⁸⁰ Exhibit H. 2. Expanding VBP beyond primary care to other care delivery areas. H.2.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 Healthcare. The term "expanded from an existing contract" includes, but is not limited to, an expansion of Contractor's existing contracts such that more Providers or Members, or both Members and Providers, are included in the arrangement, or higher level VBP components are included (or both more Members and Providers are included in the arrangements and higher level VBP components are included). Contractor will use the VBP Technical Guide for Coordinated Care Organizations for the care delivery area VBP specifications. b. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher throughout the Term of this Contract. Contractor shall implement care delivery area VBPs for a minimum of 12 months, according to the following schedule: (1) in 2020, Contractor shall develop three (3) new or expanded VBPs. The three (3) new or expanded VBPs shall be in... 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... (3) Commencing on January 1, 2022, Contractor shall implement a new VBP in one additional care delivery area in the remaining care delivery areas; (4) Commencing on January 1, 2023 Contractor shall implement one final new VBP in the remaining care delivery areas... (pp. 219-220, Effective October 2019, Exhibit H, Valued Base Payment, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health). *See Exhibit H for more details on the value base payment arrangement.*

⁸¹ 9. Value Based Purchasing... b. VBP Models:... Required Models: MCOs must participate in required VBP payment models as specified by the Department and work with the Department on the development of new models Required models include, but are not limited to: • Maternity Care Bundled Payment: The MCO . must pay Network Providers who elect to partake in the Maternity Care Bundled Payment as specified by the Department... c. Financial Goals... The PH-MCO must achieve the following percentages through VBP arrangements: Calendar year 2022 – 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 9.a.ii. through 9.a.v. In addition, the MCOs must incorporate CBOs into VBP arrangements with Network Providers to address SDOH as follows: 75% of the medical portion of the capitation and maternity care revenue expended in strategies 9.a.ii. through 9.a.v., must incorporate at least one CBO that addresses at least one SDOH domain. 25% of the medical portion of the capitation and maternity care revenue expended in strategies 9.a.ii. through 9.a.v., must incorporate one or more CBOs that together address 2 or more SDOH domains. (pp. 154-156, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Exhibit B(1). MCO PAY FOR PERFORMANCE. This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022 the Department has no payment obligation under this Exhibit. This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section II. below. I. Quality Performance Measures. For 2022, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing MY 2021 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are: HEDIS . . . 3. Prenatal Care in the First Trimester; 4. Postpartum Care. (pp. B(1)-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement).

⁸² 1.3.21 Other Outside Medical Services The Contractor, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, freestanding ambulatory surgical centers and birthing centers. (p. 8, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

⁸³ 9.18 PERFORMANCE WITHHOLD PROGRAM The Department introduced the Performance Withhold Program to reinforce VBP principles by setting performance standards and expectations for Contractors in key areas influencing member health and health outcomes. By tying financial incentives to Contractor performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members. This effort also aligns with the Virginia Medicaid focus areas by including measures pertaining to chronic conditions, prevention, and maternity care. 9.18. A PWP Assessment and Measures The PWP focuses on measures of Contractor performance in facilitating high quality care for Members under the Medallion 4.0 program. The table below entitled "Current Performance Withhold Program Measures" identified the measures relevant to the PWP. The scoring structure and processes will be made available in the Medallion Technical Manual and on the Department's website at <https://www.dmas.virginia.gov/#/valuebasedpurchasing>. The PWP withhold percentage is one percent (1%) of the Contractors' PMPM capitation rate system payments. Consistent with the methodology developed with the EQRO, the Department will determine the portion of the withhold each Contractor can earn back based on the extent to which the Contractor's performance compares favorably against benchmarks set for each measure. Current Performance Withhold Program Measures : Measure... 3. Prenatal and postpartum care (p. 251, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

9.19 VALUE-BASED PAYMENTS (VBP) Value Based Payment (VBP) includes a broad set of payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. The Contractor shall maintain a VBP strategy that follows the Alternate Payment Model (APM) framework in the White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on models in categories three (3) and four (4). The Contractor will assure annual improvement in the level of VBP penetration until such time that the contract has a minimum of 25 percent of its relevant spending for medical services governed under VBP arrangements. The Department will take this figure from the Contractors' annual HCP-LAN APM Data Collection Submissions referenced below. The Department may revisit VBP penetration targets, including potential targets for the adoption of more advanced VBP (i.e. HCP-LAN categories 3-4) in future years. 9.19.A Contractor VBP Plan The Contractor's policies and procedures shall have a VBP Plan for the adoption, evolution, and growth of APMs in its network. Each VBP Plan, as specified in the Medallion Managed Care Technical Manual and below, shall cover the current status of the Contractor's VBP efforts and strategies to enhance or further those efforts over the two subsequent contract years. The Contractor shall update its VBP Plan annually. The Contractor's VBP Plan shall, at a minimum, include:... The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals: Improved birth outcomes (pp. 252-253, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

⁸⁴ 5.22 Non-Hospital Payments Payment to Freestanding Birthing or Childbirth Centers. 5.22.1 The Contractor will pay all Freestanding Birthing or Childbirth Centers licensed by the Department of Health a facility fee at a rate no less than those published by HCA for its FFS Planned Home Births and Births in Birthing Center program. (p. 111, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

⁸⁵ MHT Medical Services: Clinical Services... Scope of Benefits:... birthing centers (p. A-3, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

⁸⁶ Maternity Services: The Contractor shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant. Members anticipated to have a low-risk delivery, may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. Refer to AMPM Policy 410. (p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services, 2. Physician Assistants, 3. Nurse Practitioners, 4. Certified Nurse Midwives, and 5. Licensed Midwives. Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice. (pp. 172-173, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

⁸⁷ 8. Nurse Midwife and Nurse Practitioner Services Contractor shall meet Federal requirements for access to Certified Nurse Midwife (CNM) services as defined in Title 22 CCR Section 51345 and Certified Nurse Practitioner (CNP) services as defined in Title 22 CCR Section 51345.1. Contractor shall inform Members that they have a right to obtain out-of- Network CNM services. (no page #, Effective FY 17-18, Access and Availability, Exhibit A, Attachment 9, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

⁸⁸ 1.1.17. Federally Qualified Health Care (FQHC) 1.1.17.1. Core services are provided in outpatient settings only, including a Member's place of residence. Core services means covered Outpatient Services that may include:... 1.1.17.1.4. Nurse midwife services;... (p. 6, Effective January 25, 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

1.1.39. Rural Health Clinics (RHC) 1.1.39.1. All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the Program.... 1.1.39.1.2. Services furnished by a... nurse midwife, under the medical supervision of a physician. (p. 13, Effective January 25, 2022, Exhibit N, Covered Services, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

⁸⁹ Table A: Medicaid Covered Services Service: Nurse Midwife services Benefit Limit: As described in 42 C.F.R. § 440.165. (p. 85, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

⁹⁰ 3.4.2 DSHP Benefit Package... 3.4.2.2 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. Service: Nurse-midwife services (p.57, Effective 2020, Addendum 1, MCO MSA, Delaware)

⁹¹ 3.9.8 Primary Care Provider (PCP)... 3.9.8.1.3 The State encourages the Contractor to promote and support the establishment and use of patient-centered, multi-disciplinary, team based approaches to care, including but not limited to:... use of non-traditional health workers... (p. 193, Effective 2020, Addendum 1, MCO MSA, Delaware)

⁹² C. Covered Services The Managed Care Plan shall ensure the provision of covered services in accordance with the provisions of Attachment II and its Exhibits, summarized in the Required MMA Services Table, Table 2A, and/or the Required LTC Services Table, Table 2B, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1. Table

2A: Required MMA Services... (5) Birth Center and Licensed Midwife Services (p. 3, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

⁹³ D. Approved Expanded Benefits The Managed Care Plan shall provide the following expanded benefits, in accordance with the provisions of Attachment II and its Exhibits and the coverage and limitations specified in Exhibit I-A of this Attachment, denoted by "X" in the Approved Expanded Benefits Table, Table 3, below, to enrollees of the applicable SMMC program(s) in the authorized region(s) specified in Table 1. Table 3: Approved Expanded Benefits... Doula Services (p. 5, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

⁹⁴ 4.8.14 Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs) 4.8.14.1 The Contractor shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider contracts or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services. (p. 111, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

⁹⁵ 4.11.8.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management. (p. 150, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

⁹⁶ 11. Other Practitioner Services a. The Health Plan shall be responsible for coverage of other practitioner services. Other practitioner services include, but are not limited to: 1) Certified nurse midwife services (p. 152, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁹⁷ 8.1 Provider Network... B. Specific Minimum Requirements... 3. 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 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 provider types:... I. Community health workers... (p. 323, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁹⁸ 15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents... e. The Health Plan shall ensure appropriate perinatal care is provided to women. The Health Plan shall have in place a system that provides, at a minimum, the following services:... 3) Availability and accessibility of:... b) Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses. (p. 157, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

⁹⁹ Table D2: Iowa Wellness Plan Benefits Coverage List... Service Category: Midwife Services (p. 230 Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

¹⁰⁰ 3.1.3.13.4 Contractor shall assure, and provide a plan to the Department, for provision of early identification of high-risk pregnancies and, if clinically indicated, ability to arrange for evaluation by a maternal fetal medicine specialist or transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements. Risk-appropriate care shall be ongoing during the perinatal period. (pp. 311-312, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

¹⁰¹ 2.20 Mid-level Practitioners Services. ...2.20.3 Nurse Midwives (Federal guidelines permit Members to access this service outside the CONTRACTOR(S)' plan if the Member desires to receive this service from a nurse midwife, the CONTRACTOR(S) is responsible for payment for this service). (p. 8, no date, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

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. 2.32.1 All medically approved services prescribed by physician/ARNP/nurse midwife and physician's assistant including diagnosis, treatment, counseling, drug, supply, or device to individuals of childbearing age shall be covered. (Page 10, Attachment C: Services. KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract with Aeta Better Health of Kansas)

¹⁰² See Medicaid Provider Specialties table on page 281 of Aetna Better Health of Kentucky Master Agreement Modification

¹⁰³ See Medicaid Provider Specialties table on page 281 of Aetna Better Health of Kentucky Master Agreement Modification

¹⁰⁴ 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: ...Nurse Midwife Services. (p. 60, Effective October_2019, Appendix B, -LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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

¹⁰⁶ MCO Covered Services: Physician (primary and specialty) – all medical, developmental pediatrician, psychiatry, radiological, laboratory, anesthesia and surgical services, including those services provided by nurse practitioners serving as primary care providers and services provided by nurse midwives. (p. 6, Appendix C, Exhibit 1, Effective 2022, Attachment A, 4th Amended and Restated Tufts)

¹⁰⁷ B. Prenatal Care Providers. For the purposes of provider network adequacy, prenatal care providers may include, but are not limited to: (1) Obstetricians; (2) Certified nurse midwives; and (3) Family practitioners who provide prenatal care and perform deliveries (p. 194, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

¹⁰⁸ D. Covered Services 1. To cover, for Enrollees: b. Doula services for pregnant and postpartum individuals as part of MCO-covered pregnancy-related benefits.. (p. 9, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

N. Network Providers... 16. To establish coverage, requirements, and reimbursement procedures for doulas who enroll in Maryland Medicaid to provide services for pregnant and postpartum individuals. (p. 25, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

¹⁰⁹ 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: ... e. Certified nurse midwife services (p. 48, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹¹⁰ VIII. Behavioral Health Integration. ...B. Provide or Arrange for Services...2. Community Health Workers (CHWs) a. Contractor must provide or arrange for the provision of Community Health Workers (CHW) in accordance with CHW requirements of this Contract or Peer-Support Specialist Services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or Peer-Support Specialist Services. b. Contractor agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by CHWs or Peer Support Specialists to promote behavioral health integration. (p. 66, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

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

¹¹¹ The MCO shall provide services that shall include but are not limited to the following:... 6.1.2 Advanced Practice Registered Nurse Services. Advanced Practice Registered Nurse Services provided by advanced practice registered nurses, certified family advanced practice registered nurses, certified adult advanced practice registered nurses, certified obstetric/gynecological advanced practice registered nurses, certified neonatal advanced practice registered nurses, and certified geriatric advanced practice registered nurses, including in independent practice are covered. Services of nurse anesthetists, nurse midwives and clinical nurse specialists are covered. [Minnesota Statutes, §256B.0625, subds. 11 and 28; Minnesota Rules Part 9505.320] (p. 90, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

6.1.35 Obstetrics and Gynecological Services. Such services include nurse-midwife services and prenatal care services as described below. MCO must comply with section 6.13.11, Direct Access to Obstetricians and Gynecologists. 6.1.35.1 Nurse-Midwife services by certified nurse-midwives are covered. [§1905(a)(17) of the SSA, Minnesota Statutes, §256B.0625, subd. 28; and Minnesota Rules, Part 9505.0320] (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹² 6.1.35 Obstetrics and Gynecological Services. Such services include nurse-midwife services and prenatal care services as described below. MCO must comply with section 6.13.11, Direct Access to Obstetricians and Gynecologists...6.1.35.2 Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered. [Minnesota Statutes, §256B.0625, subd. 28b] (p. 120, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹³ 6.1.9 Community Health Worker Services. CHW services are covered. [Minnesota Statutes, §256B.0625, subd. 49] (p. 93, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

¹¹⁴ 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/>):... v. Physician, Advanced Practice Nurse, and Certified Nurse Midwife Services: The health plan shall provide certified nurse midwife services that are medically appropriate either in-network or out-of-network at the health plan's expense. (p. 57, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹¹⁵ Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Physician Assistant, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology. For purposes of enhanced PCP payments authorized by Mississippi Code § 43-13-117 (A) (6), PCP is defined in State Plan Attachment 4.19- B. (p. 37, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹¹⁶ Covered Services and Benefits...Physician services including services provided by...certified nurse midwives (p. 122, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

Prenatal and Maternity Care Services a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis. B. The MCO must cover nurse-midwife services that are medically necessary... (p. 2375, no date, Nebraska Medicaid Managed Care Contract RFP)

¹¹⁷ Services MCO Covered... Certified Non-Nurse Midwife (p. 80, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹¹⁸ 4.7.5.10 Access Standards for Children with Special Health Care Needs 4.7.5.10.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care. 4.7.5.10.2 In addition to the "specialty care" Provider network adequacy requirements, the MCO shall contract with the following pediatric specialists:... 4.7.5.10.2.6. Neonatal-Perinatal Medicine; (p. 167, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹¹⁹ 4.1.2 BENEFIT PACKAGE A. 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. 1. Primary and Specialty Care by physicians and, within the scope of practice and in accordance with State certification/licensure requirements, standards and practices, by Certified Nurse Midwives, Doulas, Certified Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants (p. 10, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

D. Perinatal Risk Assessment Form. 1. An obstetrical Provider or other approved licensed health care Provider, including nurse midwives, shall complete the DMAHS uniform Perinatal Risk Assessment form (the form) during the first prenatal visit with a pregnant Member and shall update the form in the third trimester (p. 30, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

Below is listed the services requiring PCCs and the amount of each PCC.... Nurse Midwives (p. REQUIREMENTS FOR NJ FAMILYCARE C ENROLLEES, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

3. Certified Nurse Midwife (CNM) If the Contractor includes CNMs in its provider network as PCPs, it shall utilize the following ratios for CNMs as PCPs. a. 1 FTE CNM per 1000 enrollees per Contractor; 1 FTE CNM per 1500 enrollees across all Contractors. b. A minimum of two (2) providers shall be initially available for selection at the enrollee's option. Additional providers shall be included as capacity limits are needed. (p. 121, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

2. Certified Nurse Midwives and Nurse Practitioners [Non-Institutional File] The Contractor shall include in the network and provide access to CNMs/CNPs/CNSs at the enrollee's option. If there are no contracted CNMs/CNPs/CNSs in the Contractor's network in an enrollment area, then the Contractor shall reimburse for these services out of network. CNPs/CNSs included as PCPs or specialists in the network may provide a scope of services that comply with their licensure requirements. a. Certified Nurse Midwife b. Clinical Nurse Specialist c. Certified Nurse Practitioner (p. 122, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹²⁰ Doula--A doula is an individual who meets the community doula training requirements for doula core and community-based/cultural competencies established by DHS in consultation with DOH. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a trained, licensed medical professional, and cannot perform clinical tasks. (p. 11, Article 1, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

G. Doula care. The Contractor shall provide access to doula care to all pregnant, birthing, and postpartum individuals regardless of their medical complexity. The Contractor shall not require prior authorization for doula care. Doula care is available from conception until 180 days from the birth event. Doula care can be provided in the community, in clinical offices, or in the hospital. Doula care does not include reimbursement for transportation. Prior to the initiation of visits, doula care must be recommended by a licensed practitioner. Doula care must be provided by a community doula, defined as a doula with trainings in doula core competency and community-based/cultural competency that are among those approved by the New Jersey Department of Human Services in consultation with NJ Department of Health. All in-network doulas must be enrolled as fee-for-service providers and have the ability to serve fee-for-service members; the Contractor shall not accept registration as a 21st Century Cures Act Provider. The Contractor shall allow doulas to contract as individual providers and/or as providers affiliated with groups with the following specialties: doula-only agency, physician practices, midwifery practices, advanced nurse practitioner practices, and independent clinics. The Contractor must give DMAHS 90 days notice prior to any changes to the doula care fee schedule. (p. 31, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹²¹ ATTACHMENT C NJ Medicaid Managed Care Specialty Codes... Gynecology (Osteopaths Only) – Fetal Medicine (p. 426, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹²² 4.8.4.2 The CONTRACTOR may designate the following types of providers as PCPs, as appropriate:... 4.8.4.2.2 Certified nurse practitioners, certified nurse midwives and physician assistant (p. 109, no date, New Mexico Amended Version Sample RFP)

Non-Community Benefit Services Included Under Centennial Care... Midwife Services (p. 299, no date, New Mexico Amended Version Sample RFP)

¹²³ 4.4.12.2 The CONTRACTOR shall use local resources, such as... Community Health Workers (CHWs), Community Health Representatives (CHRs)... reimbursing them in mutually agreeable arrangements, to assist in performing the care coordination functions specified throughout Section 4.4 of this Agreement. The Contractor shall perform oversight of all care coordination functions delegated to local resources, per section 7.14.2.1.3. (p. 65, no date, New Mexico Amended Version Sample RFP)

4.14.11.6 The CONTRACTOR's Health Education Plan shall also include how the CONTRACTOR will work with Community Health Workers to improve Member Health Literacy. Specifically, the CONTRACTOR shall make Community Health Workers available to Members to, among other things:... 4.14.11.6.3 Assist Members in navigating the managed care system; 4.14.11.6.4 Assist in obtaining information about and access to available community resources; (p. 172, no date, New Mexico Amended Version Sample RFP)

¹²⁴ 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:... 7.4.2.1.29. Nurse Midwife; (pp. 99-100, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)
7.4.2.3. Nurse Midwife Services The Contractor must make nurse midwife services available to Members if such services are available in the Contractor's service area. If the Contractor does not have a provider contract for said services, the Contractor may pay the nurse midwife Provider according to a negotiated rate not to exceed the FFS rates established for pregnancy-related CPT codes for APRNs. (p. 102, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.6.3.8.2. The Contractor is required to negotiate in good faith with all of the following Essential Community Providers who are located in the Contractor's geographic service area(s). Negotiating in good faith requires, at a minimum, offering Provider Contracts that are at least as beneficial to the Provider as contracts with other Providers in the same geographic area for similar services. Contracts with Providers who work through one of the Essential Community Providers must be negotiated in good faith.... Nurse Midwives; (pp. 178-180, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

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

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

7.5.6.7.14. Case Management Program Staffing The Contractor must identify the staff that will be involved in the operations of the Care Management program, including but not limited to: Case Manager supervisors, Case Managers, Care Coordinators, social workers, Behavioral Health professionals, community health workers, peer support specialists, pharmacy consult support, physician consult support and administrative support staff. (pp. 157-158, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹²⁷ App'x K. 5. Midwifery Services . . . Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Enrollee's home as appropriate. The midwife must be licensed by the NYS Education Department and have a collaborative relationship with a physician or hospital that provides obstetric services, as described in Education Law § 6951.1, that provides for consultation, collaborative management and referral to address the health status

and risks of patients and includes plans for emergency medical OB/GYN coverage. (pp. K-19, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

¹²⁸ App'x G. COVERAGE AND SERVICES. 1. Basic Benefit Package. The MCP shall ensure members have timely access to all services outlined in OAC rule 5160-26-03 in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid and in accordance with 42 CFR 438.210, with limited exclusions, limitations, and clarifications (specified in this appendix), including emergency and post-stabilization services pursuant to 42 CFR 438.114. For information on Medicaid-covered services, the MCP shall refer to the Ohio Department of Medicaid (ODM) website. Services covered by the MCP benefit package shall include: I. Nurse-midwife. (pp. 89, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹²⁹ App'x K. 10. Specialized Services for High Risk Populations. The MCP may provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community, including home visiting, centering, community hub, community workers, etc., as appropriate, for high risk populations identified by the MCP or ODM. The MCP is responsible for ensuring that the community services are culturally-competent, meet the member's needs, honor member preference, and do not duplicate other services paid for by the MCP and/or ODM. At a minimum, if a member is pregnant or capable of becoming pregnant, resides in a community serviced by a qualified community hub, has been recommended to receive HUB pathway services by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCP or ODM, the MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub: a. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy. (pp. 163, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹³⁰ Exhibit K. 11. Traditional Health Workers. K.11.g. During each Contract Year Contractor shall collect data to measure the integration and utilization of THWs by Members regardless of whether such utilization is within Contractor's Service Area. The data collected shall be documented and reported to OHA in a THW Integration and Utilization Report using OHA's reporting template located at: <https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>. The data collected and documented in the THW Integration & Utilization Report for each Contract Year shall be provided to OHA by no later than November 15 of the following Contract Year. Data to be collected and documented in the THW Integration & Utilization Report shall include: K.11.g.3. Number THWs and the type of THW, which must include the following THW types: K.11.g.3.b. Doula (pp. 269, Effective October 2019, Exhibit K Social Determinants of Health and Equity, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹³¹ Exhibit K. 11. Traditional Health Workers. K.11.g. During each Contract Year Contractor shall collect data to measure the integration and utilization of THWs by Members regardless of whether such utilization is within Contractor's Service Area. The data collected shall be documented and reported to OHA in a THW Integration and Utilization Report using OHA's reporting template located at: <https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>. The data collected and documented in the THW Integration & Utilization Report for each Contract Year shall be provided to OHA by no later than November 15 of the following Contract Year. Data to be collected and documented in the THW Integration & Utilization Report shall include: K.11.g.3. Number THWs and the type of THW, which must include the following THW types: K.11.g.3.a. Community Health Workers (pp. 269, Effective October 2019, Exhibit K Social Determinants of Health and Equity, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

¹³² 2. Appointment Standards. e. Pregnant Women. Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. (pp. AAA-9-to-AAA-10, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement).

¹³³ Exhibit B(7). MATERNITY CARE BUNDELED [sic] PAYMENT. 1. Maternity Care Bundle: As part of VBP, the PH-MCO must utilize a Maternity Care Bundled Payment for Network Providers that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team. A PH-MCO utilizing a Maternity Care Bundled Payment must require that the Network Provider use a maternity care team that: g. Includes at least one (1) individual, such as a . . . doula . . . to coordinate the care of the pregnant woman to address other needs. (pp. B(7)-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁴ Exhibit B(7). MATERNITY CARE BUNDELED [sic] PAYMENT. 1. Maternity Care Bundle: As part of VBP, the PH-MCO must utilize a Maternity Care Bundled Payment for Network Providers that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team. A PH-MCO utilizing a Maternity Care Bundled Payment must require that the Network Provider use a maternity care team that: g. Includes at least one (1) individual, such as a . . . community health worker . . . to coordinate the care of the pregnant woman to address other needs. (pp. B(7)-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

¹³⁵ 2.09.06. Access for Women. The Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. (pp. 117–118, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹³⁶ ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS . . . SERVICE: Doula. SCOPE OF BENEFIT (ANNUAL) - Including but not limited to: Covered when medically necessary. Special Note: EOHHS must obtain approval from CMS on the proposed SPA during this contract amendment period. Until EOHHS receives such SPA approval, Contractor should not pay for any Doula services, except if offered as a value-add program. Upon SPA approval, EOHHS will communicate to Contractors the retroactive effective date of the SPA and Contractor must pay Doula services that were provided from the SPA effective date onward. (pp. 282, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

¹³⁷ 3.12.5. Provider Directory. The CONTRACTOR shall: 3.12.5.3. Include, at a minimum, information about the following Providers: . . . 3.12.5.3.5. Certified Nurse Midwives. (p. 44, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

¹³⁸ 2.7.6.4.8. Services Chart. Services Listed in Social Security Act Section 1905(a) – (17) Services furnished by a nurse-midwife. Responsible Entity in Tennessee – MCO. Comments – The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers. (pp. 73, no date, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹³⁹ Attachment B–2. STAR+PLUS Covered Services. Services included under the MCO capitation payment. Prenatal care provided by a . . . certified nurse midwife (CNM). (pp. 7, 9, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

¹⁴⁰ 1.3.24 Family Planning Services... B) Family Planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law. (p. 9, Effective July 2021, Attachment B – Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

¹⁴¹ 8.2.X Prenatal Care Requirements... c. Ancillary Services a. Certified Nurse-Midwife The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260. (p. 191, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

¹⁴² 8.2 Y Beginning February 1, 2022, the Contractor must provide Community Doula services as a covered service to address many of the drivers of poor maternal and child health outcomes. Doulas are individuals based in the community who offer a broad set of nonclinical pregnancy-related services centered on continuous support to pregnant women throughout pregnancy and in

the postpartum period. Emotional, physical, and informational support provided by Doulas include childbirth education, lactation support, and referrals for health or social services. Like other community health workers, Doulas provide culturally congruent support to pregnant and postpartum women through their grounding within the unique cultures, languages, and value systems of the populations they serve. (p.192, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract) See 8.2.Y for more details on covered Doula Services.

¹⁴³ 17.1.10 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to... midwives... (p. 304, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

Scope of Benefits... Health Care Professional Services... Maternity care, delivery, and new born care services; Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers. (p. 5, Exhibit M-1, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁴⁴ 8.2. Care coordination and health promotion 8.2.1. The Contractor shall ensure the Health Home Care Coordinator: 8.2.1.4. Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services (p. 14, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.7 Care Management Services... 14.7.1 Support of a person-centered approach to care in which Enrollee's needs, strengths, and preferences play a central role in the development and implementation of the care plan by:... 14.7.1.3 Promoting recovery using Certified Peer Counselors, Community Health Workers and community and natural supports; (p. 266, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

¹⁴⁵ 3. OB/GYN Network Adequacy Standards... Provider Specialty Codes/Descriptions... Nurse Midwife (p. 119, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁴⁶ 3) OB Medical Home Sites... The OB Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:... f) Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following:... 3. Effective strategies for addressing social factors, including the following:... Referral to community health worker services (p. 101, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁴⁷ 3) OB Medical Home Sites... The OB Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:... d) Provide appropriate best practice medical care for high-risk pregnant women, which may include: 1. Consultation from a maternal fetal specialist and close monitoring and surveillance (p. 99, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

¹⁴⁸ 2.1.3 Specialty Care The MCO must provide or arrange for necessary specialty care, including women's health services. In accordance with 42 CFR §438.206(b)(2), the MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist. The MCO must have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan. (p. 69, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

MHT Medical Service: Nurse Practitioners' Services; Definition: Services provided by a nurse midwife, nurse anesthetist, family, or pediatric nurse practitioner.; Scope of Benefits: Specific services within specialty. (p. A-5, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.2.4 Types of Primary Care Providers (PCPs) The MCO is required to contract with a mix of PCPs to ensure the primary care needs of adult and pediatric enrollees are met. The MCO may designate the following providers as PCPs, as appropriate: Certified nurse midwives (p. 75, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

¹⁴⁹ Quality Management/Performance Improvement Program: The Contractor shall have an ongoing QM/PI Program for the services it furnishes to members, regardless of payor source or eligibility category [42 CFR 457.1240(b), 42 CFR 438.330(a)(1), 42 CFR 438.330(a)(3)]. The Contractor's QM/PI program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care which is expected to have a favorable effect on health outcomes and member satisfaction, as specified in AMPM Chapter 900 [42 CFR 328.330(a)(1), 42 CFR 438.330(b)(1)-(2)]. The Contractor shall: 1. Measure and report to the State, its performance, using standard measures required by the State or as required by Centers for Medicare and Medicaid Services (CMS) [42 CFR 438.330(c)(1)(i), 42 CFR 438.330(c)(2)(i)], 2. Submit specified data to the State that enables the State to measure the Contractor's performance using standardized measures, as specified by the State [42 CFR 438.330(c)(1)(i)-(ii), 42 CFR 438.330(c)(2)(ii)], or 3. Perform a combination of the above activities [42 CFR 438.330(c)(2)(iii)]. (pp. 132)

The Contract's QM/PI shall include, but is not limited to:... 24. Collection and submission of performance measure data, including any required by the State or CMS [42 CFR 457.1201(n)(2), 42 CFR 457.1240(b), 42 CFR 438.330(a)(2), 42 CFR 438.330(b)(2), 42 CFR 438.330(c)],... 27. Performance measurement and performance improvement projects, as specified in this section, AMPM Policies [910](#), [970](#), and [980](#) [42 CFR 457.1240(b), 42 CFR 438.330(a)(2), 42 CFR 438.330(b)(1), 42 CFR 438.330(c), 42 CFR 438.330(d), 42 CFR 438.330(a)(2)],... (p. 135, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Performance Measures: To meet program and reporting requirements, standardized performance measures shall be measured and reported on an annual basis, or more frequently, as determined by AHCCCS [42 CFR 438.330 (c)]. Performance measures shall be collected, monitored, and evaluated in accordance with AMPM Policy 970. AHCCCS may utilize administrative, hybrid, or other methodologies for collecting and reporting performance measure rates, as allowed by CMS Core Measure Sets, the NCQA for selected HEDIS® measures, as allowed by other entities for nationally recognized measure sets, or as determined by AHCCCS. For Contract Year Ending (CYE) 2021 (10/1/20 through 9/30/21) Performance Measures shall be reflective of the performance measurement period for Calendar Year 2021 (1/1/2021 through 12/31/2021) in alignment with the applicable CMS Adult and Child Core Set technical specification requirements and NCQA HEDIS® technical specification requirements (for select NCQA HEDIS® measures). (p. 139, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Contractor Performance Measures (Contractor Specific): The Contractor shall comply with AHCCCS QM/PI requirements to improve the care, coordination, and services provided to AHCCCS members as demonstrated through performance metrics and performance measure reporting. The Contractor shall measure and report upon all measures included as part of the CMS Adult and Child Core Sets for the associated measurement period as well as select NCQA HEDIS® or other AHCCCS-required measures, as listed below: HEDIS OR OTHER ADULT/CHILD MEASURES: Mental Health Utilization (MPT) (HEDIS); Initial Visit within 30 days for Members Newly Identified with a CRS Condition (AHCCS). As measure sets are updated, performance measures required by AHCCCS may also be updated to reflect the changes. (p. 141, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Contractor Performance Measure Reporting: The Contractor shall include all Medicaid Managed Care enrolled members within its performance measure reporting and report rates specific to line of business; Contractors shall adhere to continuous enrollment criteria as outlined in the associated measure specifications. The Contractor must have the ability to report numerators, denominators, and rate/percentage for Title XIX as well as Title XXI, which shall be provided in accordance with AHCCCS request or instructions. The Contractor shall have the ability to report, in accordance with AHCCCS instruction and request, performance measure data specific to: 1. Applicable subpopulations (i.e. members with special health care needs, including, but not limited to:... maternal),... (pp. 143-144, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

B. PERFORMANCE MEASURES As part of AHCCCS' efforts to collect, monitor, and evaluate Contractor, line of business, agency, and system-level performance, AHCCCS utilizes standardized Performance Measures (PMs) included within CMS Core (Child and Adult) and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)® Measure Sets. AHCCCS PMs are integral to each Contractor's QM/PI Program and are focused on clinical and non-clinical areas reflective of the CMS Core Set domains of care, which include:...

2. Maternal and perinatal health. (p. 4, Effective October 1, 2022, [AMPM Policy 970 - PERFORMANCE MEASURES, AHCCCS MEDICAL POLICY MANUAL CHAPTER 900 – QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM](#))

While the contract generally includes performance measure reporting requirements, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: prenatal and postpartum care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵⁰ Maternal Child Health: The Contractor shall 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. The Contractor shall implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence. The Contractor shall submit all deliverables related to Medical Management as specified in Section F, Attachment F3, Contractor Chart of Deliverables. (p. 158, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

¹⁵¹ While the contract generally includes performance measure reporting requirements, including HEDIS, at provision #9 in Exhibit A, Attachment 4 of the Two-Plan-Non-CCI Boilerplate contract, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: contraceptive care – all women; contraceptive care – postpartum women; prenatal and postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵² While the contract generally includes performance improvement projects (PIPs) requirements at provision #9 in Exhibit A, Attachment 4 of the Two-Plan-Non-CCI Boilerplate contract, the state's latest EQR findings report provides that the state conducted the following PIP related to perinatal care: postpartum care - adult and child and racial and ethnic disparities - adult and child. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵³ 16.4 Performance Measurement 16.4.1. The Contractor shall participate in the measurement and reporting of performance measures required by the Department, with the expectation that this information will be placed in the public domain. (p. 117, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

16.4.10. Additional Performance Measurement 16.4.10.1. Public Reporting 16.4.10.1.1. The Contractor shall improve network performance on core performance measures that will be reported publicly at least one time annually. The Public Reporting measures will be divided in the following way:...

16.4.10.1.1.4. Clinical and Utilization Measures as relevant, including CMS Core Measures and HEDIS measures that align with CPC+ and other state and federal initiative. (p. 119, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: prenatal and postpartum care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

16.4.10.2 Health Equity and Performance Improvement 16.4.10.2.1. The Contractor shall disaggregate their performance and utilization data at least by race and ethnicity, language, and disability status in strategic priority areas and make this information available to the department and stakeholders upon request. (p. 120, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

¹⁵⁴ C.5.32.1.7.1 The Contractor shall at least annually, collect, and submit performance measurement data in accordance with with 42 C.F.R. § 438.330(c)(2) and 42 C.F.R. § 438.350; C.5.32.1.7.2 The Contractor shall use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all External Quality Review Organization (EQRO) activities as part of its QAPI program (p. 166, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Contraceptive Care – All Women (CCW); Postpartum Women (CCP); and Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵⁵ C.5.32.1.7.10 The Contractor shall conduct performance improvement projects (PIP) that are designed to achieve, through ongoing measurements and interventions, improvement, sustained over time in clinical care and nonclinical areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. If CMS specifies performance measures and PIPs in accordance with 42 C.F.R. § 430.330(a)(2), Contractor must report such performance measures to DHCF and conduct such PIPs (p. 167, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

While the contract generally includes performance improvement projects (PIPs) requirements, as noted above, the state's latest EQR findings report provides that the state reported conducted the following PIPs related to maternal and perinatal health: contraceptive care – adult and child, child; prenatal and postpartum care – adult and child, child. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵⁶ 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)... e. QPM Penalty: For each applicable QPM performance/measurement year, the Contractor will be assessed a financial penalty if Contractor does not achieve the performance levels specified in Section 3.g of this Appendix. i. For the CY 2019 QPM performance/measurement year, the penalty that can be assessed against the Contractor is a maximum of up to one percent (1.0%) of the Contractor's total net revenue received from the Department for all populations covered under this Agreement. If a penalty is applicable to the Contractor the Department may assess/collect the penalty either through a deduction in future payments to the Contractor or through a remittance paid by the Contractor to the Department. ii. To avoid a penalty, the Contractor must achieve at least a satisfactory performance level on each QPM as specified in the Evaluating Performance Level section of this Appendix. . QPM Performance Weighting Factor: Each QPM will have a performance weighting factor as determined by the Department. This factor determines the proportion of the maximum penalty attributable to each QPM. The performance weighting factors for each QPM are shown below: i. For the CY 2019

performance/measurement year:... 6. QPM #6: A maximum of 1/5 of the total QPM penalty... ii. For the CY 2020 performance/measurement year:... 6. QPM #6: A maximum of 1/7 of the total QPM penalty... g. Satisfactory Performance Level: For purposes of evaluating the 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:... 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. 395-398, Effective 2020, Addendum 1, MCO MSA, Delaware)

¹⁵⁷ Section IX. Quality... f. The Managed Care Plan shall submit performance measure data as specified by the Agency and in a manner and format prescribed by the Agency. (p. 119, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

B. Required Performance Measures a. The Managed Care Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in the SMMC Performance Measure Tables in the applicable Exhibits, the Managed Care Plan Report Guide, and Performance Measures Specifications Manual. b. The Managed Care Plan shall report results of PMs to the Agency as specified in Section XVI., Reporting Requirements, the Managed Care Plan Report Guide, and Performance Measures Specifications Manual. (p. 123, Updated February 2022, AHCA Contract No. FP0XX, Attachment I – Scope of Services, Florida Managed Medical Assistance (MMA) Program)

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

¹⁵⁸ 4.12.3 Performance Measures 4.12.3.1 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes; Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement. The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program. 4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure. 4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at <http://dch.georgia.gov/medicaid-quality-reporting>. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH. 4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure. (p. 160, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Live Births Weighing Less Than 2,500 Grams (LBW); and Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁵⁹ 4.12.7 Performance Improvement Projects 4.12.7.1 Georgia Families Contract RFP #DCH0000100 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols. (p. 163, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

While the contract generally includes performance improvement projects (PIPs) requirements, as noted above, the state's latest EQR findings report provides that the state reported conducted the following PIPs related to maternal and perinatal health: high-risk maternal care and prenatal care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶⁰ D. Performance Measures 1. The Health Plan shall comply with all DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements. Performance measures will be aligned with DHS Quality Strategy and shall represent the key metrics that serve as the outputs and outcomes of the Health Plan's overall QAPI activities. 2. Clinical measures, utilization measures, and other measures of program cost may be included, in addition to process measures. DHS may require reporting of performance measure at any level of granularity including Member, Provider, practice, health system, or plan level. The types of performance measures that the Health Plan shall be required to track and provide to DHS include: a. Clinical and utilization quality measures – A set of clinical and utilization measures are required from the Health Plan each year. DHS shall provide a list of the performance measures each calendar year for the next year's required measures. The measures may be HEDIS measures. b. HEDIS-like measures – A set of measures, including both clinical and utilization measures, that are based on HEDIS measure definitions, but modified, as needed, to achieve such goals as alignment with the CMS Medicaid Core Set, or alignment with DHS priorities. DHS shall provide a list of the HEDIS-like performance measures each calendar year for the next year's required measures. c. Other nationally-developed quality measures – A set of measures, including both clinical and utilization measures, with various measure stewards nationally that may or may not be endorsed by NCQA. DHS shall provide a list of nationally developed performance measures each calendar year for the next year's required measures. d. Other DHS-developed quality measures – A set of measures, including clinical, utilization, or cost-based measures, that are defined by DHS to track DHS priorities for which a HEDIS, HEDIS-like, or other nationally defined measure is unavailable, inadequate, or inappropriate. DHS will design these measures, as needed, and provide Health Plans with a format and frequency for reporting. e. Utilization dashboard – The Health Plan shall supply information that may include a variety of output measures and performance metrics designed to track volumes of patients or services, including hospital admissions and readmissions, call center statistics, provider network, Member demographics, etc. DHS shall provide a list of the measures and a format and frequency for submission. f. EPSDT data – The Health Plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc. g. DHS shall identify the measures that may be used to support auto-assignment algorithms as described in §9.1.C. h. DHS shall also identify the measures that may be eligible for performance incentives. 3. The Health Plan shall submit to DHS and the EQRO any and all Member data necessary to enable validation of the Health Plan's performance under this section. (pp. 217-219, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶¹ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶² While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state reported conducted the following PIPs related to maternal and perinatal health: postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶³ Table 1 to Attachment XI - HEALTHCARE AND QUALITY OF LIFE PERFORMANCE MEASURES: Prenatal and Postpartum Care - Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • *Timeliness of Prenatal Care*. Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care*. Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (p. 242, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

In addition to the contract including language with respect to performance measure reporting requirements for perinatal measures, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶⁴ 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... At a minimum, the following areas shall be monitored for pregnant women: 1.1.3.1.14 timeliness and frequency of prenatal visits; 1.1.3.1.15 postpartum care rate; 1.1.3.1.16 provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests; 1.1.3.1.17 birth outcomes; 1.1.3.1.18 birth intervals; 1.1.3.1.19 early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; 1.1.3.1.21 utilization of 17P; 1.1.3.1.22 referral to the Perinatal Centers, as appropriate; 1.1.3.1.23 length of hospitalization for the mother; 1.1.3.1.24 length of hospital stay for the infant; 1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider/pediatrician for the infant. (pp. 228-229, Effective 2018, Attachment XI: Quality Assurance, State of IL Model Contract)

¹⁶⁵ 4. Performance Measures and Incentive Payment Structure. a. Incentive Payments, Withholds... vi. Timeliness of Ongoing Prenatal Care. Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within forty-two (42) days of enrollment in the organization. HEDIS measure (HEDIS PPC) using hybrid data. Amount of Performance Withhold at risk: 15% If Contractor's 2022 measurement year rate is at or above the 25th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred (100%) of the amount of the Performance Withhold at risk. v. Post-partum visits. Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty four (84) days after delivery. (Includes deliveries between Nov 6th of the year prior to the measurement year and Nov 5th of the measurement year.) HEDIS measure (HEDIS) PPC) using hybrid data. Amount of Performance Withhold at risk: 15% If Contractor's 2022 measurement year rate is at or above the 25th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 50th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk. If Contractor's 2022 measurement year rate is at or above the 75th percentile of NCQA 2023 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. PPC) using hybrid data. vii. Prenatal Depression Screening and Follow-Up (PND-E). The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. HEDIS measure (PND-E) using hybrid data. Amount of Performance Withhold at risk: 5% If the Contractor timely and accurately reports this measure for the 2022 measurement year, in

accordance with State expectations, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. (P. 196, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

¹⁶⁶ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state reported conducted the following PIPs related to maternal and perinatal health: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶⁷ APPENDIX D. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES ...85. Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions. Describe activities of the EPSDT staff, including outreach, education, and care management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations. (p. 243, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

¹⁶⁸ Attachment C: Performance Measures. Measure: Prenatal and Postpartum Care -Timeliness of Prenatal Care. The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. Measure: Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2): The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery ... Measure: Contraceptive Care-Postpartum: The percentage of women ages who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported. (pp. 407-408, 417, Effective October 2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Contraceptive Care – All Women; Contraceptive Care – Postpartum Women, Elective Delivery, and Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁶⁹ Attachment C: Performance Measures. ... Measure: Initiation of Injectable Progesterone for Preterm Birth Prevention. Measure Description: The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year. Measure: Percentage of low birth weight births Percentage of live births that weighted less than 2,500 grams in the state during the reporting period. ... Measure: Elective Delivery This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. ... Measure: Cesarean Rate for Low-Risk First Birth Women The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). (pp. 417-418, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

¹⁷⁰ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷¹ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicare.gov/medicare/quality-of-care/medicare-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷² Appendix 4 - PERFORMANCE MONITORING STANDARDS...Diagnostic Dental Visits in Pregnant Women Pregnant women who received at least one diagnostic dental service during their pregnancy or 90 days postpartum. Preventive Dental Visits in Pregnant Women Pregnant women who received at least one preventive dental service during their pregnancy or 90 days postpartum. Restorative Dental Visits in Pregnant Women Pregnant members who received at least one restorative dental service during their pregnancy or 90 days postpartum. (pp. 178-179, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

¹⁷³ LOW BIRTH WEIGHT (LBW) PROJECT--APPENDIX 5B In June 2017, the Michigan Medicaid Managed Care Plan Division (MCPD) identified Low Birth Weight (LBW) as a target outcome associated with the FY 2018 Pay for Performance (P4P) Initiative for the Medicaid Health Plans (MHPs). The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated by MCPD in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population. The project will utilize the 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Live Births Weighing Less Than 2,500 Grams (LBW-CH) measure. Michigan has been reporting the LBW-CH measure rate since 2014 and ranged from 8.50% to 10.40% over the past 3 years. The Center for Disease Control and Prevention (CDC) National Center for Health Statistics indicates that the percent of babies born low birthweight was 8.07% in 2015. (Source: <https://www.cdc.gov/nchs/fastats/birthweight.htm>; https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf) The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by prosperity region and race/ethnicity. This breakdown of the data will identify health disparities and methods to improve quality care and services to pregnant women and infants. The LBW P4P project also aligns with Michigan's 2016-2019 Infant Mortality Reduction Plan (IMRP) and statewide Regional Perinatal Quality Collaborative efforts. The 2016-2019 IMRP contains 2 goals related to health equity and the elimination of racial and ethnic disparities. In Michigan, deaths due to prematurity (birth prior to 37 weeks gestation) and/or low birth weight (less than five and a half pounds) are the leading causes of infant mortality. (Source: 2016- 2019 IMRP) PROJECT GOAL MCPD is launching this multi-year statewide Pay for Performance (P4P) initiative to align MDHHS efforts to promote health equity in maternity care and infant care. For FY 2018, the goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes. PURPOSE The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: • Preconception • Timeliness of prenatal care • Postpartum care The Low-Birth Weight project will follow a similar format to the FY15-17 ED Utilization Focus Bonus. MDHHS has provided the MHPs with the following guidance: 1. Literature Review: MHPs will conduct a literature review with respect to Low-Birth Weight. The Michigan State University Institute for Health Policy (MSU IHP) has provided an extensive list of articles related to the topic. MHPs must analyze at least three scholarly articles with one of their sources from the MSU IHP literature review. 2. Member Data: MSU IHP performed a thorough data analysis of LBW rates by race/ethnicity and prosperity region. MHPs are expected to provide a barrier and gap analysis report to identify the data collection method used to their intervention. The report must incorporate the findings provided by MSU IHP. 3. Partnership Scan: MHPs must gather input from members who receive prenatal care and identify barriers and gaps based on the regional data analysis. MHPs are required to identify and partner with external organizations in specific regions. The partnerships must include evidence-based models of care that incorporate clinical care, home visiting, Community Health Workers (CHWs)/peer support, and community collaboration. 4. Intervention Considerations: MHPs will be required to create and describe potential interventions to improve LBW rates. The intervention considerations will include the identification risk factors by race/ethnicity and prosperity region as well as establishing and maintaining partnerships to support the intervention. SUBMISSION AND SCORING There are four components of the LBW project in which the health plans must complete: Baseline Analysis; Intervention Proposal; Intervention Implementation and Timeline Form; and Intervention Reporting. • Baseline Analysis: The purpose of the Baseline Analysis activity is to develop an in-depth understanding of low birth

weight that includes a review of literature; data collection and analysis. • Intervention Proposal: The purpose of the Intervention Proposal activity is to develop interventions that target low birth weight from findings of the baseline analysis. The Intervention Proposal must be approved by MDHHS to proceed with the Intervention Implementation and Reporting. • Intervention Reporting: The purpose of the Intervention Report is to report the results of the intervention and ongoing assessments at six and twelve month intervals. Requesting guidance from the QIPD Section is highly encouraged. MDHHS offers the MHPs the opportunity to submit a Review submission at least a month prior to the Final due date. The review submission allows MDHHS to review and provide feedback (if necessary) to the Plans before submission date. (pp. 185-186, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to perinatal care: prenatal care – adult and child and racial and ethnic disparities – adult and child. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷⁴ 7.12 HEDIS ANNUAL PERFORMANCE MEASURES AND RATES. 7.12.1 Measures. The MCO shall calculate and provide to the STATE the following HEDIS 2022 (based on calendar year 2021) performance measures and rates using an appropriate HEDIS method. The HEDIS measures and rates shall be submitted to the STATE by September 1 of the Contract Year... 7.12.1.8 Prenatal and Postpartum Care (p. 158, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷⁵ 7.2 PERFORMANCE IMPROVEMENT PROJECTS (PIPS). The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR §438.330(b)(1) and (d) and CMS protocol entitled "CMS EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS October 2019." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs. 7.2.1 2021 - 2023 Performance Improvement Project Proposal. 7.2.1.1 The proposal for the new PIP topic, "Healthy Start for Mothers and their Children" was due October 1, 2020. From January, 2021, the PIP with this topic will be conducted over a three year period (calendar years 2021, 2022, and 2023). The PIP must be consistent with CMS' published protocol entitled "CMS EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS October 2019," as well as STATE requirements, and include steps one through seven of the CMS protocol. The MCO shall provide annual PIP progress reports to the STATE. 7.2.1.2 For the 2021-2023 PIP, the first interim report will be due September 1, 2022. (p. 155, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

In addition to the contract including language on perinatal care-related performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to perinatal care: postpartum care - adult and child, prenatal and postpartum care – adult and child, and prenatal substance use – adult and child. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷⁶ The health plan shall submit to the state agency the HEDIS certified results for all HEDIS measures that are calculated by the plan. At a minimum, this shall include the following measures for each region:....; Prenatal and Postpartum Care (PPC);.... Results shall be reported 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-care-2017/health-plan-reportingschedules-templates/>). (pp. 139-140, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

4.6.4 The vendor should provide the vendor's proposed strategies for improving the MO HealthNet population health outcomes for the following HEDIS measures for the original contract period and each renewal option periods:... Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, and Ambulatory Care (AMB) – ED Visits. (p. 205, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

¹⁷⁷ E. Performance Measure The Contractor shall comply with the Division's Quality Management requirements to improve the health outcomes for all Members. The Contractor shall meet specific performance targets, as outlined in Exhibit F, Performance Measures, of this Contract for each of the Performance Measures identified by the Division. The Contractor shall, on an annual basis, measure and report to the Division on its performance using the standard Performance Measures required by the Division and submit to the Division data, as specified by the Division, which enables the Division to calculate the Contractor's performance using the standard measures identified by the Division. The Division may update performance targets, include additional Performance Measures or remove Performance Measures from the list of required Performance Measures and required targets at any time during the Contract period. The Division and the Contractor(s) shall have an ongoing collaborative process on the development, addition, and modification of Performance Measures and setting of performance targets to identify opportunities for improving health outcomes. Many of the MississippiCAN Performance Measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®). The Contractor shall use the standardized methodology as outlined in Volume 2, HEDIS® Technical Specifications¹, to calculate its performance rates. The Contractor shall contract with a Certified HEDIS® Audit Firm to conduct a certified audit of its HEDIS® rates, and shall report the findings of that audit, including the actual report submitted by the auditor to NCQA, to the Division. The Contractor shall report rates for all Performance Measures to the Division, regardless of whether they are based on HEDIS® technical specifications. While the Contractor must meet the Division Performance Measure Targets for each measure, it is equally important that the Contractor continually improve health outcomes from year to year. The Contractor shall strive to meet the Performance Measure targets established by the Division. The Division reserves the right to make any HEDIS® and Performance Measures results public. (pp. 129-130, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

Exhibit F: Performance Measures... Prenatal and Postpartum Care a. Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit as a Member of the organization in the first trimester or within 42 days of Enrollment in the organization b. Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. c. Report the number of Members (that received a postpartum visit on or between 21 and 56 days of delivery... (p. 260, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Contraceptive Care – All Women; Contraceptive Care – Postpartum Women, Elective Delivery, and Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁷⁸ Exhibit F: Performance Measures... Pre and post-natal complications a. Number and percent of deliveries that meet the following criteria, based on gestational weight: low birth weight, very low birth weight, or large for gestational age b. Number and percentage of deliveries with prenatal complications (list prenatal complications) Pregnancy Outcome for Members Enrolled Throughout the Pregnancy For those Members who were enrolled in the first trimester and maintained Enrollment with the same CCO throughout the pregnancy, report the outcome of the pregnancy (pp. 259-260, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

¹⁷⁹ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to maternal and infant birth outcomes and prenatal and postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁰ Attachment 14 Quality Performance Program Measure - Contract Year Five. Base Performance Requirement: Prenatal and Postpartum Care: Postpartum Care (PPC-AD): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. Payment Threshold: 74.36%. % of Payment Pool: 5%. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH): Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP. Payment Threshold: 87.59%. % of Payment Pool: 5%. (pp. 21-22, Effective 2021, Nebraska Total Care Inc. Medicaid Managed Care Contract Amendment)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸¹ EXHIBIT 0 - Quality and Oversight Reporting Requirements...HEDIS_PPC Prenatal and Postpartum Care... HEDIS_PRS-E Prenatal Immunization Status (p. 28, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

Contraceptive Care - Postpartum Women; Most or Moderately Effective Contraception - 3 Days.. Contraceptive Care - Postpartum Women: Most or Moderately Effective Contraception - 60 Days... Contraceptive Care - Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) - 3 days... Contraceptive Care Postpartum Women; Long-Acting Reversible Method of Contraception (LARC) - 60 days (p. 16, Exhibit O, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

¹⁸² Performance payment pool - Criteria for earning the performance pool payments is achieving the benchmarks on the following five metrics: Pre-term birth rate: The percent of all singleton live births which are less than 37 weeks gestation, as recorded in the New Jersey Electronic Birth Certificate system (EBC), for members consecutively enrolled with the same Contractor for the 6 months prior to the birth. < 9.25% Pre-natal care timeliness: Score as reported by the Healthcare Effectiveness Data and Information Set (HEDIS see <https://www.ncqa.org/hedis/measures/>) ≥ NCQA 75th Percentile for HEDIS MY2020 Post-partum care timeliness: Score as reported by the HEDIS ≥ NCQA 75th Percentile for HEDIS MY2020 (pp. 10-11, Article 8, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

QUALITY IMPROVEMENT PROGRAM-NEW JERSEY (QIP-NJ) PERFORMANCE PAYMENT A. Overview - To support continued population health improvement across New Jersey, the State developed a hospital performance initiative called the Quality Improvement Program–New Jersey (QIP-NJ). QIP-NJ is a Medicaid pay-for-performance initiative open to all acute care hospitals licensed in the state. The focus of the planned program is to advance statewide quality improvements in maternal health and behavioral health. Participating acute care hospitals can earn QIP-NJ incentive payments through the achievement of performance targets on state-selected quality measures that demonstrate: · improvements in maternal care processes; · reductions in maternal morbidity;

...D. Performance Calculation – Hospitals will be evaluated on the quality measures below and performance-based payments will be calculated for Medicaid enrolled individuals in the two focus populations.... Maternal Health Measures Measure # Measure Name and NQF # Measure Steward M1 Severe Maternal Morbidity (SMM) CDC M2 PC-02 Cesarean Birth - NQF #0471 Joint Commission M3 Postpartum Depression Screening N/A M4 Postpartum Care - NQF #1517 NCQA M5 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in Pregnant Women - NQF #0004 NCQA M6 Timely Transmission of the Transition Record - NQF #0648 AMA-PCPI M7 Treatment of Severe Hypertension Alliance for Innovation on Maternal Health (AIM) (pp. 17-18, Article 8, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

¹⁸³ 4.12.8.2 The performance measures (PMs) shall be evaluated using the following criteria... 4.12.8.2.6 PM #6 (2 total points) – Prenatal and Postpartum Care (PPC) The percentage of Member deliveries of live births between November 6 of the year prior to the measurement years and November 5 of the measurement year that received a prenatal care visit as a Member of the CONTRACTOR's MCO in the first trimester or within forty-two (42) Calendar Days of enrollment in the CONTRACTOR's MCO (1 point); and the percentage of Member deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) Calendar Days after delivery (1 point). 4.12.8.2.7 PM #7 (1 point) – Frequency of Ongoing Prenatal Care (FPC) The percentage of Member deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than eighty-one percent (81%) of expected prenatal visits. (p. 146, no date, New Mexico Amended Version Sample RFP)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁴ 4.12.4.10 At a minimum the CONTRACTOR shall implement Performance Improvement Projects (PIPs) in the following areas: ... one (1) Prenatal and Postpartum (p. 143, New Mexico Amended Version Sample RFP, 2022).

In addition to the state including contractual language regarding perinatal performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to maternal and perinatal care: postpartum care, prenatal and postpartum care- adult and child, and prenatal substance abuse. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁵ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁶ 7.11.7. Community Reinvestment Requirements 7.11.7.1. The Contractor must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The Contractor's community reinvestment must be used to support population health strategies, which will include, but may not be limited to, financial support for Project ECHO and Nevada's Perinatal Quality Collaborative. The Contractor is encouraged to work with other Contractors to maximize the collective impact of community reinvestment activities. 7.11.7.2. The Contractor must not use community reinvestment funding to pay for Medicaid or CHIP services covered under the Contract. 7.11.7.3. The Contractor must contribute three percent (3%) of its annual pre-tax profits to community reinvestment. The State may require the Contractor to increase the percentage of community reinvestment contributions in future years of the Contract. 7.11.7.4. The Contractor must submit a plan on an annual basis, by March 1 of each Contract Year, detailing its anticipated community reinvestment activities for State review and approval. 7.11.7.5. The Contractor must submit an annual report of actual community reinvestment expenditures within three (3) months after the end of the Contract Year. (p. 275, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

¹⁸⁷ 7.9.5.4. The Contractor will be required annually to conduct and report on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, maternal and child health outcomes, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and Appeals and Grievances. 7.9.5.5. The Contractor must participate in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by the State. 7.9.5.6. The Contractor must select an additional two (2) projects from the list below, to serve as the Contractor's required PIPs in accordance with 42 CFR 438.330(a)(2) and 42 CFR 438.358: 7.9.5.6.1. Increasing access to and use of primary care and preventive services across the covered population; 7.9.5.6.2. Improving quality of and access to Behavioral Health Services; 7.9.5.6.3. Reducing preventable thirty (30) day hospital readmissions; and 7.9.5.6.4. Social determinants of health and health equity. (p. 245, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

In addition to the state including contractual language regarding perinatal performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to maternal and perinatal care: postpartum care, prenatal and postpartum care- adult and child, and prenatal substance abuse. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁸ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁸⁹ 1. Quality Measures. For SFY 2020, SFY 2021, and SFY 2022 specific measures are designated for use in the Quality Based Assignment incentive program. For these measures, results will be used in determining the award of incentives for participating MCPs. For the measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty (see Appendix N)... Measures, Measurement Sets, Standards, and Measurement Years. The measures, accompanying Minimum Performance Standards, and measurement years for the SFY 2021, SFY 2022, and SFY 2023 contract periods are listed in Table 1 below. The measurement set associated with each measure is also provided. The measures used in the Quality Based Assignment Incentive Systems each year are denoted with a QBA in the respective Minimum Performance Standard columns. No standard will be established, or compliance assessed, for measures designated 'reporting only' for the corresponding year.

Table 1. SFY 2021, SFY 2022 and SFY 2023 Performance Measures, Measurements Sets, Standards, and Measurement Years. Measure: Prenatal and Postpartum Care – Timeliness of Prenatal Care; Prenatal and Postpartum Care – Postpartum Care; Percent of Live births Weighing Less Than 2,500 Grams (pp. 179-180, Appendix Q, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹⁰ App'x C. 42. Information Required for MCP Websites. C.42.b. The MCP provider website shall include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions: C.42.b.xi. Prominent, easily understood information on its website for members and providers regarding the optimization of pregnancy outcomes. This shall include information for providers, trusted messengers (e.g., community health workers), and patients about the prevention of preterm birth through the use of progesterone treatment by linking to the Ohio Perinatal Quality Collaborative's information about progesterone best practices at (<https://www.opqc.net/prematurity-prevention?adlt=strict>) and the Ohio Department of Health's progesterone-messaging toolkit located at (GoWhenYouKnow.org). (pp. 55, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

¹⁹¹ Exhibit B, pt. 10. 6. Performance Improvement Projects. B.6.b. Contractor shall undertake PIPs that address at least four (4) of the eight (8) focus areas listed below in this Para. b, Sec. 5, Ex. B, Part 10. One of the four shall be the Statewide PIP identified in focus area Sub.Para. (4) below of this Para. b, Sec. 5, Ex. B, Part 10. In order to satisfy the requirements set forth in 42 CFR §438.358 and 438.330(a)(2) Contractor shall select an additional three (3) PIPs from the list as follows: B.6.b.6. Improving perinatal and maternity care. (pp. 169, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

In addition to the state including contractual language regarding perinatal performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP related to maternal and perinatal care: high-risk maternal care, postpartum care, and prenatal and postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹² Exhibit B(1). MCO PAY FOR PERFORMANCE. This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022 the Department has no payment obligation under this Exhibit. This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section II. below. I. Quality Performance Measures. For 2022, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing MY 2021 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are: HEDIS . . . 3. Prenatal Care in the First Trimester; 4. Postpartum Care. (pp. B(1)-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement).

¹⁹³ Exhibit B(1). MCO PAY FOR PERFORMANCE. This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022 the Department has no payment obligation under this Exhibit. This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section II. below. I. Quality Performance Measures. For 2022, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing MY 2021 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are: . . . 2. Maternal Home Visiting. (pp. B(1)-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement).

¹⁹⁴ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹⁵ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP: maternal and infant birth outcomes. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹⁶ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹⁷ 2.15.6.1 Annually, beginning with NCQA HEDIS 2016, the CONTRACTOR shall complete all NCQA HEDIS measures designated by NCQA as relevant to Medicaid. (pp. 20, Amendment 13, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

¹⁹⁸ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIPs: postpartum care, prenatal and postpartum care, and prenatal substance use. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

¹⁹⁹ 2.4 Quality Measure Table: (A) Maternity Care: (1) Postpartum Care Rate (PPC); (2) Timeliness of Prenatal Care (PPC) (p.3, Effective July 2021, Attachment E– Health Choice, Utah Medicaid Health Choice Contract Accountable Care Organization)

While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁰ T 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:... postpartum visits, timeliness of prenatal care (p. 247, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰¹ 9.10 OTHER MEASURES In addition to HEDIS measures, DMAS has identified clinical quality, access, and utilization measures using nationally recognized measure sets to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures will be listed in the DMAS Quality Dashboard and are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the populations, DMAS will take into consideration the availability and reliability of the data for Medallion 4.0 Medicaid Managed Care Contract that are used to calculate the measure. Early elective deliveries rate, CDC: Percent of live births <2,500 grams (p. 248, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

²⁰² While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIPs: prenatal care and prenatal substance use. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰³ The Contractor shall report the following HEDIS® measures statewide for all eligible Enrollees enrolled through AH-IMC and AH-IFC contracts during the performance year. The contract marked in the Notes column applies to performance year. All measures must be publicly reported by plan name to the NCQA Quality Compass. If "Hybrid" is noted in the Notes column, the Contractor is contractually required to report using this methodology. Measure: Prenatal and Postpartum Care - Timeliness of prenatal care and postpartum care (pp. 1-2, Attachment 2-C, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

In addition to the contract including performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁴ The Contractor shall report the following HEDIS® measures statewide for all eligible Enrollees enrolled through AH-IMC and AH-IFC contracts during the performance year. The contract marked in the Notes column applies to performance year. All measures must be publicly reported by plan name to the NCQA Quality Compass. If "Hybrid" is noted in the Notes column, the Contractor is contractually required to report using this methodology. Measure: Race/ethnicity diversity of membership, prenatal depression screening and follow-up, postpartum depression screening and follow-up, prenatal immunization status (p.3, Attachment 2-C, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

²⁰⁵ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIPs: prenatal and postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁶ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁷ While the contract generally includes performance improvement projects (PIPs) requirements, the state's latest EQR findings report provides that the state conducted the following PIP: postpartum care. See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁸ While the contract generally includes performance measure reporting requirements, including HEDIS, the state's latest EQR findings report provides that the state reported on the following maternal and perinatal health measures: Contraceptive Care and Prenatal and Postpartum Care (PPC). See <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html> for more.

²⁰⁹ This may include transitioning from MCOs.

²¹⁰ 26. NETWORK DEVELOPMENT... The Contractor is expected to design a network that provides a geographically convenient flow of members among network providers to maximize member choice. The Contractor shall allow each member to choose his or her network provider to the extent possible and appropriate [42 CFR 457.1201(j), 42 CFR 438.3(l)]. (p. 161, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

29. PRIMARY CARE PROVIDER STANDARDS... The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m), 42 CFR 438.52(d), 42 CFR 438.14(b)(3) and this Contract. (p. 171, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

30. MATERNITY CARE PROVIDER REQUIREMENTS... Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. (p. 172, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

²¹¹ 26. NETWORK DEVELOPMENT... If the Contractor's network is unable to provide medically necessary services required under Contract, the Contractor shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 457.1230(a), 42 CFR 438.206(b)(4) and (5)]. (p. 160, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

Network Development and Management Plan:... The Contractor shall maintain a sufficient network in accordance with the requirements specified in ACOM Policy 436, 42 CFR 457.1218, 42 CFR 438.68, 42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c). In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area [42 CFR 457.1218, 42 CFR 438.68]. (p. 166, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

²¹² Maternity Services... Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. Refer to AMPM Policy 410. (p. 81, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

²¹³ 8. TRANSITION ACTIVITIES The Contractor shall comply with the AMPM and the ACOM standards for member transitions between AHCCCS programs, Contractors, or Geographical Service Areas (GSAs) and upon termination or expiration of a Contract. When relinquishing members, the relinquishing Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to special needs of transitioning members. Relinquishing Contractors who fail to notify the receiving Contractor or FFS Program of transitioning members with special circumstances will be responsible for covering the members' care for up to 30 days following the transition. Appropriate medical records and Contractor care management and/or provider case management files for the transitioning member shall be transmitted to the receiving Contractor. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor. The Contractor is responsible for coordinating care with the relinquishing Contractor to ensure provision of uninterrupted services, Contractor and service information, emergency numbers, and instructions on how to obtain services. Refer to AMPM Policy 520 and ACOM Policies 401, 402, and 403 for additional Contractor transition requirements. The Contractor shall implement a transition of care policy consistent with the requirements in 42 CFR 438.1216, 42 CFR 438.62(b)(1)-(2), ACOM Policy 402, and AMPM Policy 520. The Contractor shall designate a key staff person with appropriate training and experience to act as the Transition Coordinator. The Transition Coordinator shall interact closely with the Transition Coordinator of the relinquishing Contractor for a safe, timely, and orderly transition. See Section D, Paragraph 15, Staffing Requirements and ACOM Policy 402 for more information regarding the role and responsibilities of the Transition Coordinator. The Contractor shall develop and implement member transition policies and procedures, which include but are not limited to: 1. Members with significant medical conditions such as, a high-risk pregnancy or pregnancy within the third trimester... (pp. 60-61, Amendment #9, Effective October 1, 2020, Section A: Contract Amendment, ACC, AHCCCS)

III.POLICY A. MEMBER TRANSITIONS The Contractor shall identify and facilitate coordination of care for all AHCCCS members during transitions between Contractors, FFS Programs, FFS members transitioning to a Managed Care Organization (MCO), members transitioning to FFS, as well as changes in service areas, subcontractors, and/or health care providers. The Contractor shall implement a transition of care policy as specified in 42 CFR 457.1216, 42 CFR 438.62. Members with special health care needs or circumstances may require additional or distinctive assistance during a period of transition to ensure members do not experience a gap in services. Policies and procedures shall be developed by the Contractor to address these situations. Special circumstances include but are not limited to the following: 1. Pregnancy (especially women who are high risk or in their third trimester)... G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS... 2. Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery shall be allowed the option of continuing to receive services from their established physician and anticipated delivery site through the postpartum visits included in the all-inclusive maternity care as specific in [AMPM Policy 410](#). (p. 1, 6, Effective October 1, 2021, [AMPM Policy 520](#), [AHCCCS Medical Policy Manual Chapter 500 – Care Coordination Requirements](#))

²¹⁴ 1. Members Rights and Responsibilities A. Member Rights and Responsibilities Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, and, upon request, Potential Enrollees. 1) Contractor's written policies regarding Member rights shall include the

following:... c) To be able to choose a Primary Care Provider within the Contractor's Network. (no page #, Effective FY 17-18, Member Services, Exhibit A, Attachment 13, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

²¹⁵ 16. Out-of-Network Providers A. If Contractor's Network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out-of-Network for the Member, for as long as the entity is unable to provide them. Out-of-Network Providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the Network. B. Contractor shall provide for the completion of covered services by a terminated or Out-of-Network Provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to Out-of-Network Providers with whom they have an ongoing relationship if there are no quality of care issues with the Providers and the Providers will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS. D. In determining access to Out-of-Network Providers for mental health or substance use disorder benefits, Contractor must use processes, strategies, evidentiary standards, or other factors that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors for services identified within this Provision, in accordance with 42 CFR 438.910(d)(3). (no page #, Effective FY 17-18, Access and Availability, Exhibit A, Attachment 9, Two Plan Non-CCI Boilerplate; COHS Non-CCI Boilerplate; and GMC Non-CCI Boilerplate)

²¹⁶ See "Ability to obtain care from an out-of-network provider under certain circumstances" column.

²¹⁷ 9.8.3.3. The Contractor shall not impose any limitation on a Member's ability to select or change that Member's PCMP that is more restrictive than the Member's right to disenroll from the Contractor's limited managed care capitation initiative. (p. 63, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

14.4.11.1. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCMP. (p. 97, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

²¹⁸ 7.3.8. 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:... 7.3.8.1.5. Extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network Providers. (p. 41, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

9.4.14. The Contractor shall take actions necessary to ensure that all primary care, Care Coordination, and behavioral health services covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following: 9.4.14.1. Utilizing out-of-network Providers. (pp. 66-67, Effective January 25, 2022, Exhibit B-7, SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

²¹⁹ 9.3.11. The Contractor shall establish policies and procedures with other RAEs to ensure continuity of care for all Members transitioning into or out of the Contractor's enrollment list, guaranteeing that a Member's services are not disrupted or delayed. (p. 66, Effective January 25, 2022, Exhibit M-9, Additional SOW, Amendment #9, Region 1 – Rocky Mountain Health Maintenance Organization, Inc., Executed Agreement)

²²⁰ C.5.17 Selection of Primary Care Providers and Primary Dental Provider C.5.17.1 The Contractor shall allow each Enrollee freedom of choice in selecting a PCP and PDP and the ability to change Providers as requested in accordance with 42 C.F.R. § 438.3(l). These materials shall be provided in accordance with Section C.5.7. (p. 69, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²²¹ C.5.29.1.12 The Contractor shall arrange and administer Covered Services in accordance with section C.5.28 to Enrollees through its network. Where Contractor's network is not able to adequately furnish Covered Services, the Contractor shall arrange for Covered Services to be provided on an out-of-network basis in accordance with this section C.5.29. (p. 109, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

C.5.29.14 Contractor Referrals to Out-of-Network Providers for Services C.5.29.14.1 If the Contractor's network is unable to provide Medically Necessary Services required under the Contract, the Contractor must cover these services through an Out-of-Network Provider until the Contractor establishes a provider agreement. The Contractor shall coordinate with Out-of-Network Providers for authorization and payment in these instances and ensure that cost of the services and transportation to the Enrollee is no greater than it would be if the services were furnished within the Contractor's network. The accessibility standards defined in section C.5.29 are applicable to services provided to Enrollees by Out-of-Network Providers. (p. 121, Effective October 1, 2020, Contract # CW83146, Carefirst BCBS Community Health Plan Executed Agreement, District of Columbia)

²²² 3.9.8.4 PCP Selection or Assignment... 3.9.8.4.3 The Contractor must contact a non-dual member within 15 business days of his/her Enrollment date and provide information on options for selecting a PCP or confirmation that the member has been assigned to the PCP of choice. To the extent provider capacity exists, the Contractor must offer freedom of choice to members in making a selection. (p. 194, Effective 2020, Addendum 1, MCO MSA, Delaware)

²²³ 3.8.1.4 The Contractor shall implement a continuity of care transition plan to provide continuity of care for new members... 3.8.1.4.3... If the member is a pregnant woman in her second or third trimester, the Contractor shall cover prenatal services from the treating provider if located within the distance standard in Section 3.9.17.2 of this Contract through 60 calendar days post-partum. If the treating provider is not located within the distance standards specified in Section 3.9.17.2 of this Contract, the Contractor must cover the service but after a period of 30 calendar days may require the member to transfer to a qualified provider that is located within the distance standards specified in Section 3.9.17.2 of this Contract. (pp. 150-151, Effective 2020, Addendum 1, MCO MSA, Delaware)

²²⁴ 3.8.2 Transitioning between Providers 3.8.2.1 The Contractor shall actively assist members... who are pregnant in transitioning to another provider when there is a change in providers. For DSHP Plus LTSS members, this assistance shall be provided by the member's case manager. For PROMISE participants, the Contractor shall coordinate with the DSAMH care manager as appropriate to assist the member to transition between providers. For members enrolled in the DDDS Lifespan Waiver, the Contractor shall coordinate with the DDDS case manager as appropriate to assist the member to transition between providers. (p. 153, Effective 2020, Addendum 1, MCO MSA, Delaware)

²²⁵ D. Coverage Provisions 1. Primary Care Provider Initiatives a. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall establish a program to encourage enrollees to establish a relationship with their PCP. b. This program shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (s. 409.973(4), F.S.). c. The Managed Care Plan shall offer each enrollee a choice of PCPs. After making a choice, each enrollee shall have a single or group PCP. d. The Managed Care Plan shall allow pregnant enrollees to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP, as specified in Section VIII., Provider Services. (p. 27, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²²⁶ H. Continuity of Care in Enrollment 1. The Managed Care Plan shall provide continuation of services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, in accordance with Attachment II, Section IX.H., Continuity of Care in Enrollment. 2. The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of up to sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first. 3. For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services shall include the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan: a. Prior existing orders; b. Provider appointments (e.g., transportation, dental appointments, surgeries, etc.); c. Prescriptions (including prescriptions at non-participating pharmacies); d. Prior authorizations; e. Treatment plan/plan of care. 4. The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation. 5. The following services may extend beyond the sixty (60) day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient's current provider as described below: a. Prenatal and postpartum care – The Managed Care Plan shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six (6) weeks after birth), regardless of whether the provider is in the Managed Care Plan's network..... (pp. 81-82, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

H. Continuity of Care in Enrollment The Managed Care Plan shall be responsible for continuity of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, including those services previously authorized under the fee-for-service delivery system or by the enrollee's immediate former managed care plan, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers for up to sixty (60) days after the effective date of enrollment. The Managed Care Plan shall reimburse nonparticipating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate. (p. 131, Updated February 2022, AHCA Contract No. FP0XX, Attachment II – Core Contract Provisions, Florida Managed Medical Assistance (MMA) Program)

²²⁷ 5. Provider Termination and Continuity of Care... c. The Managed Care Plan shall allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the completion of postpartum care. (p. 63, Updated February 2022, AHCA Contract No. FP0XX, Attachment II, Exhibit II-A, Florida Managed Medical Assistance (MMA) Program)

²²⁸ 4.1.2.4 Georgia Families Contract RFP #DCH0000100 The Contractor shall offer its Members the freedom of selecting a PCP to serve as a Medical Home. DCH or its Agent will encourage self-selection of a PCP and continuation of any existing satisfactory Provider relationship with the current PCP if the PCP participates in the Contractor's Network. Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a PCP. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO, the Contractor shall Auto-Assign Members to a PCP based on the following Algorithm... 4.1.2.4.5 Pregnant Members may also select an obstetrician as their assigned PCP. If a pregnant Member fails to select an obstetrician, the Contractor may Auto-Assign the Member to an obstetrician, using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity. (p. 58, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²²⁹ 24. Out-of-Network Providers If the Supplier's network is unable to provide Medically Necessary Covered Services to a particular Member, the Supplier shall adequately and timely cover these services Out-of-Network for the Member. The Supplier must inform the Out-of-Network Provider that the Member cannot be balance billed. (p. 408, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²³⁰ 4.11.8.5 Transition of Care 4.11.8.5.1 Contractors shall identify and facilitate transitions for Members that are moving from one CMO to another or from a CMO to a Fee-for-Service provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Contractor shall cooperate with the receiving CMO or FFS

Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to Members who have medical conditions or circumstances such as:... 4.11.8.5.1.2 Pregnant women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date; (p. 150, no date, RFP #DCH0000100, Georgia Families Contract; Georgia Families 360 Contract)

²³¹ 9. The Health Plan shall notify all Members in writing within ten (10) days of selection, assignment, or processed PCP changes. Health Plan shall ensure its auto-assign algorithm includes the following:... f. Allow each Member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP (p. 332, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²³² F. Member Rights 1. The Health Plan shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the Member's right to:... m. Receive services out-of-network if the Health Plan is unable to provide them in-network for as long as the Health Plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network (pp. 390-391, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²³³ 9.3 Health Plan Continuity of Care... C. Transition of Care Policies and Procedures 1. The Health Plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP and submit these policies and procedures for review and approval in accordance with §13.3.B. The transition of care policy shall be consistent with the requirements set forth below. 2. The transition of care policy shall include the following: a. The Member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network (p. 380, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²³⁴ 9.3 Health Plan Continuity of Care A. Transition to Different Health Plan 1. In the event a Member entering the Health Plan is receiving Covered Services that meet Medical Necessity in addition to or other than prenatal services, including Members in the second and third trimester of pregnancy receiving prenatal services described in this section, the day before enrollment into the Health Plan, the Health Plan shall be responsible for the costs of continuation of such services that meet Medical Necessity, without any form of prior approval and without regard to whether such services are being provided by contract or non- contract Providers. Health Plans shall be responsible for services that meet Medical Necessity provided during prior period coverage and retroactive enrollment... 6. In the event the Member entering the Health Plan is in her second or third trimester of pregnancy and is receiving covered prenatal services based on Medical Necessity the day before enrollment, the Health Plan shall be responsible for providing continued access to the prenatal care provider, whether contract or non-contract, through the postpartum period. (pp. 378-379, Effective 2021, Quest Integration (QI) RFP-MQD-2021-008, Hawaii)

²³⁵ 6.2 Network Development and Adequacy 6.2.1 Member Choice Consistent with the requirements in Exhibit F, the Contractor shall maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. The Contractor shall ensure members the right to select the providers of their choice without regard to variations in reimbursement. If a member enrolls with the Contractor and is already established with a provider who is not a part of the network, the Contractor shall make every effort to arrange for the member to continue with the same provider if the member so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. Please see Section 3.3 on specific requirements related to continuity of care. (p. 106, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

²³⁶ 6.2.4 Out of Network Providers With the exception of family planning, emergency services and continuity of care requirements described in Section 3.3, once the Contractor has met the network adequacy standards set forth in Exhibit 8, the Contractor may require all of its members to seek covered services from in-network providers. Prior to closing its network, the Contractor shall seek the Agency approval. The Agency retains sole authority for determining if network access standards have been met and whether the network may be closed. If the Contractor is unable to provide medically necessary covered services to a particular member using contract providers, the Contractor shall adequately and timely cover these services for that member using non-

contract providers for as long as the Contractor's provider network is unable to provide them. The Contractor shall negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to ensure access to covered services. Out-of-network providers shall coordinate with the Contractor with respect to payment at a rate no more than 90% of the rate of reimbursement to in-network providers. The Contractor shall ensure that no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and patient liability as further described in Section 5. The Contractor shall coordinate payment with out-of-network providers and ensure that the cost to the enrollee is no greater than it would be if services were provided within the network. (pp. 108-109, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

²³⁷ 3.3 Continuity of Care The Contractor shall implement mechanisms to ensure the continuity of care of members transitioning in and out of the Contractor's enrollment. Possible transitions include, but are not limited to: (i) initial program implementation; (ii) initial enrollment with the Contractor; (iii) transitions between program Contractors during the first ninety (90) days of a member's enrollment; and (iii) at any time for cause as described in the Section 7.4.1... 3.3.2 Transition Period-Out of Network Care During the first ninety (90) days of the Contract, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Sections 3.3.4 - 3.3.5 and Section 3.3.7, the Contractor shall allow a member who is receiving covered benefits from a nonnetwork provider at the time of Contractor enrollment to continue accessing that provider, even if the network has been closed due to the Contractor meeting the network access requirements. The Contractor is permitted to establish single case agreements or otherwise authorize non-network care past the initial ninety (90) days of the Contract to provide continuity of care for members receiving out-of-network services. The Contractor shall make commercially reasonable attempts to contract with providers from whom an enrolled member is receiving ongoing care. (pp. 67-68, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

²³⁸ 3.3 Continuity of Care The Contractor shall implement mechanisms to ensure the continuity of care of members transitioning in and out of the Contractor's enrollment. Possible transitions include, but are not limited to: (i) initial program implementation; (ii) initial enrollment with the Contractor; (iii) transitions between program Contractors during the first ninety (90) days of a member's enrollment; and (iii) at any time for cause as described in the Section 7.4.1... 3.3.6 Pregnancy Continuity of Care In any Work Plan required by Section 2.13, the Contractor shall develop and implement, a continuity of care policy to address members who are pregnant at the time of enrollment with the Contractor and are receiving services from an out-of-network provider. (pp. 67, 69, Effective 2016, MCO Contract MED-16-018, Amerigroup Iowa, Inc., Iowa Health Link)

²³⁹ 5.8.5. Choice of PCP. Contractor shall afford to each Enrollee a choice of PCP, which may be, where appropriate, a WHCP. Contractor shall provide direct access to a WHCP for routine and preventative women's healthcare Covered Services when a female Enrollee's PCP is not a WHCP. 5.8.6. Specialists as PCPs. Contractor shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special healthcare needs the option of choosing a specialist to be their PCP. Such Enrollees or their Providers may request a specialist as a PCP at any time. Contractor shall contact the Enrollee promptly after the request to schedule an assessment. Contractor's medical director will approve or deny requests after determining whether the Enrollee meets criteria and whether the specialist is willing to fulfill the role and all the obligations of a PCP. (p. 83, Effective 2018, State of IL Model Contract)

²⁴⁰ 5.1 Amount, Duration, and Scope of Coverage. ...Contractor shall provide a mechanism for an Enrollee to obtain a second opinion from a qualified Provider, whether Network or non-Network, at no cost to the Enrollee. Contractor will assist in coordinating and obtaining any second opinion from a non-Network Provider. (p. 64, Effective 2018, State of IL Model Contract)

5.2.6.8 Contractor shall permit any Indian Enrollee to obtain Covered Services from non-Network IHCPs from whom the Enrollee is otherwise eligible to receive such Covered Services. (p. 67, Effective 2018, State of IL Model Contract)

5.7.7. Non-Network Providers. It is understood that in some instances, Enrollees will require specialty care not available from a Network Provider and that Contractor will arrange that such services be provided by a non-Network Provider. In such event, Contractor will promptly negotiate an agreement (single-case agreement) with a non-Network Provider to treat the Enrollee until a qualified Network Provider is available. Contractor shall ensure that any non-Network Provider billing for services rendered in Illinois is enrolled in the HFS Medical Program prior to paying a claim. (pp. 78-79, Effective 2018, State of IL Model Contract)

5.20.1.1 Emergency services. Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by a Network or a non-Network Provider... 5.20.1.2 Post-Stabilization Services. Contractor shall cover Post-Stabilization Services provided by a Network or non-Network Provider in any of the following situations: 5.20.1.2.1 Contractor authorized such services; 5.20.1.2.2 such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to Contractor for authorization of further Post-Stabilization Services; or 5.20.1.2.3 Contractor does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, Contractor could not be contacted, or Contractor and the treating Provider cannot reach an agreement concerning the Enrollee's care and a Network Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until a Network Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care. 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. 5.20.1.4 School dental program. Contractor shall cover dental services that are Covered Services provided in a school for Enrollees who are under the age of twenty-one (21). Contractor shall accept claims from non-Network Providers of such services outside of its Contracting Area. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require the program to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. 5.20.1.5 State-Operated Hospitals (SOH). Contractor shall provide inpatient psychiatric care at an SOH for an Enrollee admitted under civil status, at Medicaid established rates, whether that SOH is a Network or non-Network Provider. Payment shall be made for all days utilized as determined by the DMH and is not subject to the UR determinations or admission authorization standards of Contractor... 5.20.2.1.2 For Illinois school-based health centers outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of school-based health center services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require school-based health centers to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. ... 5.20.2.3.2 For local health departments outside of the Contracting Area, Contractor shall accept claims from non-Network Providers of local health department services. Contractor shall make payment to non-Network Providers of such services according to the Department's applicable Medicaid FFS reimbursement schedule. Contractor may require local health departments to follow Contractor's protocols for communication regarding services rendered in order to further care coordination. (pp. 101-105, Effective 2018, State of IL Model Contract)

²⁴¹ 5.19.1.1 Contractor must offer an initial ninety (90)-day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)-day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)-day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS. Contractor shall pay for Covered Services rendered by a non-Network Provider during the ninety (90)-day transition period at the same rate the Department would pay for such services under the Illinois Medicaid FFS methodology. Non-Network Providers and specialists providing an ongoing course of treatment will be offered agreements to continue to care for an individual Enrollee on a case-by-case basis beyond the transition period if the Enrollee remains outside the Network or until a qualified Network Provider is available. (p. 98, Effective 2018, State of IL Model Contract)

²⁴² 5.19.1.1 Contractor must offer an initial ninety (90)-day transition period for Enrollees new to the Health Plan, in which Enrollees may maintain a current course of treatment with a Provider who is currently not a part of Contractor's Provider Network. Contractor must offer a ninety (90)-day transition period for Enrollees switching from another Health Plan to Contractor. The ninety (90)-day transition period is applicable to all Providers, including Behavioral Health Providers and Providers of LTSS... (p. 98, Effective 2018, State of IL Model Contract)

²⁴³ 6.6 Emergency Care. The Contractor shall cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in 42 CFR 438.114, which relates to emergency and post-stabilization services, and IC 12-15-12 (i.e., subject to the "prudent layperson" standard), shall be available twenty-four (24)-hours-a-day, seven (7)-days-a-week. The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, which sets special responsibilities for hospitals in emergency cases, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor shall also comply with all applicable emergency services requirements specified in IC 12-15-12. The Contractor shall reimburse out-of-network providers at the Medicare rate or, if there is no Medicare rate, at 130% of Medicaid unless other payment arrangements are made. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet

the prudent layperson standard as an emergency medical condition unless the Contractor authorized this treatment. Effective February 1, 2020, the Contractor shall pay the contracted or fee schedule rate for an observation. (p. 72, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

6.14 Out-of-Network Services. With the exception of certain self-referral services described in Section 6.2, and the requirements to allow continuity of care for pregnant women transferring to the Contractor in their third trimester described in Section 3.4, and members with presumptive eligibility seeking initial care, the Contractor may limit its coverage to services provided by in-network providers once the Contractor has met the network access standards set forth in Section 8. However, in accordance with 42 CFR 438.206(b)(4), which relates to coverage of out-of-network services, the Contractor shall authorize and pay for out-of-network care if the Contractor is unable to provide necessary covered medical services within sixty (60)-miles of the member's residence by the Contractor's provider network. In addition, upon at least thirty (30) calendar days' advance notice, the State may also require the Contractor to begin providing out-of-network care in the event the Contractor is unable to provide necessary covered medical services within the Contractor's provider network within specified timeliness standards defined by the State. The Contractor shall authorize these out-of-network services in the timeframes established in Section 9.3.2 and shall adequately cover the services for as long as the Contractor is unable to provide the covered services in-network. The Contractor shall require out-of-network providers to coordinate with the Contractor with respect to payment. Per 42 CFR 438.206(b)(5), the cost to the member for out-of-network services shall be no greater than it would be if the services were furnished in-network. The Contractor may require providers not contracted in the Contractor's network to obtain prior authorization from the Contractor to render any non-self-referral or non-emergent services to Contractor members. If the out-of-network provider has not obtained such prior authorization, the Contractor may deny payment to that out-of-network provider. The Contractor shall cover and reimburse for all authorized, routine care provided to its members by out-of-network providers. The Contractor shall reimburse any out-of-network provider's claim for authorized services at a negotiated rate or according to administrative code 405 IAC 10-9-4 (b) and State statute IC 12-15- 44.5-5. Contractors shall make nurse practitioner services available to members. Members shall be allowed to use the services of nurse practitioners out -of-network if no nurse practitioner is available in the member's service area within the Contractor's network. If nurse practitioner services are available through the Contractor, the Contractor shall inform the member that nurse practitioner services are available. Contractors shall make covered services provided by FQHCs and RHCs available to HIP members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network. The Contractor may not require an out-of-network provider to acquire a Contractor-assigned provider number for reimbursement. An NPI number shall be sufficient for out -of-network provider reimbursement. 6.14.1 Out-of-Network Provider Reimbursement The Contractor shall reimburse any out-of-network provider's claim for authorized services provided to HIP members. Notwithstanding the foregoing, out-of-network services provided to HIP members eligible pursuant to Section 3.3.1 and billed by a hospital provider, shall be reimbursable at standard Medicaid rates, rather than the higher HIP Medicare rates. Contractor must reimburse claims for members who chose the MCE during the HPE application process on the admission date. (pp. 87-88, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

8.2.10 Indian Healthcare Providers. ... the Contractor shall...: Reimburse Indian healthcare providers, whether in- or out-of-network, for covered services provided to AI/AN members who are eligible to receive services from such providers in accordance with the requirements set out in Section 1932(h) of the Social Security Act, 42 U.S.C. 1396u-2(h). The rate of payment shall be set at the Encounter Rate established by the IHS on an annual basis and published in the Federal Register. (p. 124, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

²⁴⁴ 3.4 Pregnancy Coverage under HIP ...When a member enrolls in HIP Maternity in her third trimester of pregnancy, the Contractor shall honor the member's request to continue to receive maternity care from her current physician and reimburse for covered services provided to the member by her current physician, regardless of whether the physician is in the Contractor's network. (p. 37, Effective 2021, Amendment #14, Healthy Indiana Plan Scope of Work for Anthem Insurance Companies Inc.)

²⁴⁵ K. CONTRACTOR(S) must have written policies and procedures for assigning each of its Members to a PCP. The process must include at least the following features: ... 2. If a Member does not select a PCP within ten (10) business days of enrollment, the CONTRACTOR(S) must make an automatic assignment, taking into consideration such factors, if known, as current Provider relationships, language need, cultural competency, and area of residence. The CONTRACTOR(S) may choose to assign new Members to a PCP immediately, notify the Member of that assignment in writing, and allow the Member to change this assignment at any time if it is not acceptable. The CONTRACTOR(S) must notify the Member in writing of his or her PCP's name,

specialty, hospital affiliation, and office telephone number and also notify that the Member may change at any time, for any reason. (p. 23, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.5.2. NETWORK DEVELOPMENT. The CONTRACTOR(S) shall develop, maintain, and monitor a network of Providers that: C. Offers Members a choice of Providers to the extent possible and appropriate. (p. 68, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

5.5.4. CULTURAL COMPETENCY AND HEALTH LITERACY IN THE DELIVERY OF CARE. The Contractor shall... 6. Permit Members to choose any Participating Provider from among the CONTRACTOR(S)' network based on cultural preference. Members may submit grievances to the CONTRACTOR(S) and/or the State related to inability to obtain culturally appropriate care. (pp. 73-74, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

²⁴⁶ 5.5.9. NON-PARTICIPATING PROVIDERS. The CONTRACTOR(S) shall: A. Provide adequate, timely, and medically necessary Covered Services through a Non-Participating Provider if the CONTRACTOR(S)' network is unable to provide adequate and timely services required under this Contract and continue to provide services by a Non-Participating Provider until a Participating Provider is available. B. Provide documentation to the State on a quarterly basis describing the need to rely on Non-Participating Providers for the delivery of Covered Services for each Non-Participating Provider claim paid. G. Arrange for the service to be provided outside the network, if a qualified Provider is available, if a Member needs a specialized, medically-necessary Covered Service that is not available through the network. H. The CONTRACTOR(S) must permit American Indian Members to obtain Covered Services under this Contract from non-participating IHCPs from whom the Member is otherwise eligible to receive such services. I. The CONTRACTOR(S) must permit a non-participating IHCP to refer an American Indian Member to a Participating Provider. J. Ensure that the CONTRACTOR(S)' Provider network adheres to the following: 1. Provides female Members with direct access to a women's health specialist within the Provider 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 women's health specialist. 2. Provides for a second option from a Participating Provider, or arranges for the Member to obtain one outside the network at no cost to the Member. 3. Demonstrates that its network includes sufficient family planning Providers to ensure timely access to Covered Services. (pp. 82-83, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

²⁴⁷ 5.5.5.2. PRIMARY CARE PROVIDER STANDARDS CONTRACTOR(S) must adhere to the following requirements:... E. Ensure individuals who transition to the CONTRACTOR(S) for their physical health from another CONTRACTOR(S) and who have an established relationship with a PCP that does not participate in the CONTRACTOR(S)' Provider network, the CONTRACTOR(S) will provide, at a minimum, a six (6)-month transition period in which the individual may continue to seek care from their established PCP while the individual and the CONTRACTOR(S) finds an alternative PCP within the CONTRACTOR(S)' Provider network. (p. 75, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

²⁴⁸ 5.5.5.2. PRIMARY CARE PROVIDER STANDARDS. CONTRACTOR(S) must adhere to the following requirements: ...F. Offer pregnant Members a choice to be assigned a PCP that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member's continuity of care. (p.75, Effective 2018, KS Medicaid Managed Care RFP for Kancare 2.0)

²⁴⁹ 22.9 Enrollee Rights and Responsibilities. The Contractor's written policies and procedures that are designed to protect the rights of Enrollees, in accordance with federal and state law, shall include, without limitation, the right to: ...B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner. (p. 93, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

23.2 Enrollee Choice of Primary Care Provider. Enrollees shall choose or have the Contractor select a PCP for their medical home. (p. 94, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

23.3 Enrollees without SSI An Enrollee without SSI shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the Contractor's Network or (2) stay with their current PCP as long as such PCP is affiliated with the Contractor's Network. Each Enrollee shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee. ... The Contractor shall have procedures for serving Enrollees from the date of notification of Enrollment, whether or not the Enrollee has selected a PCP. The Contractor shall send Enrollees a written explanation of the PCP selection process within ten (10) Business Days of receiving Enrollment notification from the Department, either as a part of the Enrollee Handbook or by separate mailing. Enrollees will be asked to select a PCP by contacting the Contractor's Enrollee Services department with their selection. The written communication shall include the timeframe for selection of a PCP, an explanation of the process for assignment of a PCP if the Enrollee does not select a PCP and information on where to call for assistance with the selection process. (p. 95, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

²⁵⁰ 28.2.14 Out-of-Network Providers If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206. The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only. (p. 120, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

30.1 Medicaid Covered Services. If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206. The Contractor shall coordinate with Out-of-Network Providers with respect to payment. The Contractor will ensure that cost to the Enrollee is no greater than it would be if the services were provided within the Contractor's Network. (p. 130, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

32.4 Out-of-Network Emergency Care The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network in compliance with 42 C.F.R. 438.114. Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid Fee-For-Service rate as required by Section 6085 of the Deficit Reduction Act of 2005. For services provided by non-contracting hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in Fee-For-Service payments. (p. 146, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

²⁵¹ 32.5 Maternity Care. When a woman has entered prenatal care before enrolling with the Contractor, the Contractor shall make every effort to allow her to continue with the same prenatal care provider throughout the entire pregnancy. Contractor shall also establish procedures to ensure either prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant when they enroll. The Contractor shall provide maternity care that includes prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. All newborn Enrollees newborn screening shall be covered as specified in the Commonwealth of Kentucky metabolic screen. (p. 146, Effective January 2021, Aetna Better Health of Kentucky Master Agreement Modification)

²⁵² 7.8.1. Assignment of Primary Care Providers 7.8.1.1. As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of MCO . 7.8.1.2. If the choice of MCO is not indicated on the new eligible file transmitted by LDH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of MCO and if available the PCP of choice. 7.8.1.3. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in an MCO. 7.8.1.4. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to the MCO. 7.8.1.5. The MCO shall confirm the PCP selection information in a written notice to the member. 7.8.1.6. If no PCP is selected on the Member File received from the Enrollment Broker, the MCO shall contact the member, as part of the welcome call, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP or auto assign a PCP; 7.8.1.7. Inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members, as appropriate. 7.8.1.8. Members, for whom an MCO is the primary payor, who do not proactively choose a PCP will be auto-assigned to a PCP by the MCO. Members, for whom an MCO is a secondary payor,

will not be assigned to a PCP by the MCO, unless the members request that the MCO do so. ... 7.8.1.10. If the member does not select a PCP and is auto assigned to a PCP by the MCO, the MCO shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause. 7.8.1.11. Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve months (12) months beginning from the original date the member was assigned to the MCO. 7.8.1.12. If a member requests to change his or her PCP with cause, at any time during the enrollment period, the MCO must agree to grant the request. 7.8.1.13. The MCO shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The MCO shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP. 7.8.1.14. The MCO shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the MCO signs the Contract with LDH. 7.8.1.15. The MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination. 7.8.1.16. The MCO shall have written policies and procedures for handling the assignment of its members to a PCP. The MCO is responsible for linking to a PCP all assigned MCO members for whom the MCO is the primary payor. (pp. 125-126, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

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6.29.2. The MCO shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements: ... 6.29.2.2. Process for member referral to an out-of-network provider when there is no provider within the MCO's provider network who has the appropriate training or expertise to meet the particular health needs of the member Page 94 6.30.2. The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements: ... 6.30.2.5. Coordinate care for out-of-network services, including specialty care services. (p. 95, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

7.8.15.3. The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services. (p. 134, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

9.5. Reimbursement to Out-of-Network Providers 9.5.1. The MCO shall make payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of such services. The MCO shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the MCO to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate. 9.5.2. For services that do not meet the definition of emergency services, the MCO is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.3 and 9.4). The MCO may require prior authorization of out-of-network services, unless services are required to treat an emergency medical condition. (p. 177, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

²⁵⁴ 6.34. Continuity of Care for Individuals with Special Health Care Needs In the event a Medicaid or CHIP eligible entering the MCO is receiving medically necessary covered services, the day before MCO enrollment, the MCO shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider. (p. 163, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

6.32. Continuity of Care for Pregnant Women 6.32.1. In the event a member entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider. 6.32.2. In the event a member entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health. 6.32.3. In the event a member entering the MCO is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period. 6.32.4. The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services. (pp. 97-98, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

²⁵⁵ 6.32. Continuity of Care for Pregnant Women 6.32.1. In the event a member entering the MCO is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The MCO shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider. 6.32.2. In the event a member entering the MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before MCO enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health. (pp. 97-98, Effective October_2019, Appendix B, LA Medicaid Managed Care Organization Statement of Work for Aetna Better Health)

²⁵⁶ E. PCP Selection, Assignment, Transfers and Responsibilities 1. PCP Selection The Contractor shall: a. Allow each Enrollee to choose his or her PCP and other health care professionals to the extent possible and appropriate (p. 59, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

²⁵⁷ F. The Enrollee Information, shall include, but not be limited to, a description of the following: ... 8) The extent to which, and how, Enrollees may obtain benefits, including Emergency Services and family planning services, from out-of-network providers. (p. 52, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

2. Out-of-Network Access The Contractor shall maintain and utilize protocols to address situations when the Provider Network is unable to provide an Enrollee with appropriate access to MCO Covered Services due to lack of a qualified Network Provider within reasonable travel time of the Enrollee's residence as defined in Section 2.9.C. The Contractor's protocols must ensure, at a minimum, the following: a. If the Contractor is unable to provide a particular MCO Covered Service through a Network Provider, it will be adequately covered in a timely way out-of-network; b. When accessing an out-of-network provider, the Enrollee is able to obtain the same service or to access a provider with the same type of training, experience, and specialization as within the Provider Network; c. That out-of-network providers must coordinate with the Contractor with respect to payment, ensuring that the cost to the Enrollee is no greater than it would be if the services were furnished through the Provider Network; d. That the particular service will be provided by the most qualified and clinically appropriate provider available; e. That the provider will be located

within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location; f. That the provider will be informed of his or her obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in his or her primary language; g. That the only Provider available to the Enrollee in the Provider Network does not, because of moral or religious objections, decline to provide the service the Enrollee seeks; h. That consideration is given for an out-of-network option in instances in which the Enrollee's Provider(s) determines that the Enrollee needs a service and that the Enrollee would be subjected to unnecessary risk if the Enrollee received those services separately and not all of the related services are available within the Provider Network; and i. That the Contractor cover services furnished in another state in accordance with 42 CFR 431.52(b) and 130 CMR 450.109 (pp. 137-138, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

I. Indian Enrollees and Indian Health Care Providers All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. See also 42 CFR 438.14. 1. The Contractor shall offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain MCO Covered Services from out-of-network Indian Health Care Providers from whom the enrollee is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider (p. 285, Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

²⁵⁸ C. Continuity of Care for New Enrollees The Contractor shall develop and implement policies and procedures to ensure continuity of care for new Enrollees that are enrolling with the Contractor from another MassHealth-contracted MCO, an Accountable Care Partnership Plan, a Primary Care ACO, another MassHealth-contracted ACO, or the MassHealth PCC Plan. Such policies and procedures: 1. Shall be for the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary services; 2. Shall address continuity of care for all such Enrollees and include specific policies and procedures for the following individuals at a minimum: a. Enrollees who, at the time of their Enrollment: 1) Are pregnant; ... h. For pregnant Enrollees, the following: 1) If a pregnant Enrollee enrolls with the Contractor during a transition period after the Contract Effective Date, to be specified by EOHHS, such Enrollee may choose to remain with her current provider of obstetrical and gynecological services, even if such provider is not in the Contractor's Provider Network; 2) The Contractor is required to cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network; and 3) However, if a pregnant Enrollee would like to select a new Provider of obstetrician and gynecological services within the Contractor's Provider Network, such Enrollee may do so. (pp. 26, 28-29 Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

²⁵⁹ C. Continuity of Care for New Enrollees The Contractor shall develop and implement policies and procedures to ensure continuity of care for new Enrollees that are enrolling with the Contractor from another MassHealth-contracted MCO, an Accountable Care Partnership Plan, a Primary Care ACO, another MassHealth-contracted ACO, or the MassHealth PCC Plan. Such policies and procedures: 1. Shall be for the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary services; 2. Shall address continuity of care for all such Enrollees and include specific policies and procedures for the following individuals at a minimum: a. Enrollees who, at the time of their Enrollment: 1) Are pregnant; ... h. For pregnant Enrollees, the following: 1) If a pregnant Enrollee enrolls with the Contractor during a transition period after the Contract Effective Date, to be specified by EOHHS, such Enrollee may choose to remain with her current provider of obstetrical and gynecological services, even if such provider is not in the Contractor's Provider Network; 2) The Contractor is required to cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network; and 3) However, if a pregnant Enrollee would like to select a new Provider of obstetrician and gynecological services within the Contractor's Provider Network, such Enrollee may do so. (pp. 26, 28-29 Effective 2022, Attachment A, 4th Amended and Restated Tufts MCO Contract)

²⁶⁰ C. Enrollee Rights 1. To permit each Enrollee to choose his or her network provider to the extent possible and appropriate, as set forth in COMAR 10.67.05.05 (Appendix O). (p. 7, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

.05 Access Standards: PCPs and MCO's Provider Network. A. Primary Care Provider (PCP). (1) An MCO shall assign each enrollee to a primary care provider who is: (a) Chosen by the enrollee from the MCO's panel of qualified providers; or (b) Chosen by the MCO from its panel of qualified providers if the enrollee has failed to choose a PCP. (2) An enrollee may request a change of PCP at any time if the PCP is within the recipient's current MCO's panel of providers. (p. 188, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

²⁶¹ AGREEMENT TO PAY FQHCs FOR OUT-OF-NETWORK EMERGENCY SERVICES I. PAYMENT REQUIREMENTS A. Effective October 1, 2010, an MCO shall reimburse an out-of-network federally qualified health center (FQHC) for services provided to an Enrollee that are immediately required due to an unforeseen illness, injury, or condition if: 1. The FQHC participates in the Medical Assistance Program; 2. The FQHC does not have a contract with the MCO; 3. The services are immediately required due to the Enrollee's unforeseen illness, injury, or condition; 4. The emergent services are provided on site at the FQHC; and 5. The FQHC has, before rendering services, verified with the Enrollee's primary care provider that the Enrollee cannot be seen within a reasonable amount of time based on the severity of the Enrollee's condition. (p. 51, Effective January 2022, Maryland HealthChoice Managed Care Organization Agreement)

²⁶² E. Primary Care Provider (PCP) Selection... 2. Contractor must provide all Enrollees the opportunity to select their PCP at the time of enrollment. a. When an Enrollee chooses a PCP, Contractor must assign the Enrollee to the PCP of his or her choice as indicated on the HIPAA 834 daily enrollment file from MDHHS (5970). b. Enrollee may choose a clinic as their PCP provided that the Provider files submitted to MDHHS's Enrollment Services Contractor is completed consistent with MDHHS requirements and the clinic has been approved by MDHHS to serve as a PCP. c. Contractor must allow CSHCS Enrollees to remain with their established PCP at the time of enrollment with the Contractor not limited to Network Providers; upon consultation with the family and care team, CSHCS Enrollees may be transitioned to an in-network PCP. 3. When the Enrollee does not choose a PCP at the time of enrollment, the Contractor must assign a PCP no later than 30 Days after the effective date of enrollment. a. The assigned PCP must be within travel standards in Appendix 14 based on the PCP location compared to the Enrollee's home with the following exceptions: i. The Enrollee is CSHCS-eligible and a PCP over the travel standards to the Enrollee's home is the most appropriate for the Enrollee. ii. Contractor has been approved by MDHHS for an exception to the travel time and distance requirements for that particular Provider type and Region according to criteria in Appendix 14 and is able to document that no other Network Provider. (p. 40, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

²⁶³ D. Rural Area Exception... b. Enrollees have the option of obtaining services from any other Network or non-network provider if the following conditions exist: i. The Covered Service, practitioner, or specialist is not available within the Contractor's network. ii. The provider is not part of the network but is the main source of a service to the Enrollee. iii. The only provider available to the Enrollee does not, because of moral or religious objections, provide the service the Enrollee seeks. iv. Related services must be performed by the same provider and all of the services are not available within the Network. v. MDHHS determines other circumstances that warrant Out-of- Network treatment. (p. 26, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

3. If an Indian Health Facility or I/T/U provider is contracted with the Contractor, American Indian/Alaska Native who are Enrollees must be allowed to choose the I/T/U provider as their PCP as long as the provider has capacity to provide the services. If the I/T/U is not contracted with the Contractor, American Indian/Alaska Native must still be allowed to use the provider without authorization. (pp. 44-45, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

²⁶⁴ V. Access and Availability of Providers and Services... H. Pregnant Women 1. Contractor must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice. 2. Contractor must allow pregnant women to receive all Medically Necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in Network Provider. 3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate. 4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 41, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

²⁶⁵ V. Access and Availability of Providers and Services... H. Pregnant Women 1. Contractor must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice. 2. Contractor must allow pregnant women to receive all Medically Necessary obstetrical and prenatal care without prior authorization regardless of whether the provider is a contracted in Network Provider. 3. In the event that the Contractor does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate. 4. Contractor must provide dental services administered through Contractor's managed care structure to non-HMP Enrollees during the Enrollee's pregnancy and postpartum period. (p. 42, Effective FY 2021, State of Michigan Comprehensive Health Care Program Managed Care Contract)

²⁶⁶ 3.11.3 Provider Access Changes. The MCO shall not make any substantive changes in its method of Provider access during the term of this Contract, unless approved in advance by the STATE. For the purposes of this section, a substantive change in the method of Provider access means a change in the way in which an Enrollee must choose his or her Primary Care Provider (clinic) and his or her physician specialists. Examples of methods of Provider access include, but are not limited to: 1) Enrollee has open access to all Primary Care Providers (clinics); 2) Enrollee may self-refer to a physician specialist; 3) Enrollee must choose one Primary Care Provider (clinic); and 4) Enrollee must receive a referral to a physician specialist from his or her Primary Care Provider (clinic). For the purposes of this section, a substantive change in the method of Provider access shall not include the addition or deletion of Service Authorization requirements for services. (p. 52, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

²⁶⁷ 6.14 SERVICES RECEIVED AT INDIAN HEALTH CARE PROVIDERS. 6.14.1 Access to Indian Health Care Providers. American Indian Medical Assistance and MinnesotaCare Enrollees, living on or off a reservation, will have direct Out of Network access to IHCPs for services that would otherwise be covered under Minnesota Statutes, §256B.0625, even if such facilities are not Network Providers including IHCPs that are located out of Minnesota. The MCO shall not require any Service Authorization or impose any condition for an American Indian to access services at such facilities. This includes the right of the American Indian Enrollee to choose an IHCP as a Primary Care Provider, if the IHCP is a Network Provider. [42 CFR §438.14(b)(3)] (p. 144, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

6.17 OUT OF NETWORK AND OUT OF SERVICE AREA CARE. If the Provider Network is unable to provide necessary services, covered under the contract, to a particular Enrollee, the MCO must adequately and timely cover these services Out of Network for the Enrollee, for as long as the MCO's Network is unable to provide them. The MCO shall cover Medically Necessary Out of Network or Out of Service Area services received by an Enrollee when one of the following occurs: 6.17.1 The Enrollee requires Medical Emergency Services; 6.17.2 The Enrollee requires Post-Stabilization Care Services to maintain, improve or resolve the Enrollee's condition; 6.17.3 The Enrollee is Out of Service Area and requires Urgent Care [Minnesota Rules, Part 4685.1010, subp. 2, (G), and subp. 7]; 6.17.4 The Enrollee is Out of Network or Out of Service Area and in need of non-emergency medical services that are or have been prescribed, recommended, or are currently being provided by a Network Provider. The MCO may require Service Authorization; 6.17.5 The Enrollee moves out of the Service Area and this change is entered on MMIS after the Cut-Off Date, and a payment has been or will be made to the MCO for coverage for the Enrollee for that same or next month; or 6.17.6 Pregnancy-related services the Enrollee receives in connection with an abortion, including, but not limited to transportation and interpreter services. [42 CFR §438.206] (pp. 146-147, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

²⁶⁸ 6.18.3 Provider Termination Not for Cause or Enrollee New to MCO... 6.18.3.2 Services Previously Service Authorized. The MCO shall provide Enrollees Medically Necessary Covered Services that an Out of Network or Out of Service Area provider, another MCO, or the STATE had Service Authorized before enrollment in the MCO. The MCO may require the Enrollee to receive the services by an MCO Provider, if such a transfer would not create undue hardship on the Enrollee and is clinically appropriate. Transition services relating to orthodontia care, mental health services, at-risk pregnancy services, and substance use disorder services are covered as described in the below paragraphs of this section. (p. 148, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

²⁶⁹ 6.18.3 Provider Termination Not for Cause or Enrollee New to MCO... 6.18.3.4 At Risk Pregnancy. When the Beneficiary enrolls in the MCO while in her third trimester of pregnancy, and her non-Network physician has reported her pregnancy to be at-risk on a standardized prenatal assessment, the MCO must authorize the care by non-Network Providers for services related to prenatal care and delivery, including Inpatient Hospitalization costs for the mother and Child. The MCO is not responsible for additional Out of Network care for the mother and Child after discharge from the hospital. (pp. 148-149, Effective January 2022, Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare with F&C MCO 2, Inc.)

²⁷⁰ The health plan shall contact the member within five (5) business days from the date of the state agency's notification to the health plan of the member's anticipated enrollment date. To the extent provider capacity exists, the health plan shall offer freedom of choice to members in making a primary care provider selection. (p. 86, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

²⁷¹ 2.5.8 Direct Access and Standard Referrals: a. The health plan shall have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain: 1) A referral to an out-of-network provider when the health plan does not have a health care provider in the network with appropriate training or experience to meet the particular health care needs of the member; (p. 37, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

²⁷² d. Facilitate continuity of care for medically necessary covered services. In the event a member entering the health plan is receiving medically necessary covered services, in addition to or other than prenatal services (see below for members in their third trimester receiving prenatal services), the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. The health plan shall provide continuation of such services for the lesser of (1) sixty (60) calendar days, or (2) until the member has transferred, without disruption of care, to an in-network provider. For members eligible for care management, the new health plan shall provide continuation of services authorized by the prior health plan for up to sixty (60) calendar days after the member's enrollment in the new health plan and shall not reduce services until an assessment supporting services reduction is conducted by the new health plan. (p. 39, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

²⁷³ g. Allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network), without any form of prior authorization, through the postpartum period (defined as sixty (60) calendar days from date of birth). h. Allow pregnant members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility. (p. 39, Addendum No. 5, Effective FY 2019, MO HealthNet Managed Care Contract)

²⁷⁴ B. Choice of a Network Provider The Contractor shall offer each Member the opportunity to choose from at least two (2) network Primary Care Providers (PCPs). (p. 44, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

²⁷⁵ 11. Emergency Medical Care:... Information indicating that Emergency Services are available without Prior Authorization and out-of-network Emergency Services are available without any financial penalty to the Member; e. (p. 76, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

J. Reimbursement... The Contractor shall be responsible for full payment for services received by Members from Out-of-network Providers because the Contractor's services were not available as required pursuant to the terms of this Contract. (p. 113, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

SECTION 8 – INDIAN HEALTH SERVICES/TRIBAL 638/URBAN INDIAN HEALTH... Indian Members shall be permitted to obtain services covered under this Contract from out-of-network Indian Health Care Providers from whom the Member is otherwise eligible to receive such services... The Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a network provider. (pp. 116-117, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

2. Care Management Services... In addition, the Contractor must develop and adopt policies and procedures to address the following:... h. Ensuring that when a Provider is no longer available through the Contractor, the Contractor allows Members who are receiving an ongoing course of treatment to access services from Out-of-network Providers for sixty (60) calendar days. (pp. 120-121, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

²⁷⁶ In the event a Member entering the Contractor, either as a new Member or transferring from another Contractor, is receiving medically necessary services in addition to or other prenatal services the day before enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a Network Provider or non-contract providers. For medically necessary covered services, the Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the Member may be reasonably transferred without disruption to a Network Provider, whichever is less. The Contractor may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider. For medically necessary covered services being provided by a Network Provider, the Contractor shall provide continuation of such services from that provider. Members who are transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, or currently providing prenatal services has terminated participation with the Contractor, will receive continuation of coverage for such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less. For members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care provider and any provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder through the postpartum period. (pp. 125-126, Effective July 2017, MSCAN Magnolia Health Plan Inc. Managed Care Executed Contract)

²⁷⁷ 10.3.2 Primary Care(B) MCO shall allow Enrollees the opportunity to select a Network Primary Care Provider. Selecting a Primary Care Provider is not a requirement for participation in the Health Plan. (p. 95, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

²⁷⁸ 12.4.1 Covered Services Received Out-of-Network but Paid by MCO (A) MCO shall not be required to pay for Covered Services when the Enrollee receives the services from Out-of-Network Providers, not arranged for and not authorized by MCO except as follows: (1) Emergency Services;... (3) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable in the MCO Network. (p. 109, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

5.1.4 Out-of-Network Services ... (B) Enrollees must have the option of obtaining Medically Necessary Covered Services from any Out-of-Network Provider, if the following conditions exist: (1) All services must be Medically Necessary; (2) The type of service is not available from a Network Provider or the MCO Network does not include the type of specialist required for the Medically Necessary care; (3) The treating Provider is an Out-of-Network Provider, but is the main source of a service to the Enrollee; (4) The only Network Provider available to the Enrollee does not provide, because of moral or religious objections, the service the Enrollee seeks; (5) Related services must be performed by the same Provider, and none of the services received are available within the MCO Network; (6) MCO determines other circumstances warrant receiving Covered Services from an Outof-Network Provider; (7) The Enrollee requires Emergency Services; (8) The Enrollee requires post-stabilization care services to maintain, improve, or resolve the Enrollee's condition. MCO shall continue coverage until: (a) a Network Provider assumes responsibility for the Enrollee's care; (b) MCO reaches an agreement with the treating Provider concerning the Enrollee's care; (c) MCO has contacted the treating Provider to arrange for a transfer; or (d) the Enrollee is discharged; (9) The Enrollee is out of the MCO Service Area and requires urgent care; (10) The Enrollee seeks Family Planning Services; or (11) All services must be rendered within the United States. (pp. 46-47, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

²⁷⁹ 3.4.3 Enrollees Receiving Out-of-Network Care Prior to Initial Enrollment A) If the Enrollee receives Covered Services by an Out-of-Network Provider after the first day of the month for which a per member, per month (PMPM) premium is paid, MCO and STATE shall determine if an Enrollee could have reasonably known that the Provider was an Out-of-Network Provider. The Enrollee will be deemed to not reasonably have known that the Provider was an Out-of-Network Provider if MCO orientation, either in person, by telephone, or by writing through the Enrollee packet, had not taken place prior to the Enrollee receiving such services. (B) If STATE and MCO determine that an Enrollee could not have reasonably known that a Provider was an Out-of-Network Provider based on the above criteria, MCO shall reimburse the Out-of-Network Provider at the established MCO rate in effect on the date of service for paying Network Providers or the Maximum Allowed Amount. (C) In cases of eligibility for the three (3) month prior period, where the Enrollee could not reasonably have known that the Provider was an Out-of-Network Provider based on the above criteria, MCO shall reimburse the Out-of-Network Provider at the established MCO rate in effect on the date of service for paying Network Providers or the Maximum Allowed Amount. (pp. 27-28, Amendment B, Effective January 2020, North Dakota Sanford Health Plan Managed Care Executed Contract)

²⁸⁰ PCP Assignment...the MCO must...Inform the member that each family member has the right to choose his/her own PCP... (p. 2347, no date, Nebraska Medicaid Managed Care RFP)

²⁸¹ In developing its network, the MCO shall consider the following:.. 4.7.1.2.8 Adequacy of the primary care network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients; (pp. 158-159, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

4.3.4.3 The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(1)] In instances in which the Member does not select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member. (p. 111, -Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

²⁸² 4.7.9.4 The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and: 4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days; 4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery; 4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations. (p. 173, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

²⁸³ 4.7.9 Access to Providers During Transitions of Care 4.7.9.1 The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows: ... 4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester. ... 4.7.9.2 The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with DHHS) or another type of health insurance coverage and: 4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first; 4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery; 4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the

terminal illness or its medical manifestations. (pp. 172-173, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

²⁸⁴ 4.7.9.13 To minimize disruptions in care, the MCO shall: 4.7.9.13.1 With the exception of Members in their second or third trimester of pregnancy, provide continuation of the terminating Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less; and 4.7.9.13.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period. (p. 175, Exhibit A, Amendment #8, Effective FY 2023, AmeriHealth Caritas New Hampshire Inc. Medicaid Care Management Services Contract Contract)

²⁸⁵ C. PCP Selection. The Contractor shall provide the enrollee with the opportunity to select a PCP. If no selection is made by the enrollee, the Contractor shall assign the PCP for the enrollee according to the timeframes specified in Article 5.9. If the enrollee selects a PCP, the Contractor shall process the selection. The Contractor is responsible for monitoring the PCP capacity and limitations prior to assignment of an enrollee to a PCP. The Contractor shall notify the enrollee accordingly if a selected PCP is not available. The Contractor shall notify the PCP of newly assigned enrollees or any other enrollee roster changes that affect the PCP monthly by the second working day of the month. (p. 5, Article 3, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

PCP SELECTION AND ASSIGNMENT The Contractor shall place a high emphasis on ensuring that enrollees are informed and have access to enroll with traditional and safety net providers. The Contractor shall place a high priority on enrolling enrollees with their existing PCP. If an enrollee does not select a PCP, the enrollee shall be assigned to his/her PCP of record (based upon prior history information) if that PCP is still a participating provider with the Contractor. All contract materials shall provide equal information about enrollment with traditional and safety net providers as that provided about Contractor operated offices. All materials, documents, and phone scripts shall be reviewed and approved by the Department before use. 5.9.1 INITIAL SELECTION/ASSIGNMENT A. General. Each enrollee in the Contractor's plan shall be given the option of choosing a specific PCP in accordance with Articles 4.5 and 4.8 within the Contractor's provider network who will be responsible for the provision of primary care services and the coordination of all other health care needs through the mechanisms listed in this Article. The HBC will provide the Contractor with information, when available, of existing PCP relationships via the Plan Selection Form. The Contractor shall, at the enrollee's option, maintain the PCP-patient relationship. B. PCP Selection. The Contractor shall provide enrollees with information to facilitate the choice of an appropriate PCP. This information shall include, where known, the name of the enrollee's provider of record, and a listing of all participating providers in the Contractor's network. (See Article 4.8.4 for a description of the required listing.) C. PCP Assignment. If the Contractor has not received an enrollee's PCP selection within ten (10) calendar days from the enrollee's effective date of coverage or the selected PCP's panel is closed, the Contractor shall assign a PCP and deliver an ID card by the fifteenth (15th) calendar day after the effective date of enrollment. The assignment shall be made according to the following criteria, in hierarchical order: 1. The enrollee shall be assigned to his/her current provider, if known, as long as that provider is a part of the Contractor's provider network. 2. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, as defined in Article 4.8.8. If the language and/or cultural needs of the enrollee are known to the Contractor, the enrollee shall be assigned to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts. 5.9.2 PCP CHANGES A. Enrollee Request. Any enrollee or, where applicable, authorized person dissatisfied with the PCP selected or assigned shall be allowed to reselect or be assigned to another PCP. Such reassignment shall become effective no later than the beginning of the first month following a full month after the request to change the enrollee's PCP. (p. 21, Article 5, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

²⁸⁶ I. Non-Participating Providers. 1. The Contractor shall pay for services furnished by non-participating providers to whom an enrollee was referred, even if erroneously referred, by his/her PCP or network specialist. Under no circumstances shall the enrollee bear the cost of such services when referral errors by the Contractor or its providers occur. It is the sole responsibility of the Contractor to provide regular updates on complete network information to all its providers as well as appropriate policies and procedures for provider referrals. (p. 4, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

²⁸⁷ F. Existing Plans of Care. The Contractor shall honor and pay for services in interim and established plans of care for new enrollees or when a new benefit is added as a covered service, including MLTSS services, prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other on-going services initiated prior to enrollment with the Contractor. Services shall be continued until the enrollee is evaluated by his/her primary care physician, his/her treatment plan changes, and/or a comprehensive needs assessment is completed and an updated plan of care is developed. If the member is receiving State Plan Services (i.e. PCA, PDN, MDC), authorization for services must remain in place until face-to-face re-assessments are completed. For MLTSS Members, services must remain in place until a face-to-face assessment is conducted by the Care Manager and an individualized plan of care is developed to meet the Member's assessed needs. Contractor Exception: Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or participating HMO provider will always be covered by the HMO regardless of the treatment plan established by the HMO. The HMO's formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed. The Contractor shall use its best efforts to contact the new enrollee or, where applicable, authorized person and/or Contractor Care Manager. However, if after documented, appropriate and reasonable outreach (i.e., through mailers, certified mail, use of MEDM system provided by the State, contact with the Medical Assistance Customer Center (MACC), DDD, or DCP&P/DCF to confirm addresses and/or to request assistance in locating the enrollee) the enrollee fails to respond within 20 working days of certified mail, the Contractor may cease paying for the pre-existing service until the enrollee or, where applicable, authorized person, contacts the Contractor for reevaluation. For contacting MLTSS Members, the Contractor shall comply with Article 9.3.7. (p. 2, Article 4, Effective 2021, New Jersey Medicaid Managed Care HMO Model Contract)

²⁸⁸ 4.8.6.1 Initial Enrollment. At the time of enrollment, the CONTRACTOR shall ensure that each Member has the freedom to choose a PCP within a reasonable distance from the Member's place of residence. The process whereby a CONTRACTOR assigns Members to PCPs shall include at least the following features: ...4.8.6.1.2 The CONTRACTOR shall contact pregnant Members within five (5) Business Days of processing an enrollment file that designates the Member as pregnant to assist the Member in selecting a PCP; (p. 111, no date, New Mexico Amended Version Sample RFP)

²⁸⁹ 4.8.8 Specialty Providers for approval. The CONTRACTOR shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the Members are met within the CONTRACTOR's provider network. The CONTRACTOR shall also have a system to refer Members to Non-Contract Providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the network. (p. 115, no date, New Mexico Amended Version Sample RFP)

²⁹⁰ 4.4.16.3 Transition of Care Requirements for Pregnant Women 4.4.16.3.1 In the event a Member entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the CONTRACTOR's MCO, the CONTRACTOR shall be responsible for providing continued access to the prenatal care Provider (whether Contract or Non-Contract Provider) through the postpartum period, without any form of prior approval. 4.4.16.3.2 In the event a Member entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery without any form of prior approval and without regard to whether such services are being provided by a Contract or Non-Contract Provider for up to sixty (60) Calendar Days from the Member's enrollment or until the Member may be reasonably transferred to a Contract Provider without disruption in care, whichever is less. 4.4.16.3.3 If the Member is receiving services from a Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period. 4.4.16.3.4 If the Member is receiving services from a Non-Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the Member to a Contract Provider without impeding service delivery that might be harmful to the Member's health in accordance with this Section 4.4.16.3. 4.4.17 Transfer from the Health Insurance Exchange 4.4.17.1 The CONTRACTOR must minimize disruption of care and ensure uninterrupted access to Medically Necessary Services for individuals transitioning between Medicaid and Qualified Health Plan coverage on the Health Insurance Exchange. 4.4.17.2 At a minimum, the CONTRACTOR shall establish transition guidelines for the following individuals: 4.4.17.2.1 Pregnant women (pp. 77-78, no date, New Mexico Amended Version Sample RFP)

²⁹¹ 4.4.16.3 Transition of Care Requirements for Pregnant Women 4.4.16.3.1 In the event a Member entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the CONTRACTOR's MCO, the CONTRACTOR shall be responsible for providing continued access to the prenatal care Provider (whether Contract or Non-Contract Provider) through the postpartum period, without any form of prior approval. 4.4.16.3.2 In the event a Member entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery without any form of prior approval and without regard to whether such services are being provided by a Contract or Non-Contract Provider for up to sixty (60) Calendar Days from the Member's enrollment or until the Member may be reasonably transferred to a Contract Provider without disruption in care, whichever is less. 4.4.16.3.3 If the Member is receiving services from a Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period. 4.4.16.3.4 If the Member is receiving services from a Non-Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the Member to a Contract Provider without impeding service delivery that might be harmful to the Member's health in accordance with this Section 4.4.16.3. 4.4.17 Transfer from the Health Insurance Exchange 4.4.17.1 The CONTRACTOR must minimize disruption of care and ensure uninterrupted access to Medically Necessary Services for individuals transitioning between Medicaid and Qualified Health Plan coverage on the Health Insurance Exchange. 4.4.17.2 At a minimum, the CONTRACTOR shall establish transition guidelines for the following individuals: 4.4.17.2.1 Pregnant women (pp. 77-78, no date, New Mexico Amended Version Sample RFP)

²⁹² 7.6.2.5.3. The Contractor must allow each Member to choose his or her Provider, including the PCP, to the extent possible and appropriate (p. 170, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.6.3.6. Election and Assignment of a PCP or Primary Care Site 7.6.3.6.1. The Contractor must allow each Member the freedom to choose among its Network PCPs and change PCPs as requested. The Contractor must implement procedures to ensure each Member has an ongoing source of primary care appropriate to his or her needs. Each Member must elect or be assigned to a PCP or Primary Care Site within five (5) Business Days of the effective date or enrollment. However, Members with disabilities must be given an additional thirty (30) Calendar Days to select a PCP. Members with disabilities, chronic conditions, or complex conditions must be allowed to select a Specialist as their PCP and any Specialist can be a PCP based on Medically Necessary conditions. These Members must also be allowed to select a State-operated clinic as their PCP. If a Specialist is chosen as a PCP, the Provider should be reported as a Specialist. The Specialist does not count as both a PCP and Specialist for reporting purposes. If the Member desires, the Contractor must allow him or her to remain with his or her existing PCP if the PCP is part of the Contractor's Network. (p. 176, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

²⁹³ 7.4.2.4.2. The Contractor must cover and pay for Emergency Services both in and out of state regardless of whether the Provider who furnished the services has a contract with the Contractor. The Contractor must pay the Out-of-Network Provider for Emergency Services, applying the "prudent layperson" definition of an emergency, rendered at a rate no more than the FFS rate. (p. 102, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

7.6.4. Out-of-Network Services 7.6.4.1. If the Contractor's Provider Network is unable to provide Medically Necessary services covered under the Contract to a particular Member, the Contractor must adequately and timely cover these services Out-of-Network for the Member for as long as the Contractor is unable to provide them. The Contractor's benefit package includes covered Medically Necessary services for which the Contractor must reimburse certain types of Providers with whom formal contracts may not be in place. The Contractor must also coordinate these services with other services in the Contractor's benefit package. (p. 184, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

²⁹⁴ 6.4.4.1. The Contractor may reimburse an Out-of-Network Provider at a negotiated rate less than the FFS rates established for pregnancy-related CPT codes. 7.6.4.4.2. A Members newly enrolled with the Contractor within the last trimester of pregnancy must be allowed to remain in the care of an Out-of-Network Provider if she so chooses. The Contractor must have policies and procedures for this allowance. (p. 185, no date, Attachment AA, Scope of Work and Deliverables, Anthem Blue Cross Blue Shield, Nevada)

²⁹⁵ 7.6.2.5.5. The Contractor must allow for a pregnant Member's continued use of her OB/GYN, if at all possible. (p. 170, Nevada Attachment AA Anthem Blue Cross Blue Shield Contract, 2022).

²⁹⁶ 21.9. Enrollee PCP Changes. 21.9.a. The Contractor must allow Enrollees the freedom to change PCPs, without cause, within thirty(30)days of the Enrollee's first appointment with the PCP. After the first thirty (30) days, the Contractor may elect to limit the Enrollee to changing PCPs every six (6) months without cause. This paragraph does not apply to Enrollees restricted to an RRP Provider for primary care in accordance with Appendix Q of this Agreement. (pp. 21-9, Effective March 2019, New York Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract Draft)

²⁹⁷ App'x C. 31. Transition of Care Requirements for Managed Care Members Receiving Behavioral Health Services. The MCP is required to cover behavioral health services provided by a Community Behavioral Health Center (CBHC) to its members as directed by ODM. C.31.a. The MCP shall follow the Medicaid behavioral health coverage policies described in OAC chapter 5160-27, including utilization management requirements, except that the MCP may implement less restrictive policies than FFS. C.31.b. The MCP must work with members receiving behavioral health services from out-of-network providers as necessary to ensure a smooth transition to network providers. When a member is unable to obtain medically necessary services from an MCP network provider, the MCP must adequately and timely cover the services out-of-network until the MCP is able to provide the services from a network provider. For continuity of care purposes, the MCP will: C.31.b.i. Work with the service provider to add the provider to their network; ii. Implement a single case agreement with the provider; or iii. Assist the member in finding a provider currently in the MCP's network. (pp. 39, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

²⁹⁸ App'x C. 33. Transition of Care Requirements for New Members. The MCP shall follow the transition of care requirements as outlined below for any new member, regardless of if the individual is transitioning from FFS or another MCP. C.33.c. Continuation of Services for Members. The MCP shall allow a new member to receive services from network and out-of-network providers, as indicated, if any of the following apply: C.33.c.i. If the MCP confirms that the Adult Extension member is currently receiving care in a nursing facility on the effective date of enrollment with the MCP, the MCP shall cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's care plan. ii. Upon becoming aware of a pregnant member's enrollment, the MCP shall identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services. These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, the MCP shall allow the pregnant member to continue with an out-of-network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital. iii. The MCP shall honor any prior authorizations approved prior to the member's transition through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCP. 1. The MCP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCP must render an authorization decision pursuant to OAC rule 5160-26-03.1. 2. The MCP may assist the member to access services through a network provider when any of the following occur a. The member's condition stabilizes and the MCP can ensure no interruption to services; b. The member chooses to change to a network provider; or c. If there are quality concerns identified with the previously authorized provider. 3. Scheduled inpatient or outpatient surgeries approved and/or pre-certified shall be covered pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate); 4. Organ, bone marrow, or hematopoietic stem cell transplant shall be covered pursuant to OAC rule 5160-2-65 and Appendix G of this Agreement; iv. The MCP shall provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCP: 1. Ongoing chemotherapy or radiation treatment; 3. Private duty nursing, home care services, and Durable Medical Equipment (DME) shall be covered at the same level with the same provider as previously covered until the MCP

conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1. 4. Prescribed drugs shall be covered without prior authorization (PA) for at least the first 90 days of membership, or until a provider submits a prior authorization and the MCP completes a medical necessity review, whichever date is sooner. The MCP shall educate the member that further dispensation after the first 90 days will require the prescribing provider to request a PA. If applicable, the MCP shall offer the member the option of using an alternative medication that may be available without PA. Written member education notices shall use ODM-specified model language. Verbal member education may be substituted for written education but shall contain the same information as a written notice. Written notices or verbal member education shall be prior approved by ODM. 5. Upon notification from a member and/or provider of a need to continue services, the MCP shall allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services. (pp. 40, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

²⁹⁹ App'x C. 33. Transition of Care Requirements for New Members. The MCP shall follow the transition of care requirements as outlined below for any new member, regardless of if the individual is transitioning from FFS or another MCP. C.33.c. Continuation of Services for Members. The MCP shall allow a new member to receive services from network and out-of-network providers, as indicated, if any of the following apply: C.33.c.ii. Upon becoming aware of a pregnant member's enrollment, the MCP shall identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services. These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, the MCP shall allow the pregnant member to continue with an out-of-network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital. (pp. 40, Effective July 2022, Ohio Medical Assistance Provider Agreement for Managed Care Plan)

³⁰⁰ Exhibit B, pt. 3. 2. Member Rights under Medicaid. B.2.g. Allow each Member to choose the Member's own health professional from available Participating Providers and facilities to the extent possible and appropriate. For a Member in a Service Area serviced by only one Prepaid Health Plan, any limitation the Contractor imposes on Member's freedom to change between Primary Care Providers or to obtain services from Non-Participating Providers if the service or type of Provider is not available with the Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Sec. 9, below of this Exhibit B, Part 3. (pp. 78, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

³⁰¹ Exhibit B., pt. 3. 2. Member Rights under Medicaid. Contractor shall have written policies regarding the Member rights and responsibilities under Medicaid law specified below and Contractor shall: B.2.a. Ensure Members are aware that a second opinion is available from a Health Care Professional within the Provider Network, or that the Contractor will arrange for Members to obtain a Health Care Professional from outside the Provider Network, at no cost to the Members. (pp. 77, Effective October 2019, Exhibit B, Statement of Work, Contract # 161754, Oregon Health Plan Services Contract, Western Oregon Advanced Health, LLC d/b/a Advanced Health)

³⁰² To the extent practical, the PH-MCO must offer freedom of choice to Members in making a PCP selection. (p. 117, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

³⁰³ Section V. Program Requirements. S. Provider Network. If the PH-MCO's Provider Network is unable to provide necessary medical services covered under the Agreement, to a particular Member, the PH-MCO must adequately and timely cover these services out-of-network, for the Member for as long as the PH-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment. (pp. 122, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PHMCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. (p. AAA-1, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

Consistent with 42 C.F.R. §438.14(b)(5-6), the PH-MCO must permit American Indian members to access out of state IHCPs; or permit an outof-network IHCP to refer an American Indian member to a network provider. (p. AAA-7, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

See HealthChoices Model Member Handbook pages for more on out-of-network provider coverage.

³⁰⁴ Section V. PROGRAM REQUIREMENTS. A. In-Plan Services. 6. Self-Referral/Direct Access. In situations where a new Member is pregnant and already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery, pursuant to 28 Pa. Code §9.684. (pp. 50, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

³⁰⁵ Section V. PROGRAM REQUIREMENTS. A. In-Plan Services. 6. Self-Referral/Direct Access. In situations where a new Member is pregnant and already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery, pursuant to 28 Pa. Code §9.684. (pp. 50, Effective January 2022, Pennsylvania HealthChoices Physical Health Agreement)

³⁰⁶ 2.08.02.02. Operational Requirements for Management of APM Subcontracts with Accountable Entities. The Contractor will: . . . Maintain Attributed Members' access to or freedom of choice of providers. (pp. 97, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

³⁰⁷ 2.08.01. Network Composition. The Contractor agrees that if the network is unable to provide necessary services, covered under this Agreement, to a particular member, the Contractor must adequately and on a timely basis cover these services out of network, for as long as the Contractor is unable to provide them. The Contractor will coordinate with the out-of-network provider to arrange payment and ensure that the member is held harmless. The Contractor will report out of network utilization by provider type as part of the monthly access reporting to EOHHS. (pp. 93, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

³⁰⁸ 2.06.05.03. Continuity of Care for Former Qualified Health Plan Members. The Contractor must allow Enrollee to see an out-of-network provider on an in-network basis if (1) that provider was a part of the member's QHP network, and (2) the member had been in the care of that provider for a period of at least six months. Whether or not such provider agrees to accept the Contractor's in-network rates, the balance-billing of the Medicaid beneficiary is prohibited. (pp. 86, Effective January 2022, Contract Between State of Rhode Island Executive Office of Health and Human Services and UnitedHealthcare of New England for Medicaid Managed Care Service)

³⁰⁹ 4.6. Out-of-Network Coverage. The CONTRACTOR shall 4.6.1. Provide or arrange for out-of-network coverage of Core Benefits in emergency situations and Non-Emergency situations—when service cannot be provided by an in-network Provider in the required timeframe and in accordance with Section 8 of this contract. (p. 76, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

³¹⁰ 5.5.1. General Continuity of Care Management Activity Requirements. The CONTRACTOR shall: 5.5.1.1. Ensure Continuity of Care activities are consistent with 42 CFR § 438.208 and should provide processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network Providers and identification and resolution of problems if those interactions are not effective or do not occur. (p. 83, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

³¹¹ 5.6.6.3. Pregnant at Time of Enrollment. The CONTRACTOR shall provide transition of care for Members who are pregnant or receiving inpatient care. This requirement applies to the following stages of pregnancy: . . . 5.6.6.3.2.Prenatal Care First & Second Trimester; For Members entering the CONTRACTOR's Health Plan in the first or second trimester of pregnancy who are receiving medically necessary covered prenatal care services the day before Enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services. The CONTRACTOR shall provide these services without any form of prior approval and without regard to whether such services are being provided by a contracted or out-of-network Provider until the CONTRACTOR can reasonably transfer the Member to a network Provider without impeding service delivery that, if not provided, might be harmful to the Member's health. (p. 86, Effective July 2021, Amendment III, South Carolina Medicaid Managed Care Organization Contract Boilerplate)

³¹² 18. Section A.2.13.1.6 shall be amended by adding a new Section A.2.13.1.6.7 as follows: 2.13.1.6.7. The CONTRACTOR shall pay for emergency or prior authorized covered services provided to an enrollee by an out-of-network provider if said provider has obtained a Medicaid provider identification number prior to submission of the claim and regardless of whether said provider obtained the Medicaid provider identification number before or after the time that services are rendered to the enrollee. (pp. 11, no date, Amendment 7, UnitedHealthCare Plan of the River Valley dba UnitedHealthcare Community Plan, Executed Agreement, Tennessee)

³¹³ 8.1.3. Access to Care. If Medically Necessary Covered Services are not available through Network physicians or other providers, the MCO must, upon the request of a Network physician, or other Provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event to exceed five Business Days after receipt of reasonably requested documentation, allow a referral to a non-network physician or Provider. The MCO must fully reimburse the non-network Provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC in 1 Tex. Admin. Code §353.4 (p. 69, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

³¹⁴ 8.1.21. Continuity of Care and Out-of-Network Providers. The MCO must ensure that the care of newly enrolled Members is not disrupted or interrupted. The MCO must take special care to provide continuity in the care of newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted. (p. 156, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

³¹⁵ 8.1.3.2. Access to Network Providers. Prenatal: Members who are pregnant must have access to a Network Provider for prenatal care. The MCO must allow a pregnant Member past the 24th week of pregnancy to remain under the Member's current OB/GYN's care through the Member's post-partum checkup, even if the OB/GYN Provider is, or becomes, Out-of-Network. (p. 71, Effective March 1, 2022, Document Revision V1.39 , Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions)

³¹⁶ 8.1.L Out-of-Network Services... 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. c. The Contractor shall cover, pay for, and coordinate care rendered to members by out-of-network providers when the member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract... e. The Contractor must provide out-of-network coverage for any of the following circumstances: a. When a service or type of provider (in terms of training, experience, and specialization) is not available within the MCO's network, b. Where the MCO cannot provide the needed specialist within the contract distance standard of more than thirty (30) miles in urban areas or more than sixty (60) miles in rural areas, c. For members other than those residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the Contractor must provide out-of-network coverage for up to thirty (30) days to transition the member to an in-network provider when a provider that is not part of the MCOs network has an existing relationship with the member, is the member's main source of care, and has not accepted an offer to participate in the MCOs network, d. When the type of provider needed and available in the MCOs network does not, because of moral or religious objections, furnish the service the member seeks, e. When the Department determines that the circumstance warrants out-of-network treatment. (p. 139, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

³¹⁷ The Contractor shall provide a continuity of care period of 30 days for new populations such as the Medicaid Expansion populations, including those with out-of-network providers in accordance with the requirements in this Contract. (p. 136, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

³¹⁸ 6.3.D MCO Change for Cause... Pregnant women, who are in their third trimester of the pregnancy, may request good cause exemption to temporarily return to fee-for-service if the provider is enrolled in Medicaid FFS but not covered under any health plan. In order to be considered for good cause exemption, pregnant members shall obtain an attestation from a physician or nurse practitioner (including Certified Nurse Midwives and other Nurse Practitioners), within the third trimester, that no diagnoses are present which could increase the risk of adverse outcomes for mother or baby. (p. 101, Effective FY 2022, Virginia Medallion 4.0 Managed Care Contract)

³¹⁹ 6.16 Enrollees Residing in Rural Areas If an Enrollee resides in a rural area in which there is mandatory enrollment, the following requirements apply:... 6.16.4 The Enrollee may seek a service from a Non-Participating Provider when the state determines that circumstances warrant out-of-network treatment (42 C.F.R. § 438.52(b)(2)(ii)(E)). (p. 140, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

14.1.5 The Contractor shall allow Enrollees to continue to receive care from nonparticipating providers with whom an Enrollee has a documented established relationship. (p. 256, Effective July 2022, Washington State Health Care Authority Apple Health – Integrated Managed Care Contract)

³²⁰ C. Primary Care Provider Selection and Designation Per 42 CFR § 438.208(b)(1), the HMO must ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member. The HMO must have a process in place to link each BadgerCare Plus and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. The HMO shall allow members an initial choice of primary care provider or primary care clinic prior to designation. (p. 137, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

³²¹ Business Continuity Plan: Member's access to services. The health plan must: i. Establish provisions to ensure that members are able to see Out-of-Network Providers if the member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers. (p. 193, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

7. HMO Referrals to Out-of-Network Providers for Services The HMO must provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the HMO network. The HMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the member is no greater than it would be if the services were furnished within the network [42 CFR 438.206(b)(v)(5) and S.S.A 1932(b)(2)(D)]

8. Second Medical Opinions The HMO must have written policies for procedures guaranteeing each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand for providing members the opportunity to have a second opinion from a qualified network provider subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, the HMO must authorize and reimburse for a second opinion outside the network at no charge to the member, excluding allowable copayments.

9. Access to Indian Health Providers... Indian members of the HMO are allowed to receive primary care services from an IHCP provider, as long as such provider agrees to serve in the HMO network as a PCP and has capacity for additional patients. If no such provider is contracted, the HMO must allow the member to see the IHCP out-of-network as defined in 42 CFR § 438.14(b)(4). If an Indian member receives services through an out-of-network IHCP, the HMO must allow the out-of-network IHCP to refer the Indian member to a provider within the HMO network for

additional care. If timely access to an IHCP cannot be ensured, the HMO may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the HMO per the process outlined in Art. III, section C. (pp. 127-128, Effective January 2022, Wisconsin BadgerCare Plus and/or Medicaid SSI HMO Services Contract)

³²² 1.2.2 Emergency Care MCO policy and procedures, covered Medicaid services, claims adjudication methodology, and reimbursement performance for emergency care services must comply with all applicable state and federal laws, rules, and regulations, including 42 CFR §438.114, whether the provider is in the MCO's network or out-of-network. (p. 58, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.3 Specialty Care Providers, Hospitals, and Other Providers The MCO must contract with a sufficient number and mix of specialists and hospitals so that the enrolled adult and pediatric populations' anticipated specialty and inpatient care needs can be substantially met within the MCO's network of providers. The MCO must also have a system to refer enrollees to out-of-network providers if appropriate participating providers are not available. (p. 77, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

2.7.3 Out-of-Network Services Subject to Article III, Section 2.7, Timely Payment Requirement, the MCO must make timely payment within thirty (30) calendar days for clean claims to out-of-network providers for Medically Necessary, covered services when: 1. Services were rendered to treat a Medical Emergency; 2. Services were for family planning and sexually transmitted diseases; 3. Services were prior authorized; or 4. Retro-authorization meeting medical necessity has been granted due to the nature of service. (p. 86, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)

5.2 Out-of-Network Services In accordance with 42 CFR §438.206(b)(4), the MCO must cover out-of-network services that are otherwise covered under the Contract for the enrollee if the MCO's network is unable to provide such services. In accordance with 42 CFR §438.206(b)(5), the MCO must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as the MCO is unable to provide them through in-network providers. To the extent possible, the MCO must encourage out-of-network providers to coordinate with the MCO with respect to payment. (p. 118, Effective SFY 2022, WV MCO Mountain Health Trust Model Contract)