Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 12-State Scan

by Andy Schneider, Tanesha Mondestin, Ella Mathews, and Eni Akinniyi

Executive Summary

Each year, more than 40% of all births in the United States are financed by Medicaid, making it the single largest source of coverage for maternity care.[1] Looking more closely, more than 60% of births to all Black women and American Indian/Alaska Native women are financed by Medicaid.[2] These are the same groups of women who are at greatest risk of maternal mortality and morbidity: data show that Black women, who are disproportionately poor, are nearly three times more likely to die during or just following a pregnancy than White women and Hispanic women, and rates are worsening for all groups.[3, 4, 5] Medicaid's foundational role in financing maternity care for low-income women makes it an essential part of addressing this maternal health crisis.

Of the approximately 1.5 million pregnant women enrolled in Medicaid annually, a large majority are enrolled through Medicaid managed care organizations (MCOs), which organize networks of providers to deliver covered services.[6,7] For all intents and purposes, these MCOs are the Medicaid program for pregnant women enrolled. MCOs determine whether their pregnant enrollees have timely access to prenatal care; the quality of the hospitals or birthing centers at which the enrollees deliver; whether enrollees have timely access to postpartum services; and, for high-risk enrollees, the availability of effective care management.

States are systematically reviewing the causes of maternal deaths through their maternal mortality review committees (MMRCs), which operate in every state except Idaho and involve thorough reviews of deaths of pregnant women and women who die within one year of the end of pregnancy.[8,9] These committees have helped policymakers understand the scale and urgency of the maternal mortality crisis and have made recommendations to prevent maternal deaths.

In This Study

Our study aimed to answer the question: what information about the performance of individual Medicaid MCOs on maternal health is publicly available? In our scan of Medicaid websites in 12 states, we found that none of the state Medicaid agency websites contained information sufficient to draw firm conclusions as to how well individual MCOs are performing on maternal health generally, or on maternal mortality in particular. The same was true for the MMRC reports we reviewed.

Given the ongoing maternal mortality crisis and the central role of Medicaid MCOs as a source of coverage and service delivery for low-income pregnant women in most states, more attention needs to be focused on the performance of those MCOs. Medicaid payments to MCOs represent a major public investment in the health of pregnant enrollees. Without greater transparency, it will not be possible for beneficiaries or the public to hold MCOs (and the state Medicaid agencies that contract with them) accountable for maternal health outcomes among enrollees generally, or for racial and ethnic disparities in particular.

Introduction

The United States is in the midst of an ongoing maternal mortality crisis and Medicaid, the health insurer for low-income Americans, has an important role to play in addressing it. Medicaid is the nation's single largest maternity care insurer, paying for more than 40% of all births on average across all states, and over half in some. Medicaid is particularly important for low-income women of color, covering the majority of births to Black women and to American Indian and Alaska Native women.

Most pregnant women covered by Medicaid are enrolled in managed care organizations (MCOs), which contract with state Medicaid agencies for the delivery of covered services to enrollees through provider networks that the MCOs assemble and oversee. How an MCO performs plays an important role in the maternal health outcomes for its enrollees, yet there is little public transparency into that performance.

As of September 2023, the large majority of states have implemented or plan to implement the option to extend postpartum coverage for pregnant women from 60 days to 12 months. Because of the medical and mental health risks of the postpartum period, this extended coverage creates another important opportunity for states and the MCOs with which they contract to reduce mortality and morbidity among the mothers that Medicaid serves.

We examined 12 states that contract with MCOs to deliver covered services to Medicaid beneficiaries: Georgia, Illinois, Iowa, Kansas, Kentucky, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Tennessee, and Washington. These states varied considerably in the amount and type of information they make publicly available regarding the performance of individual MCOs on maternal health. We searched for data describing MCO performance during calendar years 2021-2022.

Key Findings

- Only three states posted the number of pregnant enrollees in each MCO, and only two of those disaggregated MCO enrollment by race and ethnicity.
- Only Kansas provided the total amount it paid its MCOs overall for enrolling pregnant women. None of the states posted the total amount of capitation payments they made on behalf of pregnant enrollees to individual MCOs.
- All of the states posted MCO-specific performance on two of the six CMS Maternity Core Set metrics for which we searched: Timeliness of Prenatal Care, and Timeliness of Postpartum Care. None of the states posted MCO-specific performance results on two of the other metrics, Live Births < 2,500 Grams or Low-Risk Cesarean Deliveries.
- Nine of the 12 states required their MCOs to conduct Performance Improvement Projects (PIPs) on a topic relating to maternal health in 2022. The most common PIP topic was Timeliness of Prenatal Care.
- Eight of the 12 state Medicaid agencies posted consumer-facing tools on their websites to help enrollees make informed choices among MCOs. All of these tools rated individual MCOs based on maternal health performance, but the metrics varied considerably in usefulness.
- All 12 states operate Maternal Mortality Review Committees that review the causes and contributing factors of death among pregnant women and new mothers and issue reports on their findings. None of the MMRC reports we scanned examined the role of individual Medicaid MCOs in managing pregnant or postpartum enrollees.
- Seven states included the state Medicaid agency on their maternal mortality review committee and five did not.

I. Maternal Health Crisis

The United States is experiencing an ongoing maternal mortality crisis. The nation's maternal mortality rate has continued to worsen over the last 20 years, even while other peer nations have generally reduced their rates of maternal mortality.[10, 11] Between 1999 and 2019, the number of women in the U.S. who died during pregnancy or within in a year after delivery doubled; Black women died at the highest rates and American Indian/Alaska Native women had the steepest rate increase in maternal deaths in this period. The stress and increased risk of severe illness and death for pregnant women during the COVID-19 pandemic only worsened outcomes: between 2018 and 2021, the U.S. maternal mortality rate nearly doubled for all women.[12,13] The Supreme Court decision in *Dobbs v. Jackson* Women's Health Organization will put pregnant women in states that restrict or ban abortion care at greater risk of maternal mortality and morbidity.[14]

These trends are not inevitable, and advocates, policymakers, and parents are working toward solutions. In 2021, Congress created an option for states to receive federal matching funds to extend Medicaid postpartum coverage from 60 days to one full year. As of September 2023, 38 states have taken up the policy option, and eight more are planning to do so (see Text Box 1).[15] Federal lawmakers are also considering the "Black Maternal Health Momnibus," a package of bills that would, among other policy changes, diversify the perinatal workforce, increase funding for research and data systems to reduce racial bias in maternal health care, and support moms with maternal mental health conditions and substance use disorders.[16,17]

The policy changes have the potential to improve outcomes for the 1.5 million pregnant or postpartum women covered by Medicaid each year.[18] As maternal mortality rates continue to rise, and the rate for Black women rises even faster, changes to the Medicaid program have the potential to spur sorely-needed system improvements that advance health equity and reduce racial disparities by more effectively serving young families of color.

1 12 Months of Postpartum Medicaid Coverage

In response to the alarming increases in maternal mortality in recent years, documented in many cases by state maternal mortality review committees, state and federal policymakers have turned to Medicaid for policy solutions.

Under federal law, Medicaid coverage is available to income-eligible pregnant women from the date of confirmed pregnancy through 60 days postpartum. But the data and the lived experiences of moms showed that the 60-day postpartum coverage cliff cut off access to prescriptions, therapies, and doctor visits, just when they need it most.[19, 20] About 30% of pregnancy-related deaths from 2017-2019 occurred between 43 days and one year postpartum.[21]

Congress took action in the American Rescue Plan Act of 2021 to create a Medicaid state plan option for states to lengthen the postpartum Medicaid and CHIP coverage period from 60 days to 12 months, and to receive federal payments at their regular matching rate for the additional 10 months of coverage.[22] The state option to lengthen postpartum coverage was made permanent by the Consolidated Appropriations Act of 2023. [23,24]

Almost all states have taken up the option. As of September 2023, 38 states and the District of Columbia are implementing the 12-month extension, and another eight states are planning to do so.[25] Three states have not taken any action to extend postpartum Medicaid coverage: Arkansas, Idaho, and Iowa. Wisconsin has submitted a Section 1115 waiver proposal to extend postpartum coverage from 60 to 90 days.[26]

Medicaid coverage for a full 12 months of postpartum care presents an opportunity for MCOs and their provider networks to reduce preventable maternal mortality, severe maternal morbidity, and health disparities. CMS has developed a postpartum care toolkit for state Medicaid and CHIP agencies that includes strategies for contracting with MCOs to increase access to postpartum care, improve the quality of postpartum care, and reduce race and ethnic disparities.[27, 28]

Unfortunately, transparency of individual MCO performance on postpartum care is not among the "CMS strategies;" nonetheless, maternal health advocates should work with their state Medicaid agencies to use transparency to hold MCOs accountable for results.

II. Medicaid and Maternal Health

Medicaid is the primary pathway to coverage for low-income pregnant women. Nationally, Medicaid financed nearly half of all births (41%) in 2021, ranging from 21% of births in Utah to 61% of births in Louisiana.[29] Federal law requires that all states cover pregnant women with incomes below a specified percentage of the Federal Poverty Level (FPL). The lowest eligibility level a state is allowed to set is 138% FPL ($20,120 for an individual, $34,307 for a family of three in 2023). But almost all states have higher thresholds for pregnant women in 2023—the median is 200% FPL ($29,160 for an individual, $49,720 for a family of three).[30]

People who qualify for Medicaid coverage on the basis of pregnancy are entitled to pregnancy-related services and services for other conditions that might complicate the pregnancy.[31]

States have discretion to define the scope of pregnancy-related services. Coverage continues through the end of the month in which the 60-day period following the end of the pregnancy falls, although states have the option of extending this postpartum coverage for 12 months, and most have done so or are planning to do so (see Text Box 1).[32]

In 40 states and the District of Columbia, the large majority of pregnant women are enrolled in Medicaid managed care organizations (MCOs).[33] For a fixed monthly capitation payment for each enrollee, MCOs, operating under the terms of contracts with the state Medicaid agency, organize networks of providers and pay them to deliver covered services, ensure access to quality care, and coordinate care for clinical and social needs (see Text Box 2).[34]

2 What is a Medicaid MCO?

A Medicaid managed care organization (MCO) is an entity that contracts with the state Medicaid agency to manage the provision of covered services to enrollees. The contract operates on a risk basis: that is, the agency pays the MCO a fixed amount each month on behalf of each beneficiary enrolled with the MCO, regardless of whether the enrollee uses services in that month. In exchange for this capitation, or per member per month, payment, the MCO agrees to make services available under the contract accessible to its enrollees through a network of hospitals, physicians, and other providers with which it subcontracts.

In contrast to fee-for-service arrangements, under which the financial incentive for providers is to furnish more services in order to generate more revenues, under a risk contract, the incentive for the MCO is to reduce the volume of services that it pays for in order to retain more of the capitation payments it receives.

State Medicaid agencies are not required to purchase covered services from MCOs for any beneficiary group, but the large majority do so, most commonly for children, parents, and pregnant women. As of March 2022, 40 states and the District of Columbia contracted with a total of 283 MCOs.[35] In 2020, five national publicly-traded companies owned 50% of all MCOs; the remaining MCOs are nonprofit, public or other for-profit entities that are not subsidiaries of the "Big Five."[36]

In general, each MCO determines the hospitals, physicians, and other providers with which it will subcontract to furnish covered services to its Medicaid enrollees. If Medicaid enrollees want Medicaid to pay for their care, they will usually be limited to receiving covered services from providers that participate in their MCO's provider network, except in emergency situations. Within their provider networks, MCOs manage the use of services by their enrollees through care managers and requirements for prior authorization of services as "medically necessary" before providers will be paid. If an MCO's provider networks are too narrow, its prior authorization requirements are too restrictive, or its care managers don't effectively manage high-risk pregnant women, then maternal outcomes will likely not be as good as they could or should be.[37,38]

For pregnant women enrolled in MCOs, their MCO is, in effect, the Medicaid program. Transparency about the performance of each MCO in managing the care of pregnant women, especially those women at greatest risk of serious complications or death related to pregnancy, is essential to identifying the causes of maternal death and implementing solutions for enrollees.

Evidence on the effects of Medicaid managed care for pregnant women is limited. Several studies reviewed indicate that women enrolled in Medicaid managed care plans have, at best, the same outcomes as those in fee-for-service, and at worst, have experienced reductions in access to care and poorer birth outcomes after their states moved from fee-for-service to managed care delivery systems.[39]

Severe obstetric complications and pregnancy-related deaths are not limited to women with low incomes and enrolled in Medicaid. Racial disparities in birth outcomes persist regardless of a woman's income, education, age, or where she lives. A landmark California study showed that even the most educated and highest income Black women were still more likely to die of pregnancy-related causes than the least educated and lowest income white women.[40] Pregnancy-related deaths and severe complications among Black women celebrities and athletes have also brought significant attention to the issue of racial bias and maternal health inequities.[41,42]

Maternal mortality rates are highest among Black women and American Indian/Alaska Native women, who are more likely to be covered by Medicaid.[43,44] As a result, it is unsurprising to see that in several cases, state maternal mortality review committee data show that women who were enrolled in Medicaid account for a larger share of pregnancy-related deaths than women covered by private insurance.[45]

This information alone is not enough to determine the role that coverage plays in maternal deaths. The factors driving maternal mortality are varied, and include preexisting health conditions, such as hypertension, diabetes, substance use disorders or untreated mental health conditions.[46,47] Other factors include limited access to care, especially in maternity care deserts; racial discrimination; food insecurity; housing instability; and other challenges that contribute to chronic stress and lower life expectancy.[48,49] While some of these factors are outside of the control of the Medicaid MCO, it can, at minimum, ensure that it is connecting pregnant women with the services it is being paid to provide.

Just as Medicaid MCOs cannot, by themselves, end the maternal health crisis, so transparency—including for MCO performance related to maternal health outcomes—will not on its own solve the maternal health crisis. But without it, we miss a critical opportunity to find solutions and address systemic problems in maternity care that contribute to the maternal mortality crisis.

III. Maternal Mortality Review Committees

Each maternal death is a tragedy for the families and communities left behind. The Centers for Disease Control and Prevention (CDC) finds that more than 80% of pregnancy-related deaths are preventable.[50] To understand the causes of and recommend solutions to prevent maternal deaths, state and local public health agencies have established maternal mortality review committees, which are multidisciplinary teams that convene regularly to review deaths that occur within a year of pregnancy.[51] Most issue regular reports on the number, demographics, and other characteristics of maternal deaths reviewed, frequently using standardized criteria from the CDC (see Text Box 3).[52]

3 Maternal Mortality Review Committees

As rates of maternal mortality have risen in the United States, maternal mortality review committees (MMRCs) have become even more critical to reviewing the causes of maternal death and making recommendations to prevent them in the future. MMRCs are state-level committees that consist of multidisciplinary representatives typically appointed to review deaths that occur during or within a year of pregnancy.[53] The scope of the MMRC review process differs by state and there is a great deal of variation in composition and operation. The committees are not mandatory, but 49 states have a formal MMRC. Idaho is the only state that has decided to disband its MMRC; it did so in 2023.

The general goal of MMRCs is to review all maternal deaths, identify root causes and contributing factors to these deaths, make recommendations to improve care at an individual and systemic level, and disseminate findings. MMRCs are provided access to clinical records and demographic information to enable them to understand the circumstances that led to a maternal death and to help identify systemic changes that could avoid maternal deaths in the future. There is no uniform analytic protocol, though many of the MMRCs follow guidelines created by the CDC.[54]

Committee membership varies by state, and may consist of public health professionals, OB/GYNs, maternal-fetal medicine specialists, physicians, midwives, doulas, Medicaid agency representatives, behavioral health experts, law enforcement representatives, individuals with lived experience, American Indian and Alaska Native tribe members, advocacy groups, and community-based organizations. MMRC reports can generally be found on the websites of state public health agencies.

The funding sources of MMRCs may include state funds, grants, or donations from private organizations. The CDC supports MMRCs in 44 states and two U.S. territories under the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program.[55]

Based on their analyses, these committees often make policy recommendations, which have included Medicaid expansion for all low-income adults and extending postpartum Medicaid coverage for 12 months after the end of pregnancy (i.e., Illinois, Kansas, Kentucky, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Tennessee, Washington).[56] While some committees have been operating quietly for decades, interest in the review process and committee reports has grown in recent years as more attention has been paid to widening racial disparities in maternal deaths and the increasing rate of maternal deaths overall.

IV. How We Did This Study

To determine what information is publicly available about the performance of individual Medicaid MCOs on maternal health, we scanned the websites of Medicaid agencies in 12 states, as well as the websites of the contracted MCOs. Additionally, we scanned the websites of the public health agencies in the selected states for MMRC reports. We also searched for financial information on state budget websites (legislative and executive). Finally, we scanned the website of the Center for Medicaid & CHIP Services at the Center for Medicare & Medicaid Services (CMS). We conducted our scan May through August 2023. (For a more detailed discussion of our methodology, see Appendix A.)

The 12 states we examined are Georgia, Illinois, Iowa, Kansas, Kentucky, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Tennessee, and Washington. These states do not represent a statistically significant sample of the 41 Medicaid managed care states (including the District of Columbia), but they do represent a mix of population sizes, urban/rural composition, regions of the U.S., managed care penetration, and Medicaid coverage policies (i.e., expansion vs. non-expansion).

As shown in Table 1, these 12 states represent about one-fifth (22%) of all Medicaid enrollees at the end of 2022 and account for 23% of all births in 2021. Their 2018-2021 maternal mortality rates ranged from 17 deaths per 100,000 live births in Illinois to 43 deaths per 100,000 live births in Mississippi.[57] In 2020, all 12 states had Medicaid managed care penetration rates of 64% or more; these rates are likely higher now.[58] The Medicaid income eligibility levels in these states for pregnant women in 2022 ranged from 165% of FPL ($22,423 for a single individual) (Nevada) to 380% of FPL ($51,642 for a single individual) (Iowa).[59] The share of births in 2021 covered by Medicaid ranged from 29% in New Jersey to 59% in Mississippi.[60] All of these states have MMRCs.

In our scans, we looked for the following information about each MCO with which the state Medicaid agency contracted during 2022: (1) the number and demographics of pregnant women enrolled under each MCO's contract with the state; (2) the amount of capitation payments made by the state to each MCO for these enrollees; (3) the performance of each MCO on Maternity Core Set metrics collected by the state (see Text Box 5); and (4) what Performance Improvement Projects relating to maternal health, if any, the state Medicaid agency required each MCO to conduct (see Text Box 7). We also checked whether the state Medicaid agency had a publicly-accessible data dashboard that includes maternal health metrics for each MCO.

The federal government does not require state Medicaid agencies to post items (1) and (2), but this information is, in our view, foundational to any understanding of the role of Medicaid managed care in improving maternal health in a state. It begins to answer the basic question: what is the size of the population of pregnant women whose care is being managed by each MCO, and what is the size of the state and federal government's investment in each MCO for this population?

CMS regulations do, on the other hand, require that state Medicaid agencies post the Annual Technical Reports prepared by External Quality Review Organizations (EQRO) (see Text Box 4). Those reports should contain the information in items (3) and (4) above, but the content varies from state to state because CMS regulations currently do not require states to collect all Maternity Core Set metrics from MCOs or to conduct Performance Improvement Projects relating specifically to maternal health. CMS regulations do, however, require that state Medicaid agencies post their risk contracts with each MCO; the ways in which those contracts approach maternal health have been analyzed in great detail by researchers at George Washington University for The Commonwealth Fund.[61,62]

Table 1. Characteristics of States Selected

State	Total Medicaid Enrollment (as of Jan. 1, 2023)	Medicaid Eligibility Level for Pregnant Women, % of FPL (2022)	Number of Contracting MCOs in Scan (2022)	Percentage of Medicaid Beneficiaries Enrolled in MCOs (2020)	Number of Live Births (2021)	Number of Births Financed by Medicaid (2021)	Share of Births Financed by Medicaid (2021)	Maternal Mortality Rate (Deaths per 100,000 live births; 2021)
National	**85,915,795**	**200%**	**285**	**72.0%**	**3,664,292**	**1,490,085**	**41%**	**–**
Georgia	2,165,047	225%	3	69.3%	124,073	57,113	46%	33.9
Illinois*	3,463,814	213%	5	74.4%	132,189	49,868	38%	17.3
Iowa	784,989	380%	2	89.6%	36,835	13,918	38%	20.2
Kansas	434,716	171%	3	88.4%	34,705	10,509	30%	22.0
Kentucky	1,487,786	195%	6	90.8%	52,214	23,430	45%	38.4
Michigan	2,924,598	200%	9	75.0%	104,980	39,585	38%	19.4
Mississippi	698,366	199%	3	63.9%	35,156	20,721	59%	43.0
Nevada**	823,792	165%	4	77.5%	33,686	14,908	44%	21.7
New Jersey	1,957,543	194%	5	94.4%	101,497	29,575	29%	25.7
New Mexico	835,044	255%	3	82.0%	21,391	11,504	54%	30.2
Tennessee***	1,646,542	200%	4	92.5%	81,717	37,328	46%	41.7
Washington	2,095,795	198%	5	87.9%	83,911	27,992	33%	20.4

National maternal mortality rate is not available given small sample sizes in 13 states and DC.

* Illinois has a total of seven plans but Humana Health Plan (Humana), which covers dual Medicare and Medicaid enrollees, and YouthCare (Centene), the enrollment of which is limited to children and youth in foster care and [juvenile justice institutions], were not included for the purposes of this study.

** Our results differed from KFF Medicaid MCO Enrollment by Plan and Parent Firm (March 2022), which lists Nevada as having three MCO plans: Anthem BlueCross Blue Shield (Elevance), Health Plan Nevada (UnitedHealth Group), and SilverSummit Health Plan (Centene). Our survey included an additional MCO plan: Molina Healthcare of Nevada (Molina), which began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022.

*** There are four MCOs parent firms operating in Tennessee, however there are a total of 10 MCO plans and results (Core Set Metrics) are reported for each of three regions in the state.

Sources:

Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies," KFF (March 2023), Table 2, https://www.kff.org/statedata/collection/medicaid-and-chip-eligibility-enrollment-and-renewal-policies/.

MACStats: Medicaid and CHIP Data Book 2022, Exhibit 29, https://www.macpac.gov/wp-content/uploads/2022/12/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-July-1-2020.pdf.

CDC, "State and Territorial Data: births, birth rates, deaths, and death rates by state and territory," https://www.cdc.gov/nchs/fastats/state-and-territorial-data.htm.

KFF, "Births Financed by Medicaid, 2021," available at https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?activeTab=map&currentTimeframe=0&selectedDistributions=percent-of-births-financed-by-medicaid&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

CDC, "Maternal deaths and mortality rates: Each state, the District of Columbia, United States, 2018-2021," available at https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2021-state-data.pdf.

4 What's an External Quality Review Organization?

Under risk contracts between state Medicaid agencies and MCOs, there is a financial incentive for the MCO to limit the amounts it pays out for covered services. This incentive is one reason that many state Medicaid agencies contract with MCOs to contain their program spending. As a check against these cost containment incentives, federal regulations require that state Medicaid agencies contract with at least one External Quality Review Organization (EQRO) to assess MCO performance and quality. The EQRO must be independent of both the state Medicaid agency and any MCO it reviews. The federal government pays 75% of the cost of the state's contract with the EQRO.

States have discretion as to the scope of their contract with an EQRO, but there are some minimum federal requirements. Among other things, the state agency must require the EQRO to produce each year a detailed report that includes the data the EQRO has collected and its assessment of "each MCO's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries."[63] The report, known as the Annual Technical Report (ATR), must be posted on the state Medicaid agency's website by April 30 of each year. The state agency may not substantively revise the content of the final ATR "without evidence of error or omission."

EQROs are a potentially powerful source of data and analysis that could inform efforts of maternal health advocates and policymakers to understand and, where necessary, improve the outcomes for pregnant and postpartum women enrolled in MCOs. The information they collect must be made available on request to interested parties, including beneficiary advocacy groups.[64] In our study, the only standardized maternal health metrics available in each state we scanned were those presented in the ATRs prepared by the EQROs.

Unfortunately, not all state Medicaid agencies have made maternal health a priority for EQRO activities, and even where they have, the ATRs tend to focus on process rather than outcomes and are often too dense to be useful to stakeholders and the public.[65] There is currently interest at the federal level in improving EQRO oversight of MCO performance generally. The Medicaid and CHIP Payment and Access Commission (MACPAC) has published a background issue brief, and CMS has proposed changes to the current EQRO regulations.[66, 67] It is possible that these efforts, combined with state-level advocacy, could lead to greater and more effective EQRO focus on MCO performance on maternal health.[68]

The MCOs contracting with each state in 2022, along with their parent companies, are listed in Table 2. (This list does not include MCOs that enroll only children and youth in foster care, as is the case in Illinois).[69] Of the 52 MCOs, 37 are owned by one of the "Big Five" national companies in the Medicaid managed care market: 11 by Centene, eight by UnitedHealth Group, seven by Elevance Health, and six by Molina, and five by CVSHealth.[70] The remaining MCO parent firms are Health Care Service Corporation, which operated subsidiaries in two states, and Humana Health Plan, McLaren Health Care, and CareSource, each of which operated in one state. In addition, there were 10 plans that are not subsidiaries of any national, publicly traded company. We scanned the websites of each of these MCOs as well as their parent companies looking for the same information for which we searched on state Medicaid agency websites, above.

Table 2. Medicaid Managed Care Organizations by State, 2022

Parent Companies as of March 2022

State	MCOs	Parent Company for MCO	Total Medicaid Enrollment for MCO (March 2022)	Pregnant Women Enrolled (March 2022)
Georgia	Amerigroup Community Care	Elevance	531,178	NR
	Care Source	CareSource	405,300	NR
	Peach State Health Plan	Centene	978,459	NR
Illinois	Cook CountyCare	N/A	428,497	9,513
	Aetna Better Health	CVS Health	440,771	6,556
	Meridian Health Plan	Centene	893,207	15,791
	Blue Cross Blue Shield of Illinois	Health Care Service Corporation	706,257	15,727
	Molina Healthcare of Illinois	Molina	345,142	5,628
Iowa	Amerigroup	Elevance	413,193	NR
	Iowa Total Care	Centene	318,532	NR
Kansas	Aetna Better Health of Kansas	CVS Health	136,320	NR
	Sunflower Health Plan	Centene	164,154	NR
	United Healthcare Community Plan	UnitedHealth Group	173,628	NR
Kentucky	Aetna Better Health of Kentucky	CVS Health	248,380	NR
	Anthem BlueCross Blue Shield	Elevance	171,031	NR
	Humana Healthy Horizons in Kentucky	Humana Health Plan	168,042	NR
	Passport Health Plan by Molina Healthcare	Molina	329,846	NR
	United Healthcare Community Plan	UnitedHealth Group	66,546	NR
	Wellcare of Kentucky	Centene	485,633	NR
Michigan	Aetna Better Health of Michigan	CVS Health	53,821	NR
	Blue Cross Complete of Michigan	N/A	330,124	NR
	HAP Empowered	N/A	30,639	NR
	McLaren Health Plan	McLaren Health Care	257,027	NR
	Meridian Health Plan of Michigan, Inc.	Centene	556,274	NR
	Molina Healthcare of Michigan	Molina	390,141	NR
	Priority Health Choice	N/A	240,404	NR
	UnitedHealthcare Community Plan of Michigan	UnitedHealth Group	300,282	NR
	Upper Peninsula Health Plan	N/A	52,693	NR
Mississippi	Magnolia Health	Centene	159,876	NR
	Molina Healthcare Plan of Mississipi	Molina	79,089	NR
Nevada	Anthem BlueCross Blue Shield	Elevance	190,859	NR
	Health Plan Nevada	UnitedHealth Group	208,850	NR
	Molina Healthcare of Nevada	Molina	N/A	NR
	SilverSummit Health Plan	Centene	137,904	NR
New Jersey	Aetna Better Health of New Jersey	CVS Health	128,603	NR
	Amerigroup New Jersey	Elevance	259,640	NR
	Horizon NJ Health	N/A	1,147,605	NR
	UnitedHealthcare Community Plan of New Jersey	UnitedHealth Group	405,675	NR
	Wellcare of New Jersey	Centene	108,523	NR

Table 2. Medicaid Managed Care Organizations by State, 2022 (cont'd)

State	MCOs	Parent Company for MCO	Total Medicaid Enrollment for MCO (March 2022)	Pregnant Women Enrolled (March 2022)
New Mexico	Blue Cross Blue Shield of New Mexico	Health Care Service Corporation	292,418	3,349
	Presbyterian Health Plan	N/A	423,306	3,707
	Western Sky Health Plan	Centene	86,145	905
Tennessee	Amerigroup Tennessee	Elevance	495,571	NR
	BlueCare	N/A	617,379	NR
	TennCare Select	N/A	52,737	NR
	UnitedHealthcare Community Plan of Tennessee	UnitedHealth Group	496,792	NR
Washington	Amerigroup Washington	Elevance	221,255	1,453
	Community Health Plan of Washington	N/A	237,208	1,671
	Coordinated Care Corporation	Centene	203,205	1,262
	Molina Healthcare Plan of Washington	Molina	951,225	5,691
	UnitedHealthcare Community Plan of Washington	UnitedHealth Group	238,016	1,493

We also examined the most recent MMRC report issued by each state's public health agency. We looked to see whether the analysis of maternal deaths took into account the source of health insurance coverage (if any) in general and Medicaid MCO enrollment in particular, and if so, what findings the report made (see Text Box 5).

Finally, we scanned the CMS Medicaid website for information about MCO-specific performance on maternal health. The CMS state managed care profiles did not have data to inform this study.[71] CMS does not post MCO-specific enrollment data, broken down by pregnancy status, or by race and ethnicity of pregnant women.[72] It does post the Maternity Core Set measures that state Medicaid agencies report, but the most recent report is for performance in federal fiscal year 2020, and the data are presented on a statewide, aggregate basis, not on an MCO-specific basis (see Text Box 6).[73] The CMS Maternity Care Action Plan (December 2022) does not mention Medicaid MCOs.[74]

5 What is a Managed Care Program Annual Report?

As part of its oversight of Medicaid managed care, CMS requires state Medicaid agencies to submit an annual report on the operation of their managed care programs. This Managed Care Program Annual Report (MCPAR) includes at least nine different elements, including the financial performance of each MCO and an evaluation of MCO performance on quality measures.[75] In June of 2021, CMS issued a reporting template for states to use in submitting their MCPARs; the template at tab D2 requires states to report measure results for each MCO in eight domains, including maternal and perinatal health.[76] The first round of submissions, for the contract year 7/21/2021 to 6/30/22, was due in December 2022.[77]

States are required to submit MCPARs to CMS annually. States are also required to post the MCPARs on their websites and provide them to their Medical Care Advisory Committees.[78] Of the 12 states we surveyed, only Mississippi posted the MCPAR for its non-specialized MCOs.[79] Michigan posted a MCPAR for its managed behavioral health program.[80] Iowa posts an MCO Annual Performance Report but not its MCPAR.[81] As of August 2023, CMS had not posted any of the MCPARs the states have submitted, but in July of 2022 it indicated that they would be publicly available on request.[82]

V. What We Found About Medicaid MCO Performance

In the 12 states we studied, there was little transparency about the performance of Medicaid MCOs on maternal health. Here is what we found for each piece of information searched:

1. Number and demographic characteristics of pregnant women enrolled in each MCO.

MCO accountability for maternal health outcomes begins with identifying how many pregnant women whose care the MCO is being paid to manage. Only three state agencies—Illinois, New Mexico, and Washington—posted the number of pregnant enrollees in each MCO. Only two—New Mexico and Washington—disaggregated those MCO-specific enrollee numbers by race and ethnicity.

2. Total amount of capitation payments made by the state Medicaid agency to each MCO for pregnant enrollees.

Accountability of an MCO also starts with the size of the state's (and federal government's) investment in each MCO's management of the care of pregnant women. Only Kansas provided the total amount its paid its MCOs for enrolling pregnant women. None of the states posted the total amount of capitation payments to individual MCOs on behalf of pregnant enrollees.

3. Performance of each MCO on Maternity Core Set metrics collected by the state with which it contracts.

As explained in Text Box 6, the Maternity Core Set is a group of nine standardized performance measures identified by CMS. State collection and reporting of these metrics is currently optional. As a result, there is wide variation from state to state as to which of the measures are collected from MCOs and whether the state posts the measures it collects on an aggregate statewide basis or on an MCO-specific basis. (This will change in 2024 when collection and reporting of six of these measures on a statewide basis will become mandatory.)[83]

We focused on six of the nine CMS Maternity Core Set measures for performance years 2021 or 2022.[89] As shown in Table 3, the two measures most frequently reported on a statewide basis were Timeliness of Prenatal Care and Postpartum Care. All 12 of the states reported statewide results for these measures.[90] The other four measures were much less frequently reported on a statewide basis.

Only Illinois reported statewide results on the measure of Live Births Weighing Less than 2,500 Grams. Iowa and Illinois were the only states to report on the measure of Low-Risk Cesarean Delivery. Only Mississippi, New Jersey, and New Mexico reported at least one of the measures on Contraceptive Care for Postpartum Women on a statewide basis.

States that report some Maternity Core Set measures on a statewide basis do not necessarily also report those measures on an MCO-specific basis. As shown in Table 3, Illinois reported statewide results for Live Births < 2500 Grams but did not report MCO-specific results for that measure. On the other hand, all 12 states reported Timeliness of Prenatal Care and Timeliness of Postpartum Care on both a statewide and MCO-specific basis.

Where available, the MCO-specific results were usually included in the Annual Technical Report prepared by the state's EQRO and posted on the state Medicaid agency's website (see Text Box 4). Our detailed findings about individual MCO performance on the Maternity Core Set measures, extracted from these EQRO reports, are presented in Appendix B.

We also searched for MCO performance on three other Healthcare Effectiveness Data and Information Set (HEDIS) metrics related to maternal health that are not included in the CMS Maternity Core Set: (1) Prenatal Immunization Status; (2) Prenatal Depression Screening and Follow-up; and (3) Postpartum Depression Screening and Follow-up.[91] New Mexico posted MCO-level performance data on the Prenatal Immunization Status measure for two of its three MCOs. No other state posted MCO-specific results for any of these measures, and only Illinois reported statewide performance data on Postpartum Depression Screening and Follow-Up.

6 What is the Maternity Core Set?

To better understand the quality of maternal and infant health care delivered to people enrolled in Medicaid, the Centers for Medicaid and CHIP Services has developed the Maternity Core Set, comprised both of child and adult quality metrics that highlight several perinatal health indicators, such as timeliness of prenatal and postpartum care and access to contraception for teens and adults.[84]

Reporting on these measures has been voluntary for states, but that will change in 2024 when state reporting becomes mandatory for the measures that are drawn from the Child Core Set. CMS regulations issued in August 2023 require that all states report Child Core Set measures for 2024 to CMS no later than December 31, 2024.[85] The nine measures in the Maternity Core Set quality metrics for 2024 are listed in Table 7 located on page 25).

State reporting on the three measures that come from the Adult Core Set will continue to be voluntary but we recommend that states report them.[86] Particularly as states implement the 12-month postpartum coverage period (see Text Box 1), measuring rates of postpartum visits and contraception will be key to measuring the effectiveness of the coverage extension.[87]

Advocates have also recommended that these metrics be disaggregated by race, ethnicity, managed care plan, geography and other demographic factors.[88] Transparency for state and MCO-level reporting on these metrics would allow pregnant women, policymakers, managed care plans and the public to see how well states and individual MCOs are performing on these metrics, and identify disparities. This level of transparency is critical to understanding the ongoing maternal health crisis and identifying where improvements in Medicaid are needed. The August 2023 CMS regulations do not require reporting of the Child Core Set measures at the MCO level, but they do give CMS the authority, after consultation with the states and interested parties, to require stratification of one or more of the measures by race and ethnicity, among other factors, over the next five years.

Table 3. State Reporting of Medicaid Maternity Core Set Measures

Results from performance year 2021 or 2022

State	Live Births < 2500 grams	Low-Risk Cesarean Delivery	Timeliness of Prenatal Care	Timeliness of Postpartum Care	Contraceptive Care Postpartum Ages 15-20	Contraceptive Care Postpartum Ages 21-44
GA			S, MCO	S, MCO		
IL	S	S	S, MCO	S, MCO		
IA		S	S, MCO	S, MCO		
KS			S, MCO	S, MCO		
KY			S, MCO	S, MCO		
MI			S, MCO	S, MCO		
MS			S, MCO	S, MCO		S, MCO
NV			S, MCO	S, MCO		
NJ			S, MCO	S, MCO	S, MCO	S, MCO
NM			S, MCO	S, MCO	S	
TN			S, MCO	S, MCO		
WA			S, MCO	S, MCO		

S = Statewide results posted (not necessarily from ATR). MCO = MCO-specific results posted.

Source:

State and MCO results for Georgia, Kentucky, New Jersey, Michigan, Nevada, Washington all found in EQRO ATR.

Illinois: "2022 Perinatal Report" (Springfield: Illinois Department of Healthcare and Family Services, 2022), https://www.ilga.gov/reports/ReportsSubmitted/3111RSGAEmail5974RSGAAttachGeneral%20Assembly%20Perinatal%20Report%202022%20FINAL.pdf/.

Kansas: "KanCare Dashboard," (Topeka: KanCare Medicaid for Kansas, 2022), https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-dashboard.pdf?sfvrsn=3b4f511b_12/; and "KanCare Program Annual External Quality Review Technical Report 2022–2023 Reporting Cycle," https://www.kancare.ks.gov/docs/default-source/quality-measurement/eqro-reports/current-eqro-report/2022-2023-annual-eqr-technical-report.pdf?sfvrsn=9770521b_2/.

New Mexico: "Healthcare Effectiveness Data and Information Set (HEDIS) Reports," New Mexico Human Services Department available here, and "New Mexico Medicaid Managed Care Centennial Care 2.0 Program" (Santa Fe: New Mexico Human Services Department, April 2023), https://www.hsd.state.nm.us/healthcare-effectiveness-data-and-information-set-hedis-reports/.

Mississippi: "Managed Care Program Annual Report (MCPAR) for Mississippi: Mississippi Coordinated Access Network (MSCAN)," (Jackson: Mississippi Division of Medicaid, December 2022), https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/27375da2-d30b-47e2-b327-ddd41fbdc6b8/EQRO-IPRO%20Annual%20Technical%20Report%202021; and "Mississippi External Quality Review Annual Comprehensive Technical Report For Contract Year 2021– 2022," op. cit.

Tennessee: "2022 Annual HEDIS/CAHPS Report," (Nashville: Division of TennCare, November 2022), https://www.tn.gov/content/dam/tn/tenncare/documents/hedis22.pdf.

4. State requirement that MCOs conduct Performance Improvement Projects relating to maternal health.

As part of their responsibility to improve the quality of their managed care programs, state Medicaid agencies must require that MCOs conduct Performance Improvement Projects (See Text Box 7). The agencies have broad latitude in determining what clinical areas their PIPs address; maternal health is just one of many possible topics.[92] The PIPs must be validated—that is, reviewed for accuracy, reliability, and freedom from bias—by the state's EQRO, which must include its analysis of the result in its ATR. We searched the ATRs posted by each state agency for PIPs relating to maternal health during performance year 2022.

7 What's a Performance Improvement Project?

State Medicaid agencies are required, as part of their responsibility for overseeing the quality of services furnished by the MCOs with which they contract, to direct the MCOs to conduct Performance Improvement Projects (PIP) and report the results at least annually. The PIPs have to be designed "to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;" there's no further federal guidance as to the specific topics a state must select.[93] One of the mandatory activities of an EQRO (see Text Box 4) is to validate the PIPs underway in each MCO. CMS has a detailed technical protocol for EQROs to follow in validating PIPs.[94] The Annual Technical Report prepared by the EQRO and posted on the state Medicaid agency's website must include a description of the data obtained and the conclusions drawn about each PIP the EQRO validated during the previous 12 months.

As noted, state Medicaid agencies determine the topics of the PIPs that MCOs must conduct. (CMS has the authority to specify PIPs that states must require MCOs to conduct, but has not done so). In 2018, Michigan became one of the states that requires PIPs relating to maternal health performance. All 10 of Michigan's MCOs were required to conduct PIPs on the topic of "Addressing Disparities in Timeliness of Prenatal Care" again in 2021. The detailed study indicators varied from MCO to MCO, but the common objective was to increase the percentage of eligible pregnant women in designated areas who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the MCO, with the goal of reducing racial disparities in these percentages. The EQRO analyzed the results achieved by each MCO; of the 10 MCOs, six met their validation rating, one partially met it, and three did not.[95]

The EQRO identified timeliness of prenatal and postpartum care as a program-wide weakness: "Although [the Michigan Medicaid agency] mandated the [MCOs] conduct an Addressing Disparities in Timeliness of Prenatal Care PIP to support improvement, many women were not always having, or accessing timely, prenatal and/or postpartum care visits, as demonstrated through lower [Medicaid managed care program] performance for the Prenatal and Postpartum Care measure rates. Both measure rates ranked below the [national Medicaid] 25th percentile and demonstrated a statistically significant decline from the prior year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants."[96]

As shown in Table 4, nine of the 12 states required one or more of their MCOs to conduct PIPs on a topic relating to maternal health in 2022; Kentucky, New Jersey, and Tennessee did not. The most frequent PIP topic was Timeliness of Prenatal Care—conducted by 18 MCOs in five states (Georgia, Illinois, Michigan, Nevada, New Mexico).

Table 4. Performance Improvement Projects Relating to Prenatal and Postpartum Care, 2022

State	PIP	Topic (# of MCOs with topic out of total MCOs)
GA	Y	Timely Prenatal Care (3 of 3)
IA	Y	Timeliness of Postpartum Care (2 of 2)
IL	Y	Timeliness of Prenatal Care (5 of 5)
KS	Y	Prenatal Care (1 of 3)
KY	N	None
MI	Y	Addressing Disparities in Timeliness of Prenatal Care (6 of 9); Improving Timeliness of Prenatal Care (3 of 9)
MS	Y	Reducing Preterm Births (1 of 3); Prenatal and Postpartum Care (1 of 3); Improved Pregnancy Outcomes (1 of 3)
NV	Y	Timeliness of Prenatal Care (3 of 4)
NJ	N	None
NM	Y	Timeliness of Prenatal Care (1 of 3); Prenatal-Postpartum (1 of 3); Addiction in Pregnancy (1 of 3)
TN	N	None
WA	Y	Improving Timeliness of Postpartum Visits (1 of 5)

VI. What We Found in the MMRC Reports

All 12 states we studied had an active MMRC, and all of those MMRCs issued reports on their findings. The reports we reviewed varied significantly in length and depth of analysis as well as in the time period covered. Here is a summary of our findings:

1. Timeline of the most recent MMRC report published and data reviewed.

We found a wide range of years reported. Only Michigan and Nevada had data reflecting maternal deaths that occurred as recently as 2021. Illinois had the oldest data of the states we scanned: its most recent maternal mortality review committee report reflects maternal deaths that occurred in 2016-2017. Importantly, this data lag puts the MCO performance data analyzed above, and the maternal deaths reviewed, on different timelines.

Table 5. Most Recent Year of Maternal Mortality Measured, as of July, 2023

Most Recent Year of Maternal Mortality Data Measured	State(s)
2021	Michigan, Nevada
2020	Georgia, Tennessee, Washington
2019	Iowa, Kansas, Kentucky, Mississippi
2018	New Mexico, New Jersey
2017	Illinois

2. State Medicaid agency participation in the MMRC.

Identifying the cause of, and promoting solutions to, maternal mortality includes understanding whether the mother can access timely, high-quality health care. As the payer for over 40% of all births each year, Medicaid has important insight into the opportunities and challenges new mothers face in accessing lifesaving care. Of the 12 states reviewed, seven states included the state Medicaid agency on their maternal mortality review committee and five did not.

Table 6. Medicaid Agency Participating on Maternal Mortality Committee

Medicaid Agency Participating on MMRC	State(s)
Yes (7)	Georgia, Illinois, Kansas, Kentucky, Michigan, New Jersey, Washington
No (5)	Iowa, Mississippi, Nevada, New Mexico, Tennessee*

*Tennessee indicated public and private insurers are represented.
Based on AMCHP Review to Action, available at https://reviewtoaction.org/tools/networking-map.

3. MMRC analysis of insurance coverage at time of death.

All but one state maternal mortality review committee (Michigan) reported the type of insurance coverage for maternity care for the mother who died of pregnancy-related causes. The reports generally separated the sources of coverage by Medicaid, private insurance, or uninsured. Where they identified Medicaid as the source of coverage, however, none of them noted whether the coverage was provided on a fee-for-service basis or through risk-based managed care.

4. MMRC analysis of enrollment by Medicaid MCO.

Simply looking at a pregnant woman's enrollment in the Medicaid program is not sufficient to understand how the performance of her MCO could be associated with her pregnancy-related death. In the 12 states reviewed, no state MMRC report included data related to the enrollment in a particular Medicaid MCO among women who died during pregnancy or within a year after birth. Without this level of information, states are missing an opportunity to understand which MCOs are doing well, which ones are doing poorly, and where changes are needed to protect the lives of new mothers.

5. MMRC analysis including Medicaid-specific findings or policy recommendations.

Each of the 12 states had an MMRC report that included either Medicaid-specific findings, such as comparing the rate of Medicaid-covered women who died versus women who had private coverage, or a Medicaid-related policy recommendation. Michigan's MMRC report was the only one not to mention Medicaid, but it did include a recommendation to refer pregnant women to its unique Medicaid-financed home visiting program.[97]

Some of the most frequent Medicaid-related recommendations were extending the duration of postpartum Medicaid coverage to one year after the end of pregnancy (Georgia, Iowa, Mississippi, Nevada, New Mexico), and utilizing presumptive eligibility to enroll more women in early prenatal care (Kentucky, Mississippi). Other recommendations included better care coordination, referral to the respective state Medicaid-financed home visiting program, and improved access to Medicaid-supported transportation.[98]

Illinois was the only state to make recommendations for actions Medicaid MCOs should take to reduce maternal mortality (see Text Box 8).

8 The Illinois MMRC's Recommendations to MCOs

In its 2021 Maternal Mortality Review Committee Report, Illinois made specific recommendations for actions that health insurance plans, including Medicaid MCOs, should take to reduce maternal mortality.[99] The report emphasized that the majority of the pregnancy-associated deaths occurred more than two months after pregnancy, and that payers should increase access to all necessary medical services during the first year postpartum, including ensuring sufficient specialist networks and non-traditional services, such as doula care and services delivered via telehealth. The committee recommended that Medicaid MCOs:[100]

- Allow reimbursement for multiple postpartum visits for all women;
- Cover intensive case management and outreach and non-medical support services (such as doulas) for women with complex medical and mental health conditions while pregnant and up to one year after delivery; and
- Reimburse for telehealth regardless of patient or provider location, for clinical services not widely geographically available in Illinois such as cardiology, pain management, psychiatry, substance use treatment, counseling services.

VII. Discussion

We undertook this research with relatively low expectations about the transparency of information relating to performance of individual MCOs on maternal health. These expectations had been set by two previous scans, one looking for performance for individual MCOs for children, and the other for performance of MCOs enrolling children and youth in foster care.[101,102] Unfortunately, we found little improvement in transparency.

In general, neither state Medicaid agencies, MCOs, nor CMS are transparent about the performance of individual MCOs relating to maternity care. For the most part, information is difficult to access from state or MCO or CMS websites, and the information that is accessible is limited, fragmented, and not sufficient to inform a judgment of how well or how poorly an individual MCO is performing.

In all 12 states we surveyed, the MCO-specific performance on Maternity Core Set metrics that states reported was not disaggregated by race or ethnicity. New Mexico and Washington posted the number of pregnant women enrolled in each MCO, disaggregated by race and ethnicity, but they did not stratify the performance metrics they reported by race or ethnicity.

Medicaid pays for a disproportionate share of births to Black women and American Indian/Alaska Native women.[103] Women in these groups have higher rates of maternal mortality than the national average.[104] In managed care states, pregnant women in those groups who are covered by Medicaid are also likely to be enrolled in an MCO. How that MCO performs—how accessible its providers are, how effectively it identifies high-risk enrollees and manages their care—matters.

Yet even the sparse MCO-specific performance data that is publicly available is not stratified by race or ethnicity. This makes it impossible, as a practical matter, for those other than the MCO, the state Medicaid agency, and (upon request) CMS, to know whether there are disparities in access to maternity care or outcomes within an MCO or how to advocate for reducing those disparities.

Even if the performance data that states report were stratified by race and ethnicity, the measures reported are insufficient to judge how an individual MCO is performing on maternal health. Appendix B tells the tale. It presents, for each MCO in each of the 12 states we scanned, the performance of the MCO on each of nine maternal health metrics. As noted in Table 3, we found MCO-specific results in all states for two of the metrics—Timeliness of Prenatal Care and Timeliness of Postpartum Care. For the other seven metrics, MCO-specific results were largely unavailable.

What, if anything, can results on just two metrics (see Text Boxes 9 and 10) tell beneficiaries and the public about an MCO's performance on maternal health? At best, by enabling the comparison of an MCO's performance to that of other MCOs in the same state, these results can serve as a flag for further inquiry. The example of Centene, which has the largest footprint in the Medicaid market and operates subsidiaries in 11 of the 12 states we scanned, is instructive.[105]

9 Timeliness of Prenatal Care Performance Metric

One of the most frequently reported measures in our scan of 12 states was state and MCO-level performance on "Timeliness of Prenatal Care." This measure provides the only available glimpse into the access to prenatal care across MCOs and states. Research shows prenatal care reduces risks of pregnancy complications for the mother and increases the likelihood that the baby will be born at full gestation at a healthy birth weight.[106] Because of the importance of prenatal care to healthy pregnancy outcomes, the measure is worth unpacking to understand just what it captures–and what it does not.

The metric counts prenatal visits for women in two groups.[107] For the first group, it counts women who were continuously enrolled in Medicaid for at least seven months before delivery and 60 days postpartum, and who had their first prenatal visit in the first trimester (roughly 12 weeks) of pregnancy. In the second group, the metric counts women who were not continuously enrolled in Medicaid within seven months of delivery, and who had one prenatal visit within 42 days of enrollment in Medicaid.

These groups are then combined and compared to the total universe of women with live births in the measurement year, who are continuously enrolled in Medicaid at least 43 days before delivery and 60 days postpartum.

From a clarity standpoint alone, this is challenging. There is no way to know how many women are in each category. The potential for pregnancy complications is vastly different for a woman who starts prenatal care in the first trimester, compared to a pregnant woman whose enrollment in Medicaid happens less than seven months before delivery and who receives a prenatal visit 42 days later. This could put a pregnant woman's prenatal visit well into month five of pregnancy or even later. While this care would be counted as "timely" for purposes of the measure, it is far from the American College of Obstetrics and Gynecology's recommendation to initiate prenatal care as soon as an individual thinks they may be pregnant.[108]

Most MCOs we reviewed exceeded 70% of enrolled pregnant women receiving a timely prenatal visit according to the measure specifications (see Appendix B). The American College of Obstetrics and Gynecology recommends roughly 15 prenatal visits throughout pregnancy.[109]

Because the metric is part of the Child Core Set of measures, reporting the Timeliness of Prenatal Care measure will be mandatory for states in 2024. Standardized state and MCO-level data reporting is an essential—if limited—first step in creating a standard for accountability for access to the most basic prenatal care.

10 Timeliness of Postpartum Care Performance Metric

The postpartum period is a critical time for physical recovery and bonding for the mother, infant and new family.[110] It can also be a dangerous time: roughly 53% of pregnancy-related deaths happen between 7 and 365 days postpartum.[111] Along with the "Timeliness of Prenatal Care," the "Timeliness of Postpartum Care" metric was the most frequently-reported metric in our 12-state scan, though just 39 states nationally reported it in federal fiscal year 2020.[112]

The metric counts how many pregnant women who were enrolled in Medicaid for at least 43 days before birth and 60 days postpartum, received one postpartum visit between 7 and 84 days after delivery.[113] The rates in the states we scanned varied from 52% to 89%.

One postpartum visit is less than the standard of care: The American College of Obstetrics and Gynecology recommends women receive at least two postpartum visits, one within the first three weeks and a comprehensive visit within 12 weeks of birth.[114]

The Timeliness of Postpartum Care measure is part of the Adult Core Set, so it will remain optional for states to report. However, as states implement the 12-month postpartum coverage option (see Text Box 1), this metric will be critical to track to see if the lengthened coverage period is leading to greater utilization of postpartum care.

In six of the 11 states where Centene operates—Georgia, Iowa, Kansas, Nevada, New Mexico, and Washington—the Centene subsidiary ranked the lowest among all the MCOs on both the Timeliness of Prenatal Care and the Timeliness of Postpartum Care (see Appendix B). In all selected states other than Kansas, the Centene subsidiaries were directed to conduct a PIP related to maternal health, and the EQRO's evaluation of that project is available in the Annual Technical Report posted on the state agency website (see Text Box 2).

These are useful flags for further inquiry, but there is little if any publicly available information beyond those metrics and PIPs in each of these states. None of these six states reported any of the remaining Maternity Core Set metrics for Centene or any other MCO, and none posted any MCO-specific maternal mortality outcomes. The websites of the Centene subsidiaries, the parent company, and CMS were also uninformative. None of the MMRC reports in the 11 states where Centene operates analyzed maternal mortality or morbidity among enrollees of individual MCOs.

11 Why does transparency matter to MCO performance on maternal health?

Transparency about performance is one tool for holding MCOs accountable for the accessibility and quality of services for pregnant women and other enrollees. It greatly enhances the primary tool for MCO accountability—the risk contract between the state Medicaid agency and the MCO (see analysis at endnote 34)—at minimal cost and administrative burden to the agency or the MCO. There are three main considerations.

First, pregnant women who are enrolled in a Medicaid MCO are dependent on that MCO for access to the services they need and for which the MCO has taken responsibility to deliver under its contract with the state Medicaid agency. The agency is paying the MCO on a monthly basis to manage the care of all of its enrollees, including pregnant women. That is a complicated undertaking that involves, among other things, organizing a network of high-quality providers, ensuring that the enrollees are accessing the services the MCO has contracted with the state agency to provide, tracking and analyzing utilization, and reporting on metrics and outcomes. And because the state pays the MCO a monthly capitation amount for each enrollee regardless of whether the enrollee uses services, the financial incentive for the MCO is to furnish fewer rather than more services.

Second, because of their size and complexity and the financial incentives inherent in capitation, holding MCOs accountable for their performance can be challenging.[115] The primary responsibility for oversight rests with the state Medicaid agency, which selects the MCOs with which it contracts, sets the terms of those contracts, establishes the rates of payment to the MCO, and monitors and enforces compliance with the contract terms. To assist the agency in its monitoring, the federal government pays 75% of the cost of independent quality review by an EQRO, giving the agency access to validated data about each MCO's performance on an annual basis, but requiring the agency to select and contract with the EQRO. These multiple responsibilities are technically and logistically complex, placing large demands on often under-resourced state Medicaid agencies. Combined with the political reach of many MCOs, these constraints limit the ability of state Medicaid agencies, by themselves, to hold MCOs accountable for performance.[116]

Finally, there is the question of behavioral incentives. If the management of an MCO knows that its performance will be available to the public, the management will likely want to ensure that the organization's performance is strong, both to maintain and expand its enrollment and to protect its wider reputation. If the leadership of a state Medicaid agency knows that the performance of each of the MCOs with which it has decided to contract and to which it is making large payments will be available to the public, it will likely want to ensure that any low-performing MCOs improve their performance to avoid reputational damage to the agency. The same dynamic would apply at the federal level as well.

Transparency of Medicaid MCO performance data will not, in and of itself, solve the maternal health crisis in this country. It is, however, an effective mechanism for holding MCOs, state Medicaid agencies, and CMS accountable for their performance on maternal health. The MCOs and the state agencies have (or should have) the data on maternal health outcomes for pregnant women enrolled in each MCO. Collection and analysis of these data, stratified by race and ethnicity, are integral to managing care, identifying health disparities, and addressing them.[117] But if these data remain hidden from public view, there is less incentive for both the MCOs and the state Medicaid agencies to improve performance. There is also less opportunity for MCOs and state agencies to learn from high-performing MCOs, and no opportunity for the public to know who those MCOs are.

VIII. Recommendations

We offer four sets of recommendations for improving maternal health in Medicaid managed care. Three focus on increasing the accountability of MCOs, state Medicaid agencies, and CMS through greater transparency (see Text Box 11). These recommendations can be implemented with minimal administrative burden and cost to CMS, states, and MCOs. The fourth set of recommendations focuses on opportunities for health advocates to hold individual MCOs accountable for performance.

States and CMS can both do better. One example of what is possible is an August 2022 CMS initiative to designate hospitals participating in Medicare as "Birthing-Friendly" if they meet a Maternal Morbidity Structural Measure.[118,119] CMS intends to post hospitals' designations on its beneficiary-facing website, Care Compare, in the fall of 2023.[120] CMS explains that its goal in creating this designation is "not simply to grant hospitals a maternal health 'gold star,' but to do so in a way that is meaningful for patients and families in search of facilities with a demonstrated commitment to the delivery of high-quality, safe, and equitable maternity care."[121]

In that same August 2022 rule, CMS also adopted two maternal health measures that hospitals participating in Medicare's Inpatient Quality Reporting (IQR) program will be required to report: Cesarean Birth (FY 2023) and Severe Obstetric Complications (FY 2024).[122] Currently, performance on the Maternal Morbidity Structural Measure is not based on these measures, but CMS "continues to assess" whether performance on those measures should be included in the "Birthing-Friendly" designation.[123]

Recommendations for State Medicaid Agencies

- State Medicaid agencies should maintain on their websites a readily-accessible data dashboard that presents MCO-specific performance metrics for maternity care, stratified by race and ethnicity.[124] These metrics should include, at a minimum, the number of pregnant women enrolled, the total amount each MCO received from the state agency to manage the care of these enrollees for the most recent contract year, and the performance of each MCO on the Maternity Core Set metrics that CMS requires states to submit beginning in 2024. The dashboard should also include Medicaid and MCO-specific information from the state Maternal Mortality Review Committee. (Appendix C provides more detail on state data dashboards.)
- In addition to the data dashboards, state Medicaid agencies should also maintain on their websites beneficiary-facing MCO maternal health scorecards/report cards (see Appendix C). These tools should synthesize the performance measures on the data dashboard and present the data in such a way that beneficiaries can understand which MCOs are high-performing on maternal health (not just women's health) and which are not.
- State Medicaid agencies should prioritize requiring MCOs to conduct at least one Performance Improvement Project each year that is designed to advance maternal health. State agencies should also require their EQRO contractors to present the results of their independent validation of each MCO's PIP in clear, non-technical language in an easy-to-find section of the EQRO's Annual Technical Report. The state agency's data dashboard should link directly to this section of the ATR. Results should also be shared with the state Maternal Mortality Review Committee.
- State Medicaid agencies should require each of the MCOs with which they contract to include at least one hospital designated as "Birthing-Friendly" by Medicare in their provider network and inform their enrollees as to which hospitals have that designation.[125] According to CMS, over 25 health insurers, including Centene, CVSHealth/Aetna, Elevance Health, and Molina, have committed to displaying "Birthing-Friendly Hospital" on their provider directories when the designation is available this fall.[126] The state agencies should also reward the MCOs that are high-performing on maternal health measures with public recognition, financial bonuses, or both.

Recommendations for State Public Health Agencies

- All states should operate Maternal Mortality Review Committees consistent with CDC guidelines. The MMRCs should include representation from the state Medicaid agency, perhaps the agency's Chief Medical Officer, as well as from MCOs.
- MMRCs should report the source of insurance coverage for all maternal deaths reviewed. In the case of a death of a woman with Medicaid (or separate CHIP) coverage while enrolled in an MCO, the MMRC should identify the MCO in which the woman was enrolled at the time of death and, where warranted, make recommendations to the state Medicaid agency and the MCO for improvements that will reduce maternal mortality and morbidity going forward.
- State Public Health agencies should post their MMRC reports, including Medicaid MCO-specific findings and recommendations, in an easy-to-find location on their agency websites. They should make the reports available to the state Medicaid agency and its Medical Care Advisory Committee as well as the individual MCOs with which the state contracts.

Recommendations for the Centers for Medicare & Medicaid Services

- Under current law and regulations issued by CMS, state Medicaid agencies are required to report state-level Child Core Set measures to CMS beginning in 2024. These include six of the nine Maternity Core Set measures. CMS should require states with managed care programs to report MCO-level data on all nine of its Maternity Core Set measures at both the State and the MCO level and post these measures on medicaid.gov.
- CMS should use its regulatory authority to specify PIPs that are likely to improve maternal health and reduce racial disparities that state Medicaid agencies would be required to direct MCOs to conduct.[127] In developing these specifications, CMS should consult with states and other stakeholders and provide public notice and opportunity to comment (see Table 7).
- CMS should add the HEDIS metrics, Prenatal Depression Screening and Follow Up, and Postpartum Depression Screening and Follow-Up, to the Behavioral Core Set measures that states will be required to report beginning in 2024.[128,129]
- CMS should make the MCO-specific results on its Maternity Core Set measures available as part of the Managed Care Program Annual Reports that states began submitting in December of 2022 (see Text Box 6). As of September 2023, CMS had not posted these reports; it should do so.

Recommendations for Advocates

- Research the performance on maternal health for each of the Medicaid MCOs in your state. Include in your search the most recent Annual Technical Report of your state's EQRO, which should be posted on the state Medicaid agency website (see Text Box 4) and the most recent report from your state's Maternal Mortality Review Committee report which is often found on the public health agency's website (see Text Box 5).
- Engage with your state Medicaid agency's stakeholder advisory committee (formally known as the Medical Care Advisory Committee) to see whether it has information on MCO-specific performance on maternal health and if not, whether it can be leveraged to obtain such information from the agency.[130]
- If there are low-performing Medicaid MCOs, engage directly with the state Medicaid agency, the state MMRC Committee, and the MCOs themselves to develop and implement a strategy for improvement. This strategy could include reporting of performance on maternal health measures by each MCO, posting of those measures by the state Medicaid agency, revising the contract between the state agency and the MCO, and incorporating performance on those measures into the evaluation of an MCO's bid during the state's procurement process.[131]

Table 7. Maternity Core Set for 2023 and 2024

Measure Name	CMS Core Set	Mandatory or Optional in 2024
Live Births Weighing Less Than 2,500 Grams	Child	Mandatory
Low-Risk Cesarean Delivery	Child	Mandatory
Well-Child Visits in the First 30 Months of Life*	Child	Mandatory
Timeliness of Prenatal Care**	Child	Mandatory
Contraceptive Care – Postpartum Women Ages 15 to 20	Child	Mandatory
Contraceptive Care – All Women Ages 15 to 20	Child	Mandatory
Postpartum Care***	Adult	Optional
Contraceptive Care – Postpartum Women Ages 21 to 44	Adult	Optional

"2023 and 2024 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set)," Centers for Medicare and Medicaid Services, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-maternity-core-set.pdf.

*Measures the percentage of children who had 6 or more well-child (preventive care) visits in their first 15 months.[a] The American Academy of Pediatrics recommends nine well-child visits in the first 15 months of life.[b]

**Measures the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.[c]

***Measures the percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.[d]

[a] "Well-Child Visits in the First 15 Months of Life" measures the percentage of children who had 6 or more well-child (preventive care) visits in their first 15 months. Information about this metric is available at https://www.medicaid.gov/state-overviews/scorecard/well-child-visits-first-15-months-of-life/index.html.

[b] "Recommendations for Preventive Pediatric Health Care," American Academy of Pediatrics, available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

[c] "Prenatal and Postpartum Care (PPC)," National Committee for Quality Assurance, available at https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/.

[d] Ibid.

IX. Conclusion

The U.S. is in the midst of a maternal health crisis that, despite increased attention, appears to be getting worse. The causes of maternal mortality and morbidity, and the racial disparities in maternal health outcomes, are complex, and the solutions need to be correspondingly sophisticated. As the nation's largest insurer of births, Medicaid has an important role to play in addressing the crisis. And in the 40 states (and the District of Columbia) that rely on MCOs to manage care for pregnant and postpartum Medicaid beneficiaries, individual MCOs have an important role to play. This role will only grow as states extend coverage through the full 12 months postpartum, giving MCOs the opportunity to ensure that their enrollees receive the services they need during this critical period.

In this scan of 12 states, we looked for information about the performance of individual MCOs on maternal health. We found little transparency. Without this, it is simply not possible for pregnant women to make an informed decision about which MCO is best for them or for the public and other stakeholders to understand which MCOs are performing well and which are not. Moreover, without this information, it is not possible to know which improvements in MCO care delivery are needed to reduce pregnancy-related deaths and other adverse outcomes. In short, greater transparency is essential to enable the public to hold MCOs, and the state Medicaid agencies that contract with them, more accountable for maternal health outcomes.

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APPENDIX A: Methodology

Data Sources

This report analyzes the performance of Medicaid managed care organizations (MCOs) for pregnant women using data from state Medicaid agency websites, state Public Health department websites, state budget websites (legislative and executive), and individual MCO websites. In some cases, state agency websites referred us to external websites, such as that of the National Committee for Quality Assurance (NCQA). For additional information on state reporting and maternal health metrics, we also used the websites of the Center for Medicaid & CHIP Services and the Centers for Disease Control and Prevention (CDC). We conducted our scans of these websites between May and August 2023.

We used the Kaiser Family Foundation's (KFF) Medicaid Managed Care Tracker to cross check our list of MCOs and parent firms for the 2023 plan year.[1,2] In some cases (GA, NJ, MI) state MCO offerings had changed since the KFF Medicaid MCO Enrollment by Plan and Parent Firm was updated in March 2022.[3]

The quality measures presented in this paper reflect MCO performance during calendar years (CY) 2021-2022. These were largely selected from the Maternity Core Set reported in the most recent External Quality Review Organization (EQRO) Annual Technical Report (ATR) posted on the state website. These rates were the most recent data available at the beginning of our scan in May 2023. Most of our data comes from state EQRO ATRs as well as reports from state Maternal Mortality Review Committees (MMRCs) and other Medicaid agency statistical reports.

We also reviewed other sources for additional information including MCO contract documents, Medicaid funding and enrollment reports, and maternal health and enrollee dashboards where available.

Data Collection

The 12 states included in this scan had ten or fewer MCOs in operation as of June 2023 and are states where CCF provides ongoing technical assistance to health advocates as part of Alliance for Early Success or the CCF Finish Line Network. Additionally, all states except Michigan, New Jersey, and New Mexico were included in the 13-state scan that CCF conducted in 2021 to assess the performance of individual Medicaid MCOs for children and pregnant women.

The states and MCOs included in this scan are not necessarily representative of all 40 states that contract with MCOs or of all MCOs contracting with those states. We include states that range in population size, rural and urban composition, regions of the U.S., Medicaid managed care penetration, Medicaid coverage policies (i.e., expansion vs. non-expansion), and political leadership.

The list of data elements included in our scan can be found in Appendix B. In our view, these elements are the minimum necessary to make an informed assessment of the performance of an MCO for pregnant and postpartum women enrolled in Medicaid.

We limited our search to publicly accessible websites. We did not file Public Records Act requests with state Medicaid agencies or insurance departments for the performance data we were seeking, nor did we file Freedom of Information Act requests for this information with CMS. We did use online search engines (i.e., Google), though we limited data collection to results from the state and MCO website domains. It is worth noting that this may have impacted our search results as various search algorithms learned which results we tended to select throughout the survey process.

Limitations

We focus on a set of performance data considered most relevant to the performance of individual MCOs in relation to maternal health metrics. Since there is little standardization of what metrics a state Medicaid agency requires its MCOs to report or what a state decides to publish, there were few instances when/where a metric was available across all states or MCOs for the same time period. For example, not every state agency requires the MCOs with which it contracts to conduct Performance Improvement Projects (PIPs) relating to maternal health each year.

Because of the lack of comparable performance data, we frequently use data for the most recent year available, instead of a common year or metric which could have allowed

us to examine trends in MCO performance or compare performance across MCOs in different states. The same applies to MMRC reports. Many states do not produce reports annually, data is often aggregated over multiple years, and there are no standardized requirements for a "report," so we include the most recent document available and do not limit collection to a certain reporting period.

By limiting our search for MCO-specific metrics to CY 2020-2021, we did not capture any changes that state Medicaid agencies may have reported in MCO performance over time. Inclusion of results from prior years may have yielded additional opportunities for comparison of MCO performance, but it would not inform the basic question of this study, i.e., what current performance information is publicly available?

As noted above, our search results may have been affected by our specific search history and patterns over this two-month survey. It is unclear if we would have found greater or less transparency around individual MCO performance for pregnant women with different online search techniques.

Finally, caution should be exercised in comparing statewide metric reporting and MCO performance across states. The demographic profile, health status of pregnant women enrolled in MCOs, and MCO provider networks may vary significantly from state to state.

APPENDIX B. MCO Performance Metrics

A state-by-state, MCO-by-MCO table of performance on Maternity Core Set metrics is available here.

APPENDIX C: MCO-Specific State Performance Data Dashboards and Scorecards/Report Cards

The purpose of transparency about MCO performance on maternity care is to hold MCOs (and the state Medicaid agencies that contract with them) accountable (see Text Box 11). One key element of accountability is whether Medicaid beneficiaries who are or expect to become pregnant are able to make an informed choice as to which MCO would be the best for them. Another is whether other stakeholders, including researchers, advocates, the press, and the public, are able to access maternal health performance metrics for each MCO on a dashboard maintained by the state Medicaid agency.

We searched each of the 12 state Medicaid agency websites for data dashboards and report cards or scorecards that contain MCO-specific performance information on maternal health. Our results are shown in the table below.

Appendix C Table. Maternal Health Performance Dashboards and Beneficiary Scorecards

State	Column 1: EQRO Annual Technical Report has Maternal Health Performance Data	Column 2: NCQA Health Plan Report Cards	Column 3: Medicaid Performance Dashboard with Maternal Health Data (Statewide)	Column 4: Medicaid Performance Dashboard with Maternal Health Data (MCO-specific)	Column 5: Beneficiary-Facing Scorecard/Report Card with Maternal Health Measures (MCO-specific)
Georgia	Y	Y	Y	Y	N
Illinois	Y	Y	N	N	Y
Iowa	Y	Y	N	N	Y
Kansas	Y	Y	Y	Y	N
Kentucky	Y	Y	N	N	Y
Michigan	Y	Y	Y	N	Y
Mississippi	Y	Y	N	N	N
Nevada	Y	Y	N	N	N
New Jersey	Y	Y	Y	Y	N
New Mexico	Y	Y	Y	Y	Y
Tennessee	Y	Y	N	N	N
Washington	Y	Y	Y	N	N

Y = Data found on state Medicaid agency website (columns 1, 3, 4, 5) or NCQA (column 2).
N = Date not found on state Medicaid agency website.

Column 1: Every state agency posted the Annual Technical Report (ATR) prepared by its External Quality Review Organization (EQRO) (see Text Box 4). In every case, the ATR contained MCO-specific results for two Maternal Core Set metrics—Timeliness of Prenatal Care, and Timeliness of Postpartum Care. In two states, there were also results on one or both of the Contraceptive Care Postpartum metrics. (See Table 3.) This is the only form of transparency on MCO-specific performance required by federal regulations other than Managed Care Program Annual Reports (MCPARs) (see below). Dashboards and scorecards or report cards, if any, are voluntarily posted by state agencies. Many stakeholders will have the ability to locate the ATRs on the state website and find the relevant metrics. Most beneficiaries may not be able to do so.

Column 2: All but one of the Medicaid MCOs in each state we reviewed is accredited by the National Committee for Quality Assurance (NCQA) (the one exception is TennCare Select in Tennessee).[4] NCQA posts "Health Plan Report Cards" that rate each of the commercial, Medicare, Medicaid, and Marketplace plans it accredits.[5] It uses a star rating system with eight tiers (1.5 to 5.0) to provide an overall rating for each plan as well as ratings on particular metrics, including three for "Women's Reproductive Health:" (1) Prenatal checkups (Did members who gave birth have a prenatal visit in their first trimester or shortly after enrolling in a health insurance plan?); (2) Postpartum care (Did members who gave birth have a postpartum visit on or between seven and 84 days after delivery?); and (3) Prenatal immunizations (Did members who gave birth receive both recommended immunizations by their delivery date?). NCQA updates its ratings every September.

The NCQA Report Card webpage is searchable by plan name and by state, so stakeholders who know of the existence of the site and understand how to interpret the star ratings will be able to access information about the Medicaid MCOs in which they are interested. Beneficiaries are unlikely to be familiar with NCQA. Mississippi and Tennessee state Medicaid agency websites provide a link to the NCQA Health Plan Report cards for the MCOs in their states. This may be helpful to some stakeholders, although posting the data on a state agency performance dashboard would be far more effective transparency. Even in these states, however, beneficiaries are unlikely to recognize the significance of the link; to the extent they do follow the link, they will have to construct their own side-by-side comparisons.

Column 3: Six of the state Medicaid agency websites we searched maintain a data dashboard on Medicaid managed care performance at the state level *and* include in that dashboard metrics on maternal health: Georgia, Kansas, Michigan, New Jersey, New Mexico, and Washington. These dashboards are available to stakeholders, the press, and the general public. They indicate what results Medicaid managed care is producing overall but they do not enable users to understand the performance of individual MCOs, even though the statewide results presumably reflect the combined performance of individual MCOs. Statewide performance data is of limited value to beneficiaries choosing among MCOs.

Column 4: Georgia, Kansas, and New Mexico are the only state Medicaid agencies among the 12 that maintain dashboards with MCO-specific performance data that includes performance on maternal health. This was surprising, because a number of these states have MCO-specific data dashboards with child health metrics.[6] For example, Iowa, which has an otherwise excellent MCO performance dashboard that it updates on a quarterly basis, does not include maternal health metrics. MCO-specific data dashboards are essential for researchers, advocates, the press, and other stakeholders to assess the maternal health performance of individual MCOs, but they are likely not useful to most beneficiaries.

Column 5: Five of the 12 state Medicaid agencies—Illinois, Iowa, Kentucky, Michigan, and New Mexico—have beneficiary-facing "scorecards" or "report cards" that include information about individual MCO performance on maternal health. (There is no uniform definition for these terms; in our summaries we use the term designated by each state). In our view, for beneficiaries to hold MCOs accountable, transparency requires a consumer-friendly page that beneficiaries can easily locate on the state Medicaid agency's website with actionable information that they can understand.

In the case of Illinois, Iowa, and Kentucky, this information is presented in the scorecard or report card under the heading "Women's Health," a topic that includes but goes beyond maternal health, so that it is not possible for the beneficiary to understand the MCO's performance on maternal health. For example, Kentucky's report card explains that an MCO's rating on "Women's Health" (on a scale of one to five stars) tells you "if women receive tests that check for female cancers and infections" and "if women receive care before and after their babies are born." Michigan's report card uses the label "Taking Care of Women" as an indicator for an MCO's performance on a number of maternal, reproductive, and preventative health services.

Managed Care Program Annual Reports

States are required to submit a MCPAR to CMS each year (See Text Box 6). Among the data elements included in the MCPAR reporting template are Plan-Level Quality and Performance Measures in eight domains, one of which is Maternal and Perinatal Health (Tab D2).[7] States must describe each measure they require MCOs to report, the performance measurement period, and the results for each MCO. If states complete the MCPAR reporting templates, and if they submit them to CMS and post them on their Medicaid agency website as required, MCPARs could serve as an important source of transparency about individual MCO performance.

We did not examine the MCPARs of the 12 states we reviewed because they were not available at the time we conducted our study. They were not posted on the CMS website and only Mississippi's Medicaid agency posted its MCPAR on its website.[8] (The state's MCPAR provides the measures on Elective Delivery, Postpartum Care, and Contraceptive Care for Postpartum Women 21-44 for each of the three MCOs). The unavailability of the MCPARs is in part a function of CMS reporting deadlines, which vary with the contract year of the state's managed care program. The first tranche of MCPARs, covering the contract year 7/1/21 – 6/30/22, was due December 27, 2022; the last, covering the contract year 4/1/22 – 3/1/23, was due September 27, 2023.

State Performance Dashboards (Columns 3-4) and Scorecards/Report Cards (Column 5)

Georgia:

"2023 Quality Performance Dashboard for Georgia Families (Measurement Year 2021)" includes both statewide and MCO-specific maternal health metrics. The Dashboard rates MCOs using a 5-star scale on three Maternity Core Set metrics: Timeliness of Prenatal Care; Postpartum Care; Well-Child Visits in First 30 Months.

Illinois:

"HealthChoice Illinois: 2021 HealthChoice Illinois Plan Report Card" rates MCOs using a 5-star scale on, among other criteria, "Women's Health," which includes "women receive care before and after their babies are born."

Iowa:

"IA Health Link: 2021 Managed Care Organizations Scorecard" rates MCOs using a 5-star scale on, among other criteria, "Women's Health," which includes "women receive care before and after their babies are born:"

Iowa's MCO performance data dashboard, updated quarterly, includes MCO-specific information on child health but not maternity care performance.

Iowa's Department of Health and Human Services has also posted a detailed report, "Access to prenatal care, selected behaviors and selected birth outcomes by Medicaid status, Iowa resident births 2017 – 2022."

Kansas:

The "KanCare Dashboard" includes three performance measures for maternal health for 2021, statewide and MCO-specific: Timeliness of Prenatal Care; Postpartum Care; and Well-child Visits in the Frst 30 Months of Life ages 0-15 months, ages 15-30 months. The MCO-specific results are positioned to be as inconspicuous as possible.

Kentucky:

"Kentucky Medicaid 2021 Guide to Choosing Your Health Plan" rates MCOs using a 5-star scale on, among other criteria, "Women's Health," which includes "women receive care before and after their babies are born."

Michigan:

"A Guide to Michigan Medicaid Health Plans" rates MCOs using a 3-apple scale on, among other criteria, "Taking Care of Women," which includes "Moms in the plan also get care before and after their baby is born to help keep mom and baby healthy."

Mississippi:

The Medicaid agency has a page on its website titled "Measuring Managed Care Performance." The page includes a link to where you can "view the most recent rating of MississippiCAN's coordinated care organizations (CCOs) published by the National Committee for Quality Assurance."

Nevada:

There are two Medicaid websites. One is unwieldy. The other is usable and contains a link to the NCQA website.

New Jersey:

The Medicaid agency has a performance dashboard that includes both statewide and MCO-specific maternal health metrics (Timeliness of Prenatal Care and Postpartum Care), but it has not been updated since 2019.

The agency has also posted a Health Plan Brochure for beneficiaries, but only one of the MCO summaries includes a Maternal Core Set metric (Postpartum care).

New Mexico:

"Departmental Performance Scorecard Goal 1 Measures: Medicaid Managed Care Organizations and Family & Children" includes three Maternity Core Set metrics in the aggregate and for each MCO for 2021 (the 2022 and 2023 data are aggregate, not MCO-specific). The Scorecard frames the metrics with the question: "I'm pregnant. How good is my MCO at working with providers to ensure (1) I receive the prenatal care I need, (2) I receive the postpartum care I need, and (3) my children will have at least 6 well-child visits by 15 months old?" The metrics are presented in horizontal bars for each MCO; it's not clear that most beneficiaries will be able to interpret them.

Tennessee:

The 2021 EQRO Annual Technical Report (March 2022), includes statewide maternal health metrics but not MCO-specific metrics; those are presented in a separate report, "2022 Annual HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs for Measurement Year (MY) 2021."

Washington:

The state Medicaid agency maintains a Medicaid Maternal and Child Health Measures Dashboard that presents statewide performance on several maternal health metrics, including Timeliness of Prenatal Care and Well-child Visits in the First 15 and 30 Months of Life, but the data are not MCO-specific.

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[1] There were two plans in Illinois that were not included for the purposes of this study: Humana Health Plan (Humana) and YouthCare (Centene). Humana Health Plan (Humana) is specific to dually eligible Medicare and Medicaid beneficiaries with few if any pregnancies and therefore was not pertinent to this study on maternal health. We excluded the MCO plan YouthCare (Centene) because the enrollment is limited to children and youth in foster care and juvenile justice institutions. Notably, it is dissimilar to other plans in our survey that enroll foster youth (Amerigroup Community Care in Georgia, TennCare Select in Tennessee, and Coordinated Care in Washington) because those plans are available to individuals from multiple eligibility categories/are not exclusive to foster youth.

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[3] To maintain accuracy, Georgetown CCF uses the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth. Where possible, we use more inclusive terms in recognition that not all individuals who become pregnant and give birth identify as women.

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[7] E. Hinton and J. Raphael, "10 Things to Know About Medicaid Managed Care" (Washington: Kaiser Family Foundation, March 1, 2023), available at https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[8] As of 2023, CDC supports maternal mortality review committees in 44 states and two U.S. territories through funding from the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program available at https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Ferasemm%2Findex.html. For the purposes of this study, our results included all states that currently operate a self-identified maternal mortality committee, not limited to those receiving funding from CDC. For more information see Review to Action available at https://reviewtoaction.org/tools/networking-map.

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