FUTURES WITHOUT VIOLENCE®

POLICY BRIEF

LEVERAGING MEDICAID MANAGED CARE CONTRACTS TO ADDRESS INTIMATE PARTNER VIOLENCE

April 30, 2021
Discussion Draft

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The Discussion Draft was prepared by staff at Futures Without Violence (FUTURES) to share preliminary ideas on specific healthcare policy issues with the public and to gather public feedback. Please submit feedback and comments to FUTURES at ipvhealth@futureswithoutviolence.org by XXX. FUTURES staff will review comments on the Discussion Draft and publish a final policy paper during the summer 2021.

Introduction

Medicaid is a critical source of health insurance for survivors of domestic violence. It provides a comprehensive benefit package that makes sure survivors can get the health and behavioral health services they need, including critical preventive services like screening and brief counseling for domestic and interpersonal violence. And yet, many states have not leveraged the full breadth of possible options available to ensure survivors can access the care they need to health and thrive.

This paper looks specifically at how states can better address domestic violence and increase access to critical services for survivors, including those delivered by non-medical providers such as domestic violence advocates, through their contracts with Medicaid Managed Care Organizations (MCO). This coverage is extremely important because survivors of violence are more likely than others to need mental and behavioral health services, to be living with chronic pain and chronic health conditions, and to need reproductive health care, including screening for sexually transmitted infections. Ensuring they can get the holistic care they need, when they need it, can improve their health and well-being for the rest of their lives. For that reason, it is important that their Medicaid coverage cover all needed services.

In many states, survivors will get their Medicaid coverage through a Medicaid Managed Care Organization (MCO). In fact, more than 80 percent of Medicaid beneficiaries receive some or all of their care from MCOs that contract with the state to deliver a comprehensive set of benefits.[1] And while not all states use managed care, the majority of states do use it and more states are switching to managed care each year.

[1] Medicaid Managed Care Tracker (January 2019). Kaiser Family Foundation. Retrieved from : https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/

States are obligated to cover all the federally-mandated benefits for all Medicaid beneficiaries. They can choose to contract those benefits out to MCOs or pay for certain services in a fee-for-service model. In a comprehensive contract, the MCO must cover inpatient hospital services plus certain other services.[2] States then choose to include other benefits like behavioral health in the contract or provide those services directly to beneficiaries in a fee-for-service model. This means that states have a lot of leverage to design the benefit packages offered by MCOs. The requirements between the state and the MCO will be outlined in the contract. State MCO contracts are an important tool for shaping the policies and practices in the state.

Increasingly, states can, and do, use many different policy levers to encourage or require MCOs to address their members' social determinants of health.[3] This reflects a growing understanding of the nonmedical factors that impact health outcomes such as housing or food instability; employment and poverty; and exposure to domestic violence.

States can require health plans to provide incentive payments to network providers who routinely screen for social determinants of health.[4] States can link health plan payment to meeting quality metrics linked to specific health interventions.[5]

States can also make it easier for plans to cover non-traditional services by fostering a policy environment that encourages MCOs to provide additional services on top of those covered in the Medicaid state plan. There are two buckets of these additional services, "in lieu of services" and "value-added services".

- **In lieu of services.** In lieu of services are services or settings that are an appropriate and/or cost-effective alternative to the services offered in the state plan. They must be approved by the state and included in the MCO contract. These tend to be medical services.
- **Value-added services.** Value-added services are services that the plan volunteers to offer its members and may not be medical in nature.

States can also hold plans accountable for implementing already covered services. For example, it would be appropriate for a state to ensure plans are providing all required and/or covered screenings.[6]

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[2] Types of Managed Care Arrangements. MACPAC. Retrieved May 10, 2019 from: https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/

[3] Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care (January 2019). Institute for Medicaid Innovation. Retrieved from https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf

[4] Addressing the Social Determinants of Health Through Medicaid Managed Care (November 2017). The Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2017/nov/social-determinants-health-medicaid-managed-care

[5] Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care (January 2019). Institute for Medicaid Innovation. Retrieved from https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf

[6] https://www.jsi.com/resource/engaging-health-care-organizations-in-violence-prevention/

Medicaid covers all Health Resources and Services Administration-recommended adult preventive services. Women's preventive services include screening and counseling for domestic and interpersonal violence.

Each of the strategies above offers a real path forward to ensuring that survivors have access to the services they need to heal and thrive—and that the services are covered through their Medicaid plan. Unfortunately, not many states have picked up these options to advance care and care coordination for survivors. But these paths offer future opportunities for a state or an MCO to offer the services delivered by non-traditional providers such as domestic violence advocates.

Use of MCO Contracts to Advance Social Determinants of Health

The majority of states address at least one social determinants of health using their MCO contracts—though it is a patchwork of how they are covered, both in terms of how much focus the contract puts on social determinants of health, as well as what the MCO is required to do. One state—North Carolina—has developed a comprehensive strategy for addressing social determinants of health. But most states discuss social determinants of health in select parts of the contract.[7]

For example, Kansas specifically addresses social determinants of health in many places throughout the Request for Proposal, and is prescriptive in its approach in the care coordination terms as well as requiring the creation of a community service coordinator who will coordinate needed services for plan members.[8] Whereas in Georgia, the model contract suggests that MCOs address SDOH but does not make any requirements.[9] New Mexico's MCO draft contract is very specific, narrow, and requires that plans maintain a "full-time Supportive Housing Specialist" to provide training to care coordination teams.[10]

Most states include their social determinants of health-related activities as part of their care coordination activities in the MCO contract. Under federal rules, an MCO must make a strong effort to

[7] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[8] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[9] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[10] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

do an initial screening and assessment of a member's needs. When a member is identified as having needs, the MCO must develop a care plan for them, which often includes an analysis of social needs:[11]

- Iowa requires that MCOs use a standard screening tool to determine the need for community services.
- Massachusetts requires MCOs to develop care plans for their members that address identified needs, including housing, employment status, food security, and risk of abuse.
- Ohio requires the MCO to consider social determinants of health and safety risk factors.

Under federal rules[12], MCOs must coordinate their services with community based and social support organizations. States can require MCOs to refer and link members to community resources. This can include requiring formal relationships between the MCO and community-based organizations such as in Massachusetts where MCOs are required to contract with the state's Housing First program[13]. Nebraska's MCO contract requires that MCOs use a "tool accessible to their care management staff" that manages information on community resources that can help address their members' social determinants of health needs.[14] Other states simply require that the MCO develop relationships that link members with community programs.

To address chronic or transitional homelessness, plans both make a significant capital investment in housing stock and also invest in the community-based housing organizations to provide case management, care coordination and other traditional health care support services.[15] Similarly, health plans have addressed food insecurity by increasing access to healthy food while similarly making investments in community-based programs and providers. The investments in nutrition counseling, diabetes self-management, and a focus on physical activity are provided by providers--and have both short and long term positive health care outcomes as well as health care savings.[16] The plans want to invest in sustainable and measurable programs and those that are evidence-based.

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[11] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[12] https://www.law.cornell.edu/cfr/text/42/438.208

[13] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[14] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

[15] Safe and Affordable Housing: Social Determinants of Health. (September 2018). America's Health Insurance Plans (AHIP). https://www.ahip.org/wp-content/uploads/2018/09/SDOH-Housing-IB-FINAL.pdf

[16] Access to Healthy Foods: Social Determinants of Health. September 2018). America's Health Insurance Plans (AHIP). https://www.ahip.org/wp-content/uploads/2018/05/HealthyFoods_IssueBrief_4.18_FINAL.pdf

States that Address Domestic Violence in their Contracts

In order to understand what states are doing to address domestic violence in their MCO contracts, we built on the recent work by the Center for Health Care Strategies who analyzed the MCO contracts in all 50 states and how states have used contract to create incentives or establish requirements to address social determinants of health broadly.[17]

Their analysis looked at the 41 states including DC where there is Medicaid managed care activity related to social determinants of health and they list the social determinants of health-related topics that each state covers including housing, food, employment, wellness, and violence/abuse.

We identified the seven states where violence or abuse are specifically mentioned: Arizona, Kansas, Massachusetts, North Carolina, Rhode Island, Virginia, and Wisconsin. Our analysis focused on the model contracts between the state and the health plan for these states with a goal of identifying what each model contract says about violence or abuse. We were trying to determine how the state required or encouraged plans to address domestic violence—and where there are best practice for contracting.

In these seven states, the policies and contract language around domestic violence was varied but fell in to three primary categories:

- **Screening.** Plans are required to do a health risk assessment or screening for their members, and the screening tool must include a question about domestic violence (or violence in general);
- **Build provider networks.** Plans must build provider networks with the capacity to serve patients who are impacted by violence; and
- **Community-based organizations.** Plans should have in-network community-based organizations with experience serving survivors.

It is important to note that the underlying model contracts do include provisions about how the "general population" can access care coordination and services. Many of these provisions offer strong supports and expanded services that would benefit survivors. This review does not look at whether and when these general contract provision could be leveraged to support the health care needs of survivors of domestic violence. Our review is narrowly focused on the specific provisions that mention domestic violence. However, the general protections that improve access to medical and behavioral health services for all members can be used to support survivors. Similarly, the provisions of model contracts that address other social determinants of health—like housing and food instability—will support survivors of domestic violence.

[17] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstration. (December 2018). Association for Community Affiliated Plans & Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf.

Listed below is a description of what each of the seven states who specifically mention domestic violence or violence generally includes in their model contracts. While it is unclear the extent to which these provisions are in final MCO contracts or put into practice, they provide important lessons on how MCO contracts could be structured to improve for survivors of domestic violence.

Arizona[18]

Arizona Medicaid requires that plans make a best effort to conduct an initial screening of each member's needs and have procedures to coordinate the services needed. The plan provides care management to members who have physical or behavioral health needs or risks that need immediate attention. As part of this care coordination, plans will make sure that members get the service they need to prevent or reduce bad health outcomes. It is noted, however, that this care management is short term.

In addition to certain high need/high cost populations, this care coordination is to be provided to survivors of sex trafficking. Specifically:

> The Contractor is responsible for providing outreach to members identified by the Arizona Child Abuse Hotline assessed as survivors of sex trafficking once notification is received from the Hotline. The Contractor or its contracted provider shall outreach to the member's guardian to provide trauma-informed resources, including the description of how to access behavioral health assessment services and subsequent treatment if medically necessary. The Contractor shall ensure the results of the outreach are communicated back to the Arizona Child Abuse Hotline within 30 days of the referral, including the date of contact with the member's guardian, and a description of services referred or delivered.

There is no mention of partnerships with community-based organizations or advocates with specific knowledge of the needs of the community they serve.. There is a mention that the plan's network must include "[c]ommunity-based, family support providers in urban, suburban and rural areas of the State." While these organizations are not specific to survivors of violence, according to the model plan, these are "locally established, Arizona-based, independent Peer-Run and Family-Run Organizations. The [plan] shall provide technical assistance and support to Peer-Run and Family-Run Organizations as necessary."

Kansas[19]

In Kansas, plans are required to complete an initial assessment of every member to identify those that may need service coordination. There are a total of 37 questions, some of which automatically trigger a

[18] AZ materials accessed from https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Contract_Amend_1.pdf

[19] All Kansas materials accessed from: https://admin.ks.gov/offices/procurement-and-contracts/kancare-award

full health risk assessment if a positive response is given. The questions cover a series of general health questions (e.g., have you seen your doctor on a regular basis; are you up to date on your immunizations), as well as questions on a number of social determinants of health, including housing (Do you have a regular, safe place where you sleep and store your things?); workforce (What is your Employment Status?); and food insecurity (Are you currently receiving supports for health eating?).

Included in this screener is a question on domestic violence:

> *"Because difficult relationships can cause health problems, we are asking all of our patients the following question: Does a partner, or anyone at home, hurt, hit, or threaten you?"*[20]

If a patient says yes to this question, the full health assessment will be triggered.

The full health assessment includes a deeper set of screening questions and is used to design a coordinated plan of care. While here are many questions on the full health risk assessment form that, if addressed, would provide important supports for survivors, there are no direct questions on the full health risk assessment form about exposure to IPV or violence.[21]

According to the state's documents, if an individual requires additional services, the plan is responsible, among other things, for physical and behavioral health coordination; transportation coordination; linkages and referrals to community resources and non-Medicaid supports; and support for education, employment and housing including making referrals, advocacy and follow up.[22]

Massachusetts

Massachusetts model contract requires plans to screen members to identify their health and functional needs, including their behavioral health-related needs.[23] It does specify that the screenings must be done in culturally and linguistically appropriate ways.

> [Plans must] 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;

[20] Need to find a better site for this but here is the full screener: https://drive.google.com/open?id=0B7Pr72ja8BfvYjFMLWxSdHYwTUdWNmJFODZDRmxvRTRSbHhF

[21] Need to find a better site for this but here is the full assessment: https://drive.google.com/open?id=1LTbSy9PLVNhxufgLr6Vvk4356vexwKr0

[22] KS.State vs. Plan obligations after health risk assessment

[23] MassHealth, Massachusetts Managed Care Contract, Section 2.5(B) (4) and 2.7(F). Available at: https://www.commbuys.com/bso/external/ bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true &parentUrl=bid

- Housing search and placement;
- Utility assistance;
- Physical activity and nutrition; and
- Support for Enrollees who have experience of violence.[24]

Members who are identified as having health care needs are to be referred to appropriate services, including those provided by health care providers, social service providers and other community-based organizations that address the enrollee's needs, "including but not limited to Medically Necessary services".[25]

The distinction that services are not limited to medically necessary services is important. Medically necessary services are subject to the state's definition of medical necessity, and are typically health care services. Supports and non-traditional services are not likely to be considered medically necessary under the state definition, but can still be critically important pieces of the individuals care plan.

While the contract does mention screening for violence, there are no additional provisions made about supporting survivors of violence. The model contract does encourage the use of existing covered services, such as behavioral health services, peer supports and other key services that could benefit survivors, it does not necessarily allow for the in-network provision of domestic violence services.

For certain members, the state requires that the MCO provide a comprehensive assessment and member-centered care planning. At a minimum, this must be done for a member who: a) has a long term care need; has special health care needs; or who has significant behavioral health needs. The comprehensive assessment will consider a range of social determinants (e.g., housing needs; employment status; food security) as well as "risk factors for abuse or neglect".[26] The resulting care plan is to address the needs identified on the comprehensive assessment.

North Carolina

North Carolina is in the process of a major overhaul to their Medicaid programs, introducing managed care for the first time. As part of this transformation, the state will launch the Healthy Opportunity Pilots. This pilot program will test if evidence-based interventions will reduce costs and improve health

[24] MassHealth, Massachusetts Managed Care Contract, Section 2.5(B) (4) and 2.7(F). Available at: https://www.commbuys.com/bso/external/ bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true &parentUrl=bid

[25] MassHealth, Massachusetts Managed Care Contract, Section 2.5(B) (4) and 2.7(F). Available at: https://www.commbuys.com/bso/external/ bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true &parentUrl=bid

[26] MassHealth, Massachusetts Managed Care Contract, Section 2.5(B) (4) and 2.7(F). Available at: https://www.commbuys.com/bso/external/ bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true &parentUrl=bid

by focusing on housing, food and transportation instability, as well as interpersonal violence and toxic stress.[27]

Participating plans are required to provide a bundle of services for members who have experienced interpersonal violence including:

Interpersonal violence related transportation

- Transportation services to/from IPV service providers for enrollees transitioning out of a traumatic situation

IPV and parenting

- Assistance with linkages to community-based social service and mental health agencies with IPV expertise.

Support Resources

- Assistance with linking to high quality childcare and after-school programs.
- Assistance with linkages to programs that increase adults' capacity to participate in community engagement activities
- Providing navigational services focusing on identifying and improving existing factors posing a risk to the safety and health of victims transitioning out of traumatic situations (i.e., obtaining a new phone number, updating mailing addresses, securing immediate shelter and longer-term housing, school arrangements to minimize disruption of school schedule, connecting enrollees to medical-legal partnerships to address overlap between healthcare and legal needs)

Legal Assistance

- Assistance with directing the beneficiary to available legal services within the legal system for interpersonal violence related issues, such as securing a Domestic Violence Protection Order. This pilot service does not include legal representation or payment for legal representation

Child-Parent Support

- Evidence-based parenting support programs (i.e., Triple P – Positive Parenting Program, the Incredible Years, and Circle of Security International).
- Evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care and community integration.
- Dyadic therapy treatment for children and adolescents at risk for or with an attachment disorder, or as a diagnostic tool to determine an attachment disorder.

[27] Healthy Opportunities Pilots Fact Sheet. (November 2018). North Carolina Medicaid. https://files.nc.gov/ncdhhs/SDOH-HealthyOpptys-FactSheet-FINAL-20181114.pdf

The plans are required to work with community-based organizations, care managers, and "human services organizations". These providers contract with the plans and will be paid by the plan for the services delivered.

As part of their work, the community-based care managers will identify members who are eligible for pilot services. In particular the Healthy Opportunities pilot will provide an enhanced set of coordinated services to people who are at risk of witnessing or experiencing interpersonal violence as defined based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool.

Rhode Island[28]

The Rhode Island contract with MCOs includes network adequacy provisions that outline the mix of providers that must be in-network for behavioral health and substance use providers—for both children and adults. The goal is to offer the right range of providers to offer treatment options representing a continuum of care. The language in the model contract states:

> The network must include providers experienced in serving adults and children, low income populations, subspecialists or specialty providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (behavioral health and substance use) in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network shall also recognize the multi-lingual, multicultural nature of the population to be served and include providers in locations where members are concentrated. Contractor will include all BHDDH-licensed Community Mental Health Centers (CMHCs) in its network. Contractor will include Evidence Based Practice/ABA providers in the network.

What is noteworthy about this language is that it specifically requires that the network include providers with experience serving survivors of domestic violence and sexual assault, as well as those that work with populations experiencing dual diagnosis.

Separately, Rhode Island's new Accountable Entities program includes domestic violence.[29] This program is run through the Medicaid managed care program. Accountable Entities are multi-disciplinary organizations who engage in a coordinated effort to improve population health and to specifically address social determinants of health. The Accountable Entities contract with Managed Care Organizations, and will have the responsibility for coordinating a full continuum of care services for their populations.

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[28] Hard copy of the contract available from Lena. Not publically available on the web. Need to find a written permission.

[29] National Academy of State Health Policy (November 27, 2018) Q&A: How Rhode Island Tackles Social Determinants of Health through its Accountable Entity Model. Accessed at: https://nashp.org/qa-how-rhode-island-tackles-social-determinants-of-health-through-its-accountable-entity-model/

The state plays a key role in certifying these AEs--and will hold the AEs and the plans responsible for having additional capacity to serve members who experience domestic violence. Rhode Island's Accountable Entity Certification Standards,[30] as part of their Medicaid Accountable Entity Program, also address domestic violence and acknowledge it as a critical social determinant of health. The certification standards are used by the state to certify the parties who are participating as AEs. Specifically:

> Social determinants capacity shall be evidenced by the participation of providers of pertinent social supports within the Accountable Entities. This may be through defined relationships with community-based organizations, through in-house social support capacity within a single entity AE, or through an Associate Provider agreement with a separate social supports agency. It is not required that direct capacity within the AE be able to provide the full range of social supports that may be appropriate to meet the needs of the attributed population (see for reference Table 2 below). Qualifying will be demonstrated in-house capacity and/or defined affiliations and working arrangements with CBOs that might fill in gaps in in-house capacity, such as Health Equity Zone participants, to address identified social contexts impacting health outcomes. The requirement is for three domains of social determinants, not necessarily multiple affiliations.

Accountable Entities will be evaluated on a number of criteria and one of the metrics that they must report on is the number of members who receive a social determinants of health assessment.[31] They are required to develop a social determinants of health Care Needs Screening instrument that will screen members' health-related social needs including "support for members who have experienced domestic violence."[32] The Accountable Entities will demonstrate that they have defined "[a]bility to work effectively at key points of life transition or impact, as appropriate for the population served, such as discharge from corrections, engagement with DCYF protective custody, risk of loss of housing, homelessness, substance use, domestic violence/sexual violence."

Virginia[33]

Virginia's managed care services agreement (known as Medallion 4.0) includes several mentions of violence and abuse.

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[30] Rhode Island Medicaid Accountable Entity Program: Accountable Entity Certification Standards. (May 31, 2017). Rhode Island Executive Office of Health and Human Services. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/AE_CertificationStandards_053117.pdf

[31] Rhode Island Medicaid Accountable Entity Program Attachment L 1: Accountable Entity Total Cost of Care Requirements – Program Year Two (December 11, 2018) http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/AE%20PY2%20Documents/Attachment%20L%201%20(TCOC%20Requirements)_PY%202%20FINAL.pdf

[32] Rhode Island Medicaid Accountable Entity Program Attachment L 1: Accountable Entity Total Cost of Care Requirements – Program Year Two (December 11, 2018) http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/AE%20PY2%20Documents/Attachment%20L%201%20(TCOC%20Requirements)_PY%202%20FINAL.pdf

[33] Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Program. (July 26, 2018) Commonwealth of Virginia, Departmetn of Medical Assistance Services. http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf

Health plans are required to have written policies about healthcare for patients with high risk pregnancies. At a minimum, these policies 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 and/or other behavioral health issues;
- The member's personal safety (e.g., housing situation, violence).

The contract does not discuss what the plan must do to address these issues.

Separately, the contract requires that plans have in place in-network supports for victims and perpetrators of domestic violence and child abuse.[34]

> 8.6.F.a.b Assurance of Expertise for Child Abuse and Neglect and Domestic Violence The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse, neglect, and domestic violence. The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community.
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> The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

Finally, plans are required to address social determinants of health and provide an annual report on how they meet that requirement. While domestic violence is specifically listed as a social determinant of health, "crime and violence" is listed as a social factor that impacts health and health care[35.]

[34] Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Program. (July 26, 2018) Commonwealth of Virginia, Departmetn of Medical Assistance Services. http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf

[35] Contract to Provide Managed Care Services for the Medicaid and Family Access to Medical Insurance Security (FAMIS) Program. (July 26, 2018) Commonwealth of Virginia, Department of Medical Assistance Services. http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf

Wisconsin

The Wisconsin model contract between the state Medicaid agency and the Medicaid Managed Care plans includes language that references the plans' in-network capacity to address domestic violence.[36]

> The MCO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence. The MCO shall consult with human service agencies on appropriate providers in their community. The MCO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

[36] Contract Between Wisconsin Department of Health Services; Division of Medicaid Services and [Name of MCO]. (January 1, 2018). https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf