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Medicaid Access & Coverage to Care in 2017

Results from the Institute for Medicaid Innovation's 2018 Annual Medicaid Managed Care Survey

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Executive Summary

The inaugural Annual Medicaid Managed Care Survey represents one of the first comprehensive efforts to collect robust, longitudinal data on Medicaid managed care organizations (MCOs). National experts in Medicaid, managed care operations, survey methodology, health services research and policy, and clinical care were engaged throughout the process to design, test, refine, and finalize the survey while utilizing rigorous scientific methods. The findings from the inaugural survey that are contained in this report are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care.

Overall, the Medicaid MCOs that responded to the survey provided health care coverage to more than 20 million Medicaid beneficiaries, representing 44.4 percent of all covered lives enrolled in Medicaid managed care across 34 states. The survey, with more than 70 questions, provides a comprehensive look into Medicaid managed care. Highlighted in this report are findings specific to critical elements of the Medicaid program, including:

- High-risk care coordination
- Value-based payment
- Pharmacy
- Women's health
- Behavioral health
- Child and adolescent health
- Long-term services and supports.

High-Risk Care Coordination

Key findings from the data were noted in the high-risk care coordination, value-based payment models, women's health, and behavioral health sections. For instance, results from the survey demonstrate that the majority of **Medicaid MCOs in 2017 performed a number of core functions in providing comprehensive, high-risk care coordination.** The most commonly performed core functions included developing a plan of care for members, supporting adherence to the plan of care, engaging a care team of professionals to address the needs of the member, and conducting risk assessments.

Value-Based Payment

The findings also indicate that **Medicaid MCOs are increasingly using value-based payment (VBP) models** when providing care for their members. In 2017, half of Medicaid MCOs indicated that they were piloting population-specific VBP models, while over 15 percent were expanding successful pilots. Finally, approximately 10 percent of MCOs surveyed reported that they had extensive VBP arrangements in place in 2017. As barriers to VBP adoption are removed, we anticipate an increase in the number of Medicaid MCOs transitioning from the pilot phase to fully implemented arrangements.

Women's Health

Although we found that many women's health issues were not viewed as being a significant need among their membership, the **majority of Medicaid MCOs in 2017 still offered targeted programs and engagement strategies in women's health**. For example, Medicaid MCOs indicated that cancer screening and treatment was not an area of significant need among their membership, with only 9.1 percent indicating that it was a significant issue. However, despite this low number, over 90 percent reported that they had active targeted programs and engagement strategies for cancer screening and treatment.

Behavioral and Physical Health Integration

Behavioral and physical health integration was a key challenge for Medicaid MCOs. The most common barriers were categorized as policy, network, or operational barriers. The most significant policy barrier in 2017 was attributed to the limitations of CFR 42 on the sharing of substance use disorder treatment information. The most significant network barrier was access to behavioral health providers in select regions (e.g., rural), and the most significant operational barrier was access to data between care management and behavioral health teams.

Overall, findings from the survey highlight the continued value of the managed care model in Medicaid. However, it was also found that existing barriers may inhibit continued success and growth. This report presents the findings from data collected on these challenges and potential solutions.

Acknowledgments

The Institute for Medicaid Innovation's annual Medicaid Managed Care Organization survey would not be possible without the support and guidance from national experts who volunteered countless hours over the past three years reviewing, editing, and finalizing the instrument. We received over 700 potential questions from Medicaid stakeholders for consideration of inclusion in the final survey. We thank everyone for submitting their initial ideas and suggestions to help launch the beginning of the survey.

A thoughtful and iterative process of prioritizing and selecting the most important questions to capture the national landscape of Medicaid managed care and to inform salient policy issues was undertaken to develop the survey. After the top 200 questions were selected, every word, phrase, and concept in every question and answer option underwent extensive review, applying rigorous survey design and methodology, while discussing its intended, implied, and potential meaning and its impact on informing Medicaid policy.

We owe a tremendous debt of gratitude to those who have been with us on this journey, giving more than we could ever have expected. A huge thank you to **Kate Paris**, **Scott Brunner**, **Dr. Katrina Miller**, **Dr. Ben Sommers**, **Dr. Eric Schneider**, **Dr. Gloria Eldridge**, and **Sean Dunbar** for their commitment and dedication to this project. We also thank the members of **IMI's Data & Research Committee**, **IMI's National Advisory Board**, and our colleagues who serve in the federal government for their critical feedback. A special thank you is also extended to the incredibly talented team of survey methodology experts at the **University of Michigan's Institute for Social Research**.

Finally, this survey could not have been accomplished without the active support and participation of the **Medicaid managed care organizations**. Thank you for reviewing endless drafts and testing questions within your organizations to help us refine and finalize the survey. Thank you to those who coordinated survey responses; oftentimes requiring up to ten different people to answer portions of the single survey. We also thank **Jeff Myers**, former CEO of the Medicaid Health Plans of America, and the **MHPA Board of Directors** for supporting IMI's efforts and encouraging the MHPA membership to participate in the inaugural survey. Thank you all for helping us to achieve a 68 percent response rate!

Overview

The Institute for Medicaid Innovation's (IMI's) annual Medicaid Managed Care Organization (MCO) survey was developed over a three-year period to address the paucity of national data on Medicaid managed care. National experts in Medicaid, managed care operations, survey methodology, health services research and policy, and clinical care were engaged throughout the process to design, test, refine, and finalize the survey while utilizing rigorous scientific methods. The findings from the inaugural survey that are contained in this report are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. Furthermore, the longitudinal design of the survey has the potential to provide critical trend data and analysis in the future to evaluate the impact of state and federal policies on the Medicaid program.

Background

Included in this report are descriptive statistics for each survey item representing aggregated 2017 data provided to the IMI from Medicaid MCOs. The survey was emailed in February 2018 to all Medicaid Health Plans of America (MHPA) members, representing 44.4 percent of all covered lives enrolled in Medicaid managed care across 34 unique states. Responses were received in March 2018 from 68 percent of all MHPA members. In aggregate, the Medicaid MCOs that responded to the survey provide health care coverage to over 20 million Medicaid beneficiaries in the United States. Details on the survey design and methods are provided in Appendix A, with key definitions used for the survey provided in Appendix B.

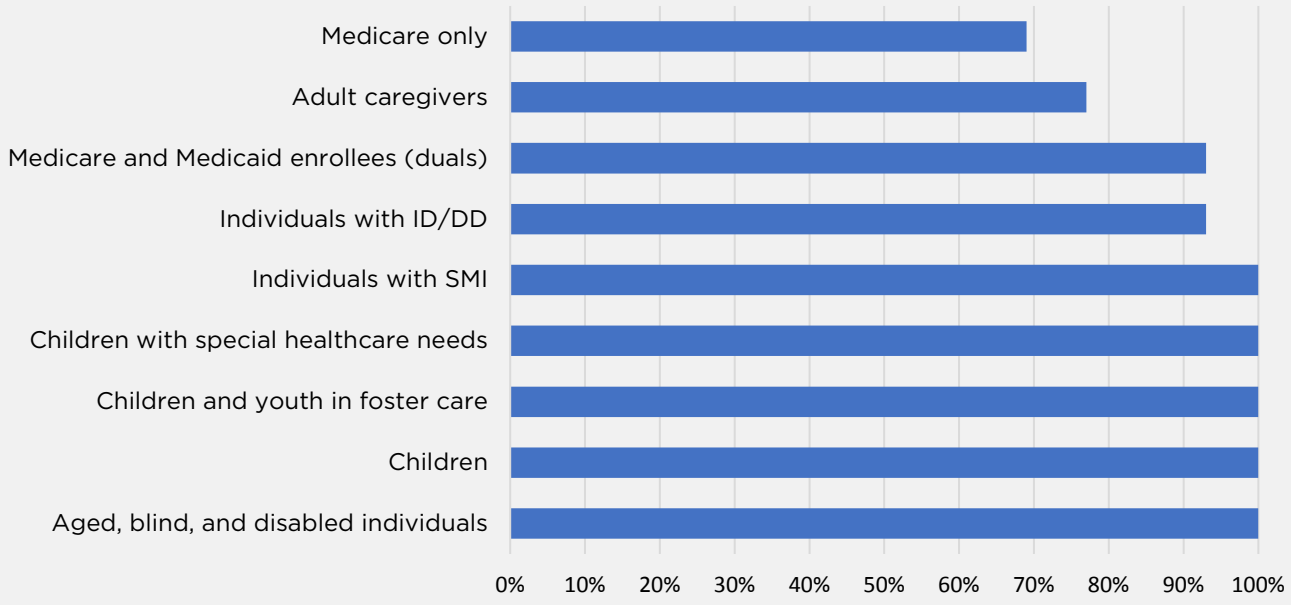
The survey findings highlighted in this report are divided into the following seven sections: high-risk care coordination, value-based purchasing, pharmacy, women's health, behavioral health, child and adolescent health, and long-term services and supports. For each section of the survey, Medicaid MCOs were provided an opportunity through open text boxes to type in qualitative information that identified specific state and/or federal policy barriers, opportunities for innovation, and emerging or effective best practices that are addressing salient issues. The high-risk care coordination, value-based purchasing, and women's health sections generated the highest volume of write-in responses.

Characteristics of Medicaid MCOs

Health plan survey respondents indicated participating in Medicaid programs as a managed care organization starting as early as 1981 and as late as 2013. An equal number of respondents were private, non-profit organizations (38.5%) and private, for-profit organizations (38.5%). Less than a quarter (23.1%) of Medicaid MCOs were either public or government organizations. The majority of respondents (53.9%) indicated that they provided coverage in a single state or a single region within a single state in 2017, with 46.2 percent providing coverage in multiple states (Table 1).

The majority of Medicaid MCO survey respondents provided coverage to at least 500,001 covered lives (Table 1) in 2017, with under 40 percent covering fewer than 500,000 Medicaid lives. Health plans reported managing a number of benefits at full risk, including physical health (84.6%), behavioral health (92.3%), institutional care (84.6%), home and community-based waiver services (92.3%), pharmacy (84.6%), and dental (61.5%). Further, Medicaid MCOs reported participating in a number of programs, including the Children's Health Insurance Program (CHIP; 61.5%), Medicare Advantage (76.9%), Medicare Special Needs Plan (61.5%), Health Insurance Marketplace/Exchange (61.5%), individual markets (38.5%), employer markets (53.8%), and other programs (38.5%). Figure 1 highlights the populations served in 2017.

Figure 1. Populations Served by Medicaid MCOs, 2017.



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Table 1. Overview of Medicaid Managed Care Survey Respondents' Characteristics, 2017

Survey Sample Characteristics	
Total Number of Medicaid Covered Lives (as of September 2017)	
20,000,000 (44.4% of covered lives in Medicaid managed care)	
Medicaid MCO Tax Status	
Private, non-profit	38.5%
Private, for-profit	38.5%
Other (public or government)	23.1%
Medicaid MCO Markets	
Multiple states	46.2%
Single state or single region within a state	53.9%
Number of Covered Lives	
Under 100,000	15.4%
100,001 – 250,000	7.7%
250,001 – 500,000	15.4%
500,001 – 1,000,000	30.8%
More than one million	30.8%
Benefits Managed at Full Risk	
Physical health	84.6%
Behavioral health	92.3%
Institutional care	84.6%
Home and community-based waiver services	92.3%
Pharmacy	84.6%
Dental	61.5%
MCO Program Participation	
Children's Health Insurance Program (CHIP)	61.5%
Medicare Advantage	76.9%
Medicare Special Needs Plan	61.5%
Health Insurance Marketplace/Exchange	61.5%
Individual market	38.5%
Employer market	53.8%
Other	38.5%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

In 2017, 81 percent of Medicaid MCOs reported that less than 5 percent of their enrollees received high-risk care coordination services. Of the respondents, approximately 9 percent of Medicaid MCOs reported that less than15 percent of their enrollees had received services. It is unknown if these individuals were enrolled or engaged in programs. For the purpose of this report, high-risk is identified by clinical data risk stratification or definitions of certain populations with focused needs that require specific or high utilization. High-risk care coordination is defined as a specific approach within Care Management that targets individuals at increased risk by providing support to navigate and coordinate needed care. These services are provided directly by the MCO or a delegated entity and include programs such as Complex Member Management, Disease Management, High-Risk Maternity Management, etc. The most common barriers reported by Medicaid MCOs when conducting individual health risk assessments of members to determine if they were high risk were difficulty reaching members (76.9%), inaccurate member information (46.2%), and lack of members' willingness to conduct a needs assessment (30.8%; Table 2).

Table 2. Most Frequently Reported Barriers to Completing Individual Health Risk Assessments, 2017

Barriers	Frequency
Difficulty reaching members	76.9%
Inaccurate member information	46.2%
Willingness of member to participate in a needs assessment	30.8%
State deadline to complete assessments within timeframe	7.7%
Overlapping assessments tied to eligibility	7.7%
Dispute in resolving the identity of members	0%
Lack of confirmed member record	0%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs indicated that they share member health risk assessments in a number of ways. All of the health plans reported sharing this information with the member, with the member's preferred provider, and with the care coordinator at the health plan (Table 3). The least-common method for dissemination of information was from the network provider to the health plan (84.6%).

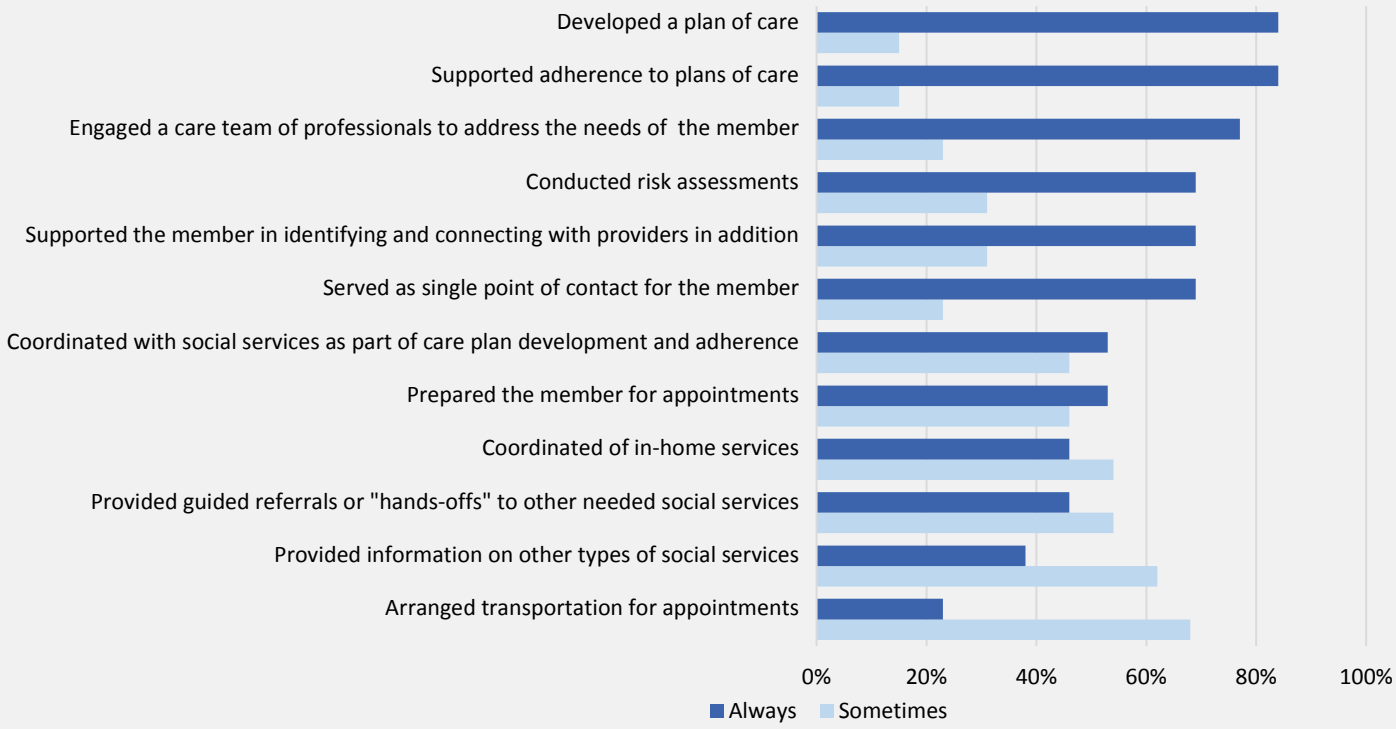
Table 3. Frequency of Sharing Member Health Risk Assessments, 2017

Method of Sharing	Frequency
Health plan to member	100%
Health plan to member preferred provider	100%
Health plan to care coordinator	100%
Health plan to network providers	92.3%
Health plan to member guardian or responsible party	92.3%
Network provider to health plan	84.6%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Over 92 percent of Medicaid MCOs reported a combined approach to assigning care coordinators to members. The approaches included having care coordinators serve a specific population and assigning care coordinators based on the specific needs of their members. As part of the survey, health plans were also asked to provide information on the core functions performed under high-risk care coordination. Developing a plan of care and supporting adherence to plans of care were the two most commonly reported core functions reported, with 84.6 percent of plans reporting that this was always performed (Figure 2).

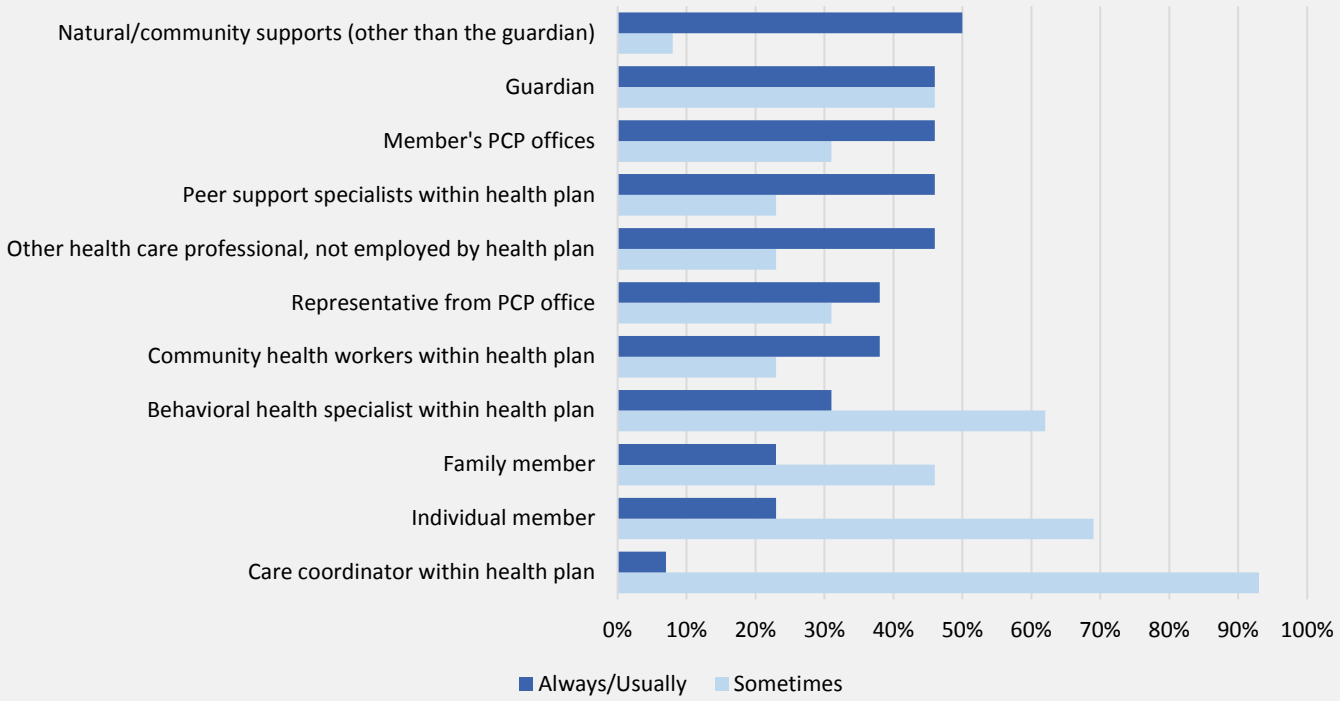
Figure 2. Core Functions Performed under High-Risk Care Coordination, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs indicated that care teams include a number of individuals, most frequently a care coordinator within the health plan (92.4%), the individual member (69.3%), behavioral health specialist within the health plan (61.6%), and family members (46.2%; Figure 3).

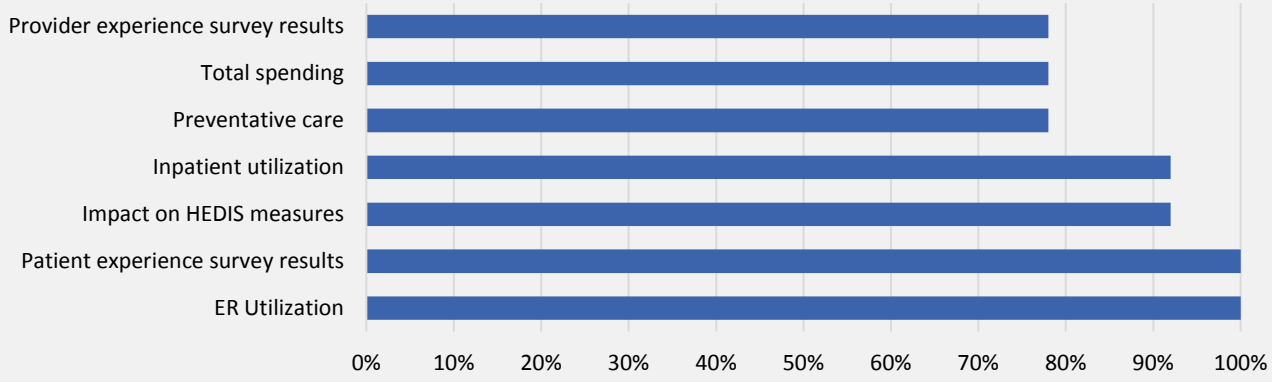
Figure 3. Frequency of Engagement of Individuals with Medicaid MCO Care Teams, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs reported a number of methods to assess and measure the effectiveness of high-risk care coordination. The most common methods included emergency room (ER) utilization (100%; Figure 4) and patient experience survey results (100%).

Figure 4. Most Common Measurement of Effectiveness of High-Risk Care Coordination, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Recognizing the value of providing high-risk care coordination by Medicaid MCOs, the survey sought to identify barriers to effective case management. The most common barriers identified by Medicaid MCOs were the ability to contact the member (84.6%; Table 4) and the member's willingness to be engaged (38.5%). It was often cited that Medicaid MCOs receive incomplete, inaccurate, or outdated contact information for enrollees.

Table 4. Most Frequent Barriers to Effective High-Risk Case Management, 2017

Barriers	Frequently a Challenge
Ability to contact member	84.6%
Member's willingness to be engaged	38.5%
Access to information from previous providers	30.8%
Obtaining consent	23.1%
Ability to share information with service providers	23.1%
Member's access to specialty care	15.4%
Ability to connect individuals to necessary non-clinical social supports	15.4%
Provider's willingness to engage with plan	7.7%
Member's access to primary care	0%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Opportunities to Enhance Targeted Care Coordination

Medicaid MCOs were asked to identify, as part of the write-in portion of the survey, opportunities to collaborate with state Medicaid agencies that could help health plans better target care coordination. Respondents frequently indicated that having access to historical claims data and social determinants of health information would support care coordination efforts. The following suggestions were offered.

- Collaboration and data sharing as part of the Home and Community-Based Waiver Program.
- Sharing community information such as school enrollment and supportive housing services data.

- Care Connect 360 data to identify additional gaps in care (e.g., dental) or to inform health plans of state resources that the member is using such as adult home help and behavioral health services (e.g., substance use disorder, inpatient psych).
- Information regarding social determinants of health as part of the 834 Form.
- Timely access to historical claims data, established providers, accurate demographic information, previous authorization information and service level plans to ensure continuity of care, and previous assessment and care plan information.
- Ability to flag Medicaid files for children in foster care and/or criminal justice-involved.
- Accurate contact information including address, phone numbers, and email. Include information on second insurance coverage for MCLA members and provide any workman's compensation information if there is an active case.
- Information and documentation on power of attorney, guardian, head of household information, consent forms, advance directives, and linking individual member to family members within enrollment files.
- Partnering with Medicaid MCOs to develop the stratification criteria and ratios by utilizing the significant data and experience of the health plans while exploring opportunities for the requirements to be specific to the membership types (i.e., children, LTSS, etc.).

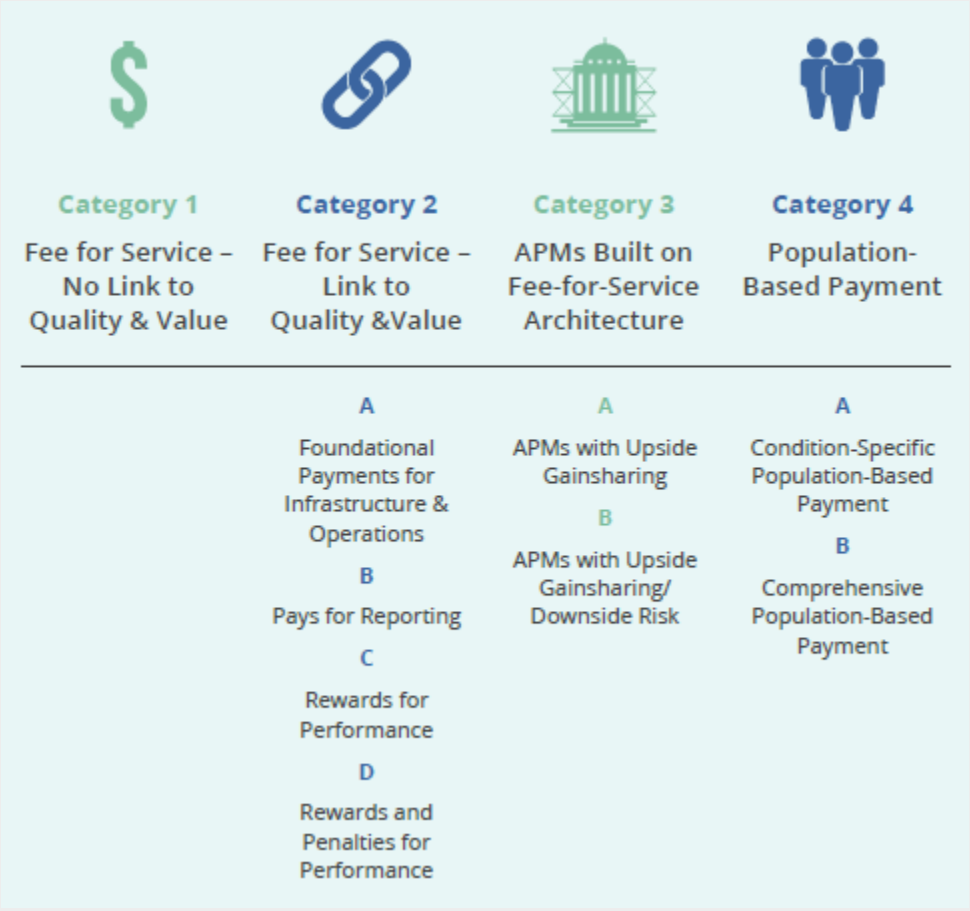
Barriers to High-Risk Care Coordination

Medicaid MCOs offered additional information regarding barriers that they experienced when providing high-risk care coordination services. For instance, it was noted that obtaining consent to share information from an assessment is often challenging due to logistics. However, obtaining consent from the member to participate in care coordination is typically not a challenge. Respondents shared that state Medicaid programs oftentimes have several "carve out" components, which makes care coordination complicated. For instance, it can be challenging for the Medicaid MCO to partner and coordinate with the various entities that provide coverage for a specific carved-out piece of the Medicaid benefit such as prepaid mental health plans, dental, and fee-for-service Medicaid. In addition, the design of the carved-out services creates confusion for the member and his or her family who are seeking care. Establishing clear and effective mechanisms for communication would help to facilitate efforts.

Several Medicaid MCOs noted that sharing sensitive behavioral health information is governed by CFR42, of which Part 2 can create challenges for behavioral and physical integrated care coordination. Finally, it was suggested that it would be helpful if Medicaid MCOs could optimize networks by targeting contracts with providers who are partners in care coordination or by allowing MCOs flexibility to define value-based care in a way that promotes care coordination to support continued system advancements.

When responding to the survey questions on value-based purchasing, we requested that the Medicaid MCOs report spending across the four Health Care Payment Learning Action Network (HCP-LAN) Alternative Payment Model (APM) categories. The APM framework represents payments from public and private payers to provider organizations. It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer.

Table 1. HCP-LAN Alternative Payment Model Framework

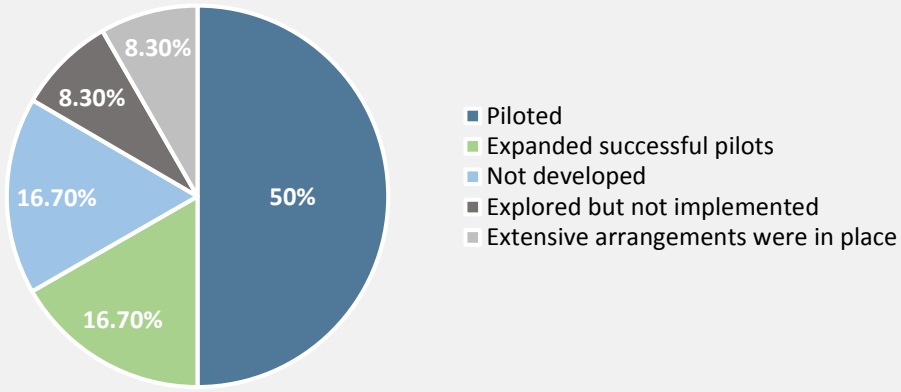


Source: Centers for Medicare and Medicaid Services. Health Care Payment Learning & Action Network *(https://hcp-lan.org/)*.

For category 1 (fee-for-service, no link to quality or value), health plans reported a range of spending from 31.67 to 97.10 percent. Health plans reported spending anywhere from 0.4 percent to 70 percent for category 2 (fee-for-service, link to quality and value) and for category 3 (APMs built on fee-for-service architecture), a range of spending from 0 percent to 67.93 percent. For category 4 (population-based payment), health plans reported a range of spending from 0 percent to 10 percent.

Over 83 percent of Medicaid MCO contracts (markets) in 2017 required the health plan to implement value-based purchasing (VBP) or alternative payment model (APM) contracting with providers. However, there was substantial variation between Medicaid MCOs on the implementation of VBP within specific populations. Half of the health plan respondents are currently piloting population-specific VBP arrangements (Figure 5). An equal number of plans are either expanding successful pilot programs with population-specific VBP arrangements (16.7%) or have not developed population-specific VBP models (16.7%). Similarly, an equal number of health plans are exploring but have not implemented population-specific VBP arrangements (8.3%) or have extensive VBP arrangements that are population specific (8.3%).

Figure 5. Percentage of MCOs' VBP Implementation in Specific Populations, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs reported that they were working with a majority of primary care providers (58.3%; Table 5) in their network to implement VBP, far more than any other type of provider. More than 80 percent of health plans reported that they were not implementing VBP with nurse-midwives at this time. However, a number of health plans were piloting initiatives in 2017 with nurse-midwives (16.7%), OBGYNs (16.7%), and other specialists (16.7%). No health plans implemented VBP with dentists in 2017. The results obtained from the survey may be in part the result of carve-outs for services such as behavioral and oral health care.

Table 5. Percentage of Medicaid MCOs Implementing VBP with Specific Types of Providers, 2017

Providers	Working with a majority of providers	Working with select providers	Piloting	Not at this time
Primary care providers	58.3%	33.3%	0%	8.3%
OBGYNs	16.7%	33.3%	16.7%	33.3%
Behavioral health	16.7%	25%	8.3%	50%
Orthopedics	16.7%	8.3%	8.3%	66.7%
Home and community-based service providers	8.3%	8.3%	33.3%	50%
Long-term care facilities	8.3%	0%	33.3%	58.3%
Other specialists	8.3%	41.7%	16.7%	33.3%
Nurse-Midwives	0%	0%	16.7%	83.3%
Dentists	0%	0%	0%	100%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

The Medicaid MCOs identified a number of critical operational barriers to adopting VBP and APMs. The most commonly reported operational barrier was data reporting to providers, with 75 percent of health plans responding that this was a significant barrier (Table 6).

Table 6. Most Common Operational Barriers to Adoption and Innovation in VBP/APMs, as Reported by Medicaid MCOs, 2017

Operational Barriers	Most Common/Frequent
Data reporting to providers	91.7%
IT system preparedness	91.6%
Tracking quality and reporting within new structure	75%
Contract requirements on VBP/APM approaches	75%
Support to providers to make determinations on VBP/APM	66.7%
Pricing VBP/APM	58.3%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

External factors may also influence the rate of adoption and innovation in VBPs or APMs. The most important external factors that influenced the rate of adoption and innovation in 2017 was the impact of 42CFR on limiting access to behavioral health data (100%), and providers' readiness and willingness was considered to be of high importance (91.7%). Provider IT capabilities, state requirements limiting VBP/APM models (91.7%), and Medicaid payment rates (83.3%) were also very influential.

State-Level Opportunities to Enhance VBP/APM Adoption & Innovation

Medicaid MCOs were asked to provide suggestions on opportunities to partner with state Medicaid agencies or change state requirements that would remove current barriers to assist in the adoption and innovation of VBP or APM. As an example, respondents frequently stated that many state Medicaid Management Information Systems (MMIS) are not equipped to support VBP or APM efforts beyond small pilot projects. However, opportunities to remove those barriers exist. The most common responses are provided below.

- Increase in the base Medicaid fee schedule rates and capitated premiums to MCOs to provide room for implementing VBP and APM contracts.
- Flexibility in the approaches to member assignment that take into account the move toward VBP/APMs.
- Reviewing restrictions around data sharing from a legal and privacy standpoint and identifying solutions that support VBP/APM efforts.
- Allowing for flexibility in the VBP/APM arrangements, including incentive structures, based on the readiness of providers.
- Supporting the Medicaid MCOs ability to optimize provider networks and removing provisions such as “any willing provider” to target providers who are ready and willing to drive services toward quality-based care rather than quantity.
- Aligning consistent performance indicators across federal and state programs.
- State mandated interoperable Health Information Exchange (IHIE) for all stakeholders including providers.
- Ensuring that Medicaid MCOs get "credit" for encounter data that is collected through VBP/APM models with state Medicaid Management Information Systems (MMIS) and allowing for inclusion of this type of data in the health plan’s per-member per-month (PMPM) calculation or in contractual quality measures. Currently, VBP/APM encounter data does not meet the contractual obligations to submit acceptable encounters to the state system. As a result, Medicaid MCOs are unable to implement on a large scale.
- States should explore implementing VBP/APM based on a baseline threshold, then increasing via percentages on an annual basis. Furthermore, states should provide standardized reporting requirements for Medicaid MCOs, including the types and frequency of reporting.

One Medicaid MCO noted that a forthcoming challenge will be balancing the states' desire to push more providers toward Category 4 (population-based payment) without ample time for the providers to develop the resources and experience to be successful at that level. They noted that when you compound this push with small profit margins for the providers, it will have an effect on the number of providers who exit APMs.

Federal-Level Opportunities to Enhance VBP/APM Adoption & Innovation

Medicaid MCOs were asked to provide suggestions on opportunities to change federal requirements that would remove current barriers to assist in the adoption and innovation of VBP or APM. Respondents suggested reviewing opportunities to reduce the number of restrictions in sharing data from a legal and privacy perspective. It was also suggested that 42 CFR Part 2 be aligned with current HIPAA requirements/protections to remove barriers to effective care coordination for specific members such as those with substance use disorder. To support engagement in VBP/APM efforts, several health plans stated that the CMS should consider implementing a federal requirement for providers to participate in state HIEs.

Approximately 63 percent of Medicaid MCOs indicated that they have community-based contracts with pharmacists that specifically focus on medication adherence rates, drug utilization rates, and identification of lower-cost medication alternatives (Table 7).

Table 7. Frequency of Community-based Contracts with Specific Pharmacy Quality Metrics, 2017

Pharmacy Quality Metrics	Frequency
Medication adherence rates	62.5%
Drug utilization rates	62.5%
Identification of lower-cost medication alternatives	62.5%
Pharmacotherapy consults	37.5%
Hospital readmissions	12.5%
Emergency department visits	12.5%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

All Medicaid MCOs reported that the utilization and unknown cost history for new drugs entering a market was a challenge (100%; Table 8). Other frequently cited challenges included pharmacy benefits or subset of benefits carved out of managed care (77.7%), differences between plan formularies and methodologies and state requirements (55.5%), and members' comprehension of and engagement in programs (44.4%).

Table 8. Most Significant Challenges in Managing Medicaid Prescription Drug Benefit, 2017

Prescription Drug Benefit Challenges	Frequency
Utilization and cost history unknown for new drugs entering a market; impacting capitation rates and pricing	100%
Pharmacy benefits or subset of benefits carved out of managed care	77.7%
Difference between plan formularies and methodologies and state requirements	55.5%
Members' comprehension of and engagement in programs	44.4%
Formulary notification requirements as part of MCCO Final Rule	11.1%
Pharmacy network requirements	11.1%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Over 87 percent of Medicaid MCOs reported supporting an e-prescribing system through their contracted pharmacy benefit manager (PBM) for activities such as sending eligibility information and reviewing medical histories. Electronic prior authorization systems were utilized by the majority of health plans in 2017, with 55.6 percent indicating that it was available through a separate electronic portal; 22.2 percent reported that it was available through electronic health records. Medicaid MCOs utilized a number of approaches to address new or high-cost drugs. The most common approaches were carving out the drug costs completely (66.7%; Table 9), paying fee-for-service for certain drugs (66.7%), or using a capitation rate adjustment as part of regular rate adjustments (66.7%).

Table 9. Most Common Approaches by States to Address New or High-Cost Drugs, 2017

State Approaches	Frequency
Carved-out the drug costs completely	66.7%
Paid fee-for-service for certain drug(s)	66.7%
Capitation rate adjusted as part of regular rate adjustments	66.7%
Capitation rate adjusted made off the normal rate cycle	55.6%
Stopped loss provision to cap the plan's cost for the drug	33.3%
Transition period where drug(s) is/are offered in FFS to get claims data, then rolled into contracts	11.1%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

More than 90 percent of Medicaid MCOs surveyed reported having targeted programs to address specific women's health care needs. Health plans noted that the most significant priorities for women enrolled in Medicaid were prenatal and postpartum care (100%; Table 10) and substance use disorder (91.7%).

All respondents reported having a targeted program or engagement strategy to address prenatal and postpartum care (100%; Table 10) and diabetes (100%). Over half of the Medicaid MCOs had targeted programs or engagement strategies to address family planning (80%), heart disease (81.8%), obesity (63.6%), substance use disorder (91.7%), and depression/anxiety (75.0%). Although cancer screening and treatment was not identified as a significant priority, approximately 90 percent had targeted programs in 2017 with active engagement strategies.

Table 10. Most Significant Women's Health Issues Identified & Addressed by Medicaid MCOs Across the Lifespan, 2017

Priorities	Most Significant	Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies
Prenatal and postpartum care	100%	100%
Substance use disorder	91.7%	91.7%
Behavioral health	75%	75%
Diabetes	72.7%	100%
Family planning	72.7%	80%
Depression/Anxiety	66.7%	75%
Heart disease	36.4%	81.8%
Obesity	36.4%	63.6%
Eating disorders	18.2%	27.3%
Cancer screening and treatment	9.1%	90.9%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

The majority of Medicaid MCOs (55.6%) reported that pregnant women were enrolled for more than one year but less than two years (Table 11). Overall, the survey found that parents; aged, blind, and disabled individuals; and Medicare- and Medicaid-eligible individuals were continuously enrolled in Medicaid for two or more years.

Table 11. Average Duration of Enrollment among Female Medicaid MCO Members, 2017

Member population	Enrolled < 6 months	Enrolled 6-12 months	Enrolled > 1 but < 2 years	Enrolled 2+ years
Pregnant women	0%	33.3%	55.6%	0%
Parents	12.5%	0%	25%	37.5%
Childless adults	0%	0%	37.5%	37.5%
Aged, blind, and disabled	0%	0%	11.1%	88.9%
Medicare and Medicaid eligible	0%	0%	11.1%	77.8%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Churn is a significant concern for the long-term health and well-being of women enrolled in Medicaid, including the impact on outcomes of future pregnancies and management of chronic conditions. Medicaid MCOs noted that the most significant challenges associated with churn for women enrolled in Medicaid were completeness of patient and member history (50%) and maintaining access to providers and care (41.7%; Table 12). Half of those responding to the survey reported that repeated member on-boarding was not a significant challenge with churn.

Table 12. Most Significant Issues Associated with Churn for Women Enrolled in Medicaid MCOs, 2017

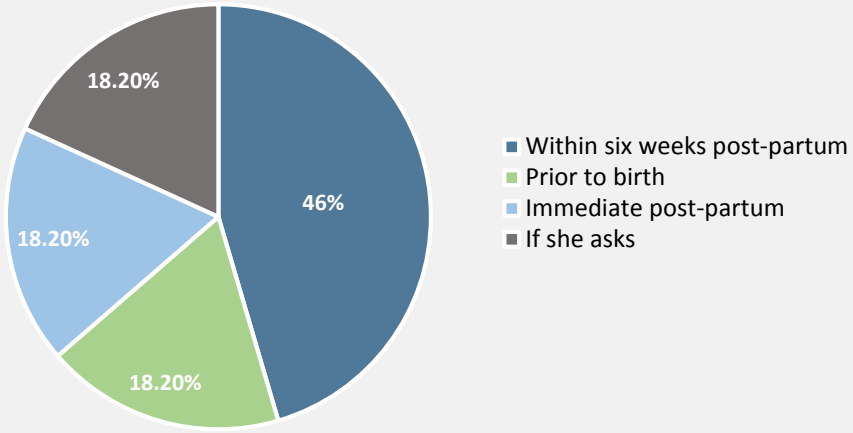
Issues	Very Significant	Somewhat Significant	Least Significant
Completeness of patient/member history	50%	33.3%	16.7%
Maintaining access to providers and care	41.7%	33.3%	25%
Clinical care disruption and care management continuity	33.3%	58.3%	8.3%
Quality measure disruption	33.3%	41.7%	25%
Repeated member on-boarding	16.7%	33.3%	50%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

All Medicaid MCOs reported that 100 percent of the family physicians and pediatricians in their network in 2017 served as a medical home or primary care provider. Almost 90 percent of OBGYNs, 87.5 percent of gerontologists, 77.8 percent of nurse practitioners/nurse-midwives, and 42.9 percent of school-based health centers served as a medical home or primary care provider.

The majority of Medicaid MCOs reported providing information on post-partum contraception or sterilization to enrollees within 6 weeks of delivery (45.5%; Figure 6). The majority of health plans were evenly split between providing this information immediate post-partum (during inpatient stay for delivery, 18.2%), prior to birth (18.2%), or if the member asks (18.2%). None of the health plans provided this information annually to women of reproductive age or never provided this information.

Figure 6. Timing of Post-Partum Contraception or Sterilization Information Provided by Medicaid MCOs, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Top Challenges in Women's Health

Medicaid MCOs were asked to identify their top challenges in addressing the health care needs of women enrolled in their health plan; including reproductive health and family planning services and supplies. Consistently, the respondents cited the same challenges.

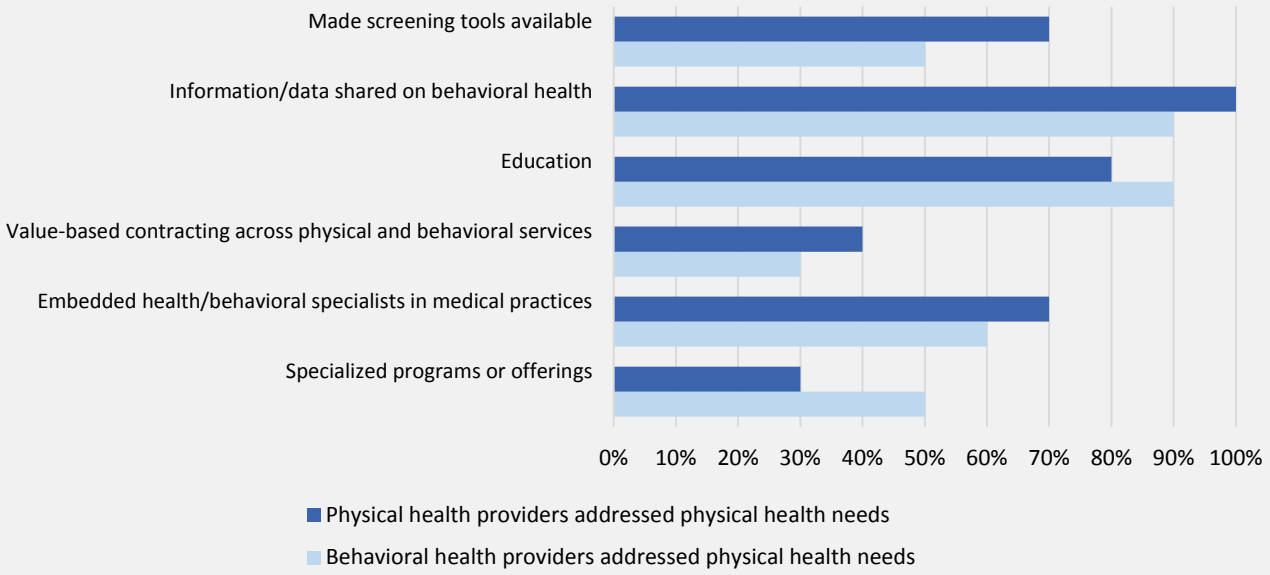
- Limited or no access to essential services in rural areas or communities without clinicians/hospitals willing and/or trained to provide services such as long-acting reversible contraception and medication-assisted therapy for pregnant women with an opioid use disorder.
- Limited number of women's health providers in a geographic region; not exclusive to rural settings.
- Lack of continuous enrollment and coverage for health care services.
- Impact of trauma, domestic violence, poverty, and instability.
- Delayed identification, enrollment, and notification by the state of pregnant women eligible for the Medicaid program.
- Inaccurate or limited contact information for women enrolled in Medicaid.
- State and/or federal constraints in providing timely, comprehensive, and evidence-based family planning information, especially to sexually active adolescents.
- Misinterpretation of when a referral is needed.

In 2017, 60 percent of Medicaid MCO care coordinators and medical directors had access to medical records, inclusive of physical and behavioral health information to review. Overall, 30 percent of respondents indicated that they subcontracted behavioral health services in 2017. Of these plans, 20 percent merged subcontractor operations within the health plan and 10 percent managed behavioral health services separately. Approximately 70 percent of health plans did not subcontract for behavioral health in 2017. Of these plans, 60 percent coordinated and managed physical and behavioral health and 10 percent did not manage behavioral health benefits.

Medicaid MCOs worked with physical health providers to address behavioral health needs in a number of ways. Figure 8 highlights that all health plans reported information and data sharing on behavioral health. Other common methods were education (80%), making screening tools available (70%), embedding health/behavioral specialists into medical practices (70%), and allowing payment for multiple services at the same location and date of service (70%).

Conversely, the most common approaches in 2017 that Medicaid MCOs worked with behavioral health providers to address physical health needs included education (90%) and information and data sharing on behavioral health (90%). Allowing payment for multiple services at the same time was reported by 70 percent of physical health providers when addressing behavioral health needs. The least common method was using value-based contracting across physical and behavioral health services (30%).

Figure 7. Approaches Medicaid MCOs Worked with Behavioral & Physical Health Providers to Address Needs, 2017



Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs reported a number of barriers in addressing behavioral and physical health integration. The most significant barriers (Table 13) were the CFR 42 limitations on substance use disorder (SUD) treatment information being shared (80.0%), access to behavioral health providers in select regions (70.0%), and fragmentation in program funding and contracting for physical and behavioral health services (60.0%).

Table 13. Most Common Barriers Medicaid MCOs Experienced Integrating Behavioral and Physical Health, 2017

Barriers	Most Common
CFR 42 limitations on SUD treatment information being shared	80%
Access to behavioral health providers in select regions (e.g., rural, underserved)	70%
Fragmentation in program funding and contracting for physical and behavioral health services	60%
Provider capacity to provide integrated physical and behavioral health at point of care	50%
Access to data between care management and behavioral health teams	40%
Staffing in care management to align skill sets with integrated care needs	30%
Communication between care management and behavioral health	20%
System differences with subcontractor	20%
Institutions on Mental Disease (IMD) exclusion	20%
Behavioral health provider adoption of electronic health records	20%
Behavioral health provider readiness for managed care	0%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Of the significant barriers identified, those attributed to policy challenges, such as the CFR 42 limitations on SUD treatment information being shared, were the most common cited followed by network barriers and then operational barriers (Table 14).

Table 14. Most Significant Barriers Medicaid MCOs Experience Integrating Behavioral and Physical Health by Category, 2017

Barriers
Policy Barriers
CFR 42 limitations on SUD treatment information being shared
Fragmentation in program funding and contracting for physical and behavioral health services
Institutions for Mental Disease (IMD) exclusion
Network Barriers
Access to behavioral health providers in select regions (e.g., rural, underserved)
Provider capacity to provide integrated physical and behavioral health at point of care
Behavioral health provider adoption of electronic health records
Behavioral health provider readiness for managed care
Operational Barriers
Access to data between care management and behavioral health teams
Staffing in care management to align skill sets with integrated care needs
Communication between care management and behavioral health
System differences with subcontractor

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Barriers in Behavioral & Physical Health Integration

Medicaid MCOs agreed that there were significant challenges and barriers in 2017 for behavioral and physical health integration. Many health plans used the write-in feature of the survey to list the following issues, with many using the word "fragmented" or "fragmentation" repeatedly when describing challenges that they encounter.

- Cultural differences and fragmentation between physical and behavioral health and delivery systems.
- Funding fragmentation from the federal, state and county levels impact how programs are delivered.
- Obtaining appropriate consents and ensuring that providers will accept these consents is a barrier to care coordination.
- States have exclusions and benefit exhaustion parameters that negatively impact the MCO's ability to serve the behavioral health and related care coordination needs for these members.

Over 90 percent of Medicaid MCOs reported having targeted programs to address child and adolescent health care needs. Of the targeted programs, health plans indicated that their most significant priorities for children and adolescents were children with special healthcare needs (91.7%) and ADHD/ADD (75.0%; Table 15). Medicaid MCOs reported having specific targeted programs or engagement strategies to address child and adolescent health priorities (Table 15), with the most common in 2017 being focused on children with special healthcare needs (100%) and asthma (75%).

Table 15. Most Significant Child and Adolescent Health Priorities Identified & Addressed by Medicaid MCOs, 2017

Health Priorities	Most Significant	Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies
Children with special healthcare needs	91.7%	100%
Autism spectrum disorder	75%	58.3%
ADHD/ADD	75%	58.3%
Asthma	72.7%	75%
Adverse childhood experiences	66.7%	50%
Dental health	63.6%	58.3%
Diabetes	63.6%	66.7%
Depression/anxiety	58.3%	50%
Transitioning to adulthood and independence	58.3%	54.5%
Mental health screening and treatment	50%	66.7%
Substance use disorder	50%	66.7%
Tobacco use	45.5%	66.7%
Obesity	45.5%	66.7%
Success in school	36.4%	25%
Teen pregnancy	27.3%	58.3%
Sex education	0%	16.7%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

The majority (83.3%) of Medicaid MCOs reported that states contracted with them for children with special healthcare needs (CSHCN). In 2017, health plans reported that they had various arrangements, including stand-alone contracts for CSHCN, CSHCN could opt into managed care but were not required to do so, or CSHCN were carved out of managed care.

Medicaid MCOs identified a number of barriers specific to access and coverage to care for children. The most significant barriers noted by health plans in 2017 were identifying and coordinating with schools (41.7%) and program fragmentation (41.7%). A quarter of Medicaid MCOs also indicated that engaging family members not enrolled in the child(ren)'s health plan to address social determinants of health was a significant barrier.

The most significant barrier the Medicaid MCOs reported when serving children with special healthcare needs in 2017 were poor communication among multiple providers to families (41.7%), consistency in identification parameters (33.3%), carved-out services creating increased risk for duplication and increased costs (33.3%), and carved-out services creating increased risk for families (33.3%).

All Medicaid MCOs reported utilizing a different care model for individuals enrolled in managed long-term services and supports (MLTSS) programs compared to their general population Medicaid MCO contracts. Nearly all health plans surveyed (90%) reported that more than 75 percent of their LTSS members had an assigned care coordinator. The remaining 10 percent of health plans reported that less than 5 percent of LTSS members had an assigned care coordinator.

Health plans indicated that they performed a number of core functions under LTSS care coordination models (Table 16). In 2017, all health plans reported always conducting risk assessments, developing plans of care, and providing transition planning.

Table 16. Frequency of Core Functions Performed under LTSS Care Coordination Models in Medicaid MCOs, 2017

Core Funtions	Frequency
Conducted risk assessments	100%
Developed a plan of care	100%
Transitioned planning	100%
Engaged a care team of professionals to address the needs of the member	90.9%
Supported and encouraged adherence to care plan	90.9%
Supported the member in identifying and connecting with providers in addition to supplying the provider directory,	90.9%
Coordinated of home and community-based services	90.9%
Caregiver supported	81.8%
Served as a single point of contact for the member	72.7%
Coordinated of in-home services	72.7%
Coordinated with social services as part of care plan development, adherence	72.7%
Coordinated of behavioral health	72.7%
Provided information on other needed social services	63.6%
Supported making appointments with providers	45.5%
Supported the member preparedness for appointments	36.4%
Provided guided referrals or “hand-offs” to other needed social services	36.4%
Arranged transportation for appointments	27.3%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs reported that individual members were always part of the LTSS care team (100%; Table 17). Other members who were almost always included on care teams in 2017 were care coordinators (90.9%) and guardians (81.8%).

Table 17. Frequency-of-Care Team Composition in LTSS for Medicaid MCOs, 2017

Care Team Composition	
Individual member	100%
Care coordinator within the health plan	90.9%
Guardian	81.8%
Family member	45.5%
Member's primary care clinician	36.4%
Behavioral health specialist within the health plan	27.3%
Natural/community supports other than guardian	27.3%
Representative from primary care clinician office	18.2%
Pharmacist within the health plan	18.2%
Other health care professional not employed by the health plan	18.2%
Peer support specialist within the health plan	18.2%
Community health worker within the health plan	9.1%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Approximately 55 percent of Medicaid MCO reported that they their care coordinators and medical directors in 2017 had access to medical records to review information (e.g., medical, facility-based care, and community-based care) and approximately the same percentage had access to review medical records inclusive of medical, behavioral health, and LTSS information. The most commonly reported care plan components were caregiver information and status (100%; Table 18), personal and care goals (100%), primary care clinicians (100%), and emergency (crisis) plans (100%). The most common medical components included having a community transition plan (100%), indicating use of durable medical equipment, hearing aids, and vision impairments (100%), and activities of daily living (100%).

Table 18. LTSS Plan-of-Care Components in Medicaid MCOs, 2017

Care Plan Components	Percentage
Caregiver information and status	100%
Goals – personal and care goals	100%
Primary care clinician information	100%
Emergency (crisis) plan	100%
Demographic and social information	90.9%
End-of-life plan, including MOLST and DPOA/POA/Guardianship	90.9%
Medical Components	**Percentage**
Community transition plan	100%
Durable medical equipment use, hearing aids, vision impairments.	100%
Activities of daily living	100%
Current health/medical status	90.9%
Behavioral health status/condition	90.9%
Medication list	90.9%
Safety screening	90.9%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

A number of program design considerations, as identified in Table 19, can impact the ability of a Medicaid MCO to manage LTSS. Design considerations that significantly affected the health plan's ability to manage LTSS in 2017 included the fragmented Medicaid benefit design (72.7%), Medicare and Medicaid misalignment (72.7%), and appropriate benefit and program design to allow for community transitions and long-term sustainability (72.7%).

Table 19. Considerations that Impact Management of LTSS in Medicaid MCOs, 2017

Program Design Considerations	Very Significant Impact	Somewhat Significant Impact	No Significant Impact
Fragmented Medicaid benefit design – behavioral health and/or physical health benefits – limited ability to serve the whole individual	72.7%	27.3%	0.0%
Medicare and Medicaid misalignment created challenges and financial disincentives	72.7%	27.3%	0.0%
Appropriate benefit and program design to allowed for community transitions and long-term sustainability	72.7%	18.2%	9.1%
State program requirements that limited effectiveness of managed care strategies	54.5%	36.4%	9.1%
Waiver waitlists	45.5%	18.2%	36.4%
Institutional level-of-care requirements that did not align with state goals	36.4%	45.5%	18.2%
State requirements for health plans to contract with specific organizations or providers for care coordination	27.3%	54.5%	18.2%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Medicaid MCOs have also adopted a number of LTSS innovations in 2017, including tools for self-direction (72.7%), self-advocacy approaches (72.7%), money following the person or community transition programs (72.7%), partnerships with community-based organizations (36.4%), and wellness initiatives (36.4%; Table 20). Value-based payment arrangements with LTSS providers (45.5%), telehealth other than remote monitoring (36.4%), and healthy eating or nutrition programs (36.4%) were not offered by over a third of health plans. Several respondents shared that the 2017 discontinuation of "follow-the-person" programs in some states had a significant negative impact on supporting member transitions from a facility to home and community-based services (HCBS). They noted that transitions from fee-for-service or waiver to the MCO were often fragmented and lacked the necessary collaboration on the part of the state provider to the MCO; resulting in barriers to ensure continuity of care and a smooth transition with no gaps in services. An opportunity exists for states to enhance communication and collaboration with Medicaid MCOs.

Table 20. Frequency of LTSS Innovations Utilized by Medicaid MCOs, 2017

LTSS Innovations	Always	Sometimes	Limited	Not Provided in 2017
Tools for self-direction	72.7%	27.3%	0%	0%
Self-advocacy approaches	72.7%	18.2%	9.1%	0%
Money follows the person or community transition programs	72.7%	18.2%	0%	9.1%
Partnerships with community-based organizations	36.4%	54.5%	0%	9.1%
Wellness initiatives	36.4%	45.5%	0%	18.2%
Employment initiatives outside of administering benefits required in state plan	27.3%	36.4%	9.1%	27.3%
Caregiver supports and services	18.2%	72.7%	0%	9.1%
Care coordination communication tools with caregivers, direct services workers and other in-home providers or support organizations	18.2%	63.6%	0%	18.2%
Remote monitoring	18.2%	9.1%	45.5%	27.3%
Unique housing strategies outside of administering benefits required in state plan	9.1%	72.7%	18.2%	0%
Transportation innovations	9.1%	54.5%	27.3%	9.1%
Healthy eating or nutrition programs outside of administering benefits required in state plan	9.1%	54.5%	0%	36.4%
Electronic Visit Verification	9.1%	27.3%	27.3%	36.4%
Telehealth other than remote monitoring that is specific to the LTSS population	0%	45.5%	18.2%	36.4%
Value-based payment arrangements with LTSS providers	0%	27.3%	27.3%	45.5%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Appendix A: Methods

The Institute for Medicaid Innovation's Annual Medicaid MCO Survey was developed to address the paucity of national data on Medicaid managed care. The findings from the inaugural survey that are contained in this report are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. The survey was distributed to MHPA member health plans on February 15, 2018, with a deadline of March 22, 2018. The Institute strongly encouraged each Medicaid health plan to identify a primary person within their organization to coordinate the completion of the survey, recognizing that multiple people will need to complete various sections of the survey. Health plans were instructed to complete the survey and return them to IMI's executive director.

Overall, the survey captured key characteristics of Medicaid MCOs across 34 states, representing 20 million covered lives. In addition, the survey also was able to capture unique qualitative data on the barriers and challenges Medicaid MCOs experience when providing access and coverage to beneficiaries, including state and federal requirements, as well as top priorities for a number of unique populations (e.g., women, children and adolescents, and individuals utilizing LTSS).

Sample Characteristics and Sample Representation

The survey was intended to capture accurate, relevant data on Medicaid managed care; therefore, Medicaid MCOs were the target population. Specifically, the sampling frame consisted of Medicaid Health Plans of America (MHPA) February 2018 member health plans. All 19 MHPA member health plans were invited to respond to the survey. To be eligible to participate in the survey, health plans had to have participated in Medicaid managed care in 2017; otherwise, there were no exclusion criteria. There was a total of 13 respondents for an overall survey response rate of 68 percent (Table 21), representing Medicaid MCOs across 34 unique states (Table 23). Sample representation was determined by combining the number of covered lives for each survey respondent using November 2017 data from Health Management Associates (HMA). Overall, the respondents to the survey represented 20 million covered lives, approximately 44.4 percent of all covered lives enrolled in Medicaid managed care in the country (Table 22). There were an equal number of health plans that were for-profit and non-profit (38.5% respectively, Table 22).

Table 21. 2018 Annual Medicaid MCO Survey Sampling Frame.

Sampling Frame	
MHPA Member Medicaid MCOs	19*
Completed Surveys	13
Survey Response Rate	68%
Partially Completed Surveys	0

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.
*February 2018 MHPA Medicaid MCO membership number.

Table 22. 2018 Annual Medicaid MCO Survey Representation and Profit Status.

	All Medicaid MCO Plans	MHPA Member Plans
Number of states	39	34
Total MMCO enrollment	48 million	20 million (44.4%)
Non-Profit	48%	38.5%
For-Profit	47%	38.5%

Source: Institute for Medicaid Innovation. 2018 Annual Medicaid MCO Survey.

Survey Development Process

All surveys that IMI develops and implements are created in coordination with experts from Medicaid health plans, researchers, and clinicians. The development of the survey used a methodical, iterative, and collaborative approach over the past three years, including the following steps:

1. Engagement with IMI's Data & Research and Dissemination & Implementation committees, which consist of MHPA member health plan representatives, on the concept and key design elements, including multiple reviews and editorial opportunities.

2. The establishment of three topical workgroups (value-based care, care coordination & transitions of care, and pharmacy), with representatives from the Medicaid health plans serving on each of the workgroups to identify key concepts for inclusion in the survey and the development of potential questions.
3. Solicitation of potential questions for consideration in the survey from external Medicaid stakeholders, including state and federal governments, Medicaid health plans, advocacy organizations, nonprofit organizations, and researchers.
4. Establishment of a workgroup representing research methodology experts from academic and non-academic institutions and Medicaid health plans to review the deliverables of the three topical workgroups and 700+ questions received from the external Medicaid stakeholders, with refinement until a draft survey was created. This process included ongoing consultation from Medicaid experts representing the U.S. Department of Health and Human Services and the University of Michigan's Institute for Social Research.
5. Review by the IMI National Advisory Board inclusive of Medicaid health plans, academic and non-academic researchers, and clinicians experienced in Medicaid and knowledgeable about IMI's strategic priorities. This step led to the expansion of the survey to include the expansion of questions in the women, children, and behavioral health sections.
6. Review by the MHPA Board of Directors, which led to the addition of a long-term services and supports (LTSS) section on the survey.
7. Pilot testing the survey tool with Medicaid health plans with further refinement by the workgroup before finalization.

Key Details

- The survey is intended to collect information longitudinally to capture trends that can inform and guide policy regarding Medicaid managed care.
- The survey collects information designed to provide an accurate and timely narrative about Medicaid health plans, highlighting what works and opportunities for improvement.
- The development of the survey included representatives from Medicaid health plans who were engaged in all steps of the three-year survey development, testing, and implementation phases.

- The survey is divided into several key categories that were identified by the Medicaid health plan representatives and Medicaid experts. They include High Risk Care Coordination, Value-Based Purchasing, Pharmacy, Behavioral Health, Women's Health, Child and Adolescent Health, and LTSS.
- The survey collected information at the parent company/corporate levels.
- Reported findings from the analysis of the survey have been aggregated as a composite with no plan-level identifiable data being released. Furthermore, for variables with a small sample size, information has not been reported to protect the identity of the health plans.
- The database containing information collected as part of the survey will not be released, further protecting the identity of the Medicaid health plan respondents. Access to the information will be limited to the Institute for Medicaid Innovation staff and fellows.
- A list of the organizations that participated in the development of this survey is provided below.

Strengths and Limitations

It is possible that the data shown in the current report may not generalize to all Medicaid-covered lives. However, the survey was able to capture data representing 20 million covered Medicaid lives, approximately 44.4 percent of all covered lives enrolled in Medicaid managed care overall, suggesting that the data presented is representative. The data provides a strong representation of the range of Medicaid MCOs. Further, nearly 70 percent of MHPA health plan members responded to the survey in its inaugural year, with 100 percent of MHPA health plans committing to completing the 2019 survey.

Finally, although the questions included in the survey were robust and were created with input from a number of expert stakeholders, data from a few questions were dropped from the report because of confusion around the question wording, which was not uncovered during the pilot testing. These challenges will be discussed with IMI's Data and Research Committee and the expert workgroup for refinement of the 2019 survey.

2015 – 2018 Medicaid Health Plan Representation for Survey Development*

Aetna Medicaid
Alliance Behavioral Healthcare
Anthem, Inc.
Centene
Gateway Health Plan
Health Care Services Corporation
Health Plan of San Joaquin
Inland Empire Health Plan
L.A. Care Health Plan
Meridian Health
Tenet Health Plans
Trillium Health Resources
Trusted Health Plan
United Healthcare Community & State
UPMC *For You*
Upper Peninsula Health Plan
Vaya Health

*The list of Medicaid health plan representation who participated in the development, piloting, and refinement of the survey do not necessarily represent the health plans that completed the survey for the purpose of this annual report.

Appendix B: Survey Acronyms and Definitions

The following are a list of definitions that were provided in the survey to help guide responses.

APM: Alternative payment methodology.

Care Team: Group of individuals (clinicians and non-clinicians) within and outside of the health plan that supports the members' access, coverage and coordination of care.

Children with Special Healthcare Needs: Individual (under the age of 18) who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally.

Complex population contracts: Contracts that include individuals with intellectual and developmental disabilities (ID/DD), Children with Special Healthcare Needs, Individuals with Serious Mental Illness (SMI), and Foster Care.

General Medicaid contract: Medicaid contracts with managed care that primarily focus on Medicaid benefits outlined in the state plan; typically consisting of eligibility categories for women, children, and childless adults.

HCBS: Home and Community-Based Services

High-Risk: Identified by clinical data risk stratification or definitions of certain populations with focused needs that require specific or high utilization.

High-risk care coordination: A specific approach within Care Management that targets individuals at increased risk by providing support to navigate and coordinate needed care. These services are provided directly by the MCO or a delegated entity and include programs such as Complex Member Management, Disease Management, High-Risk Maternity Management, etc.

ID/DD: Individuals with Intellectual and Developmental Disabilities.

LTSS: Long-Term Services and Supports.

LTSS Medicaid Contract: Contracts inclusive of institutional, home, and community-based services that are targeted to individuals who qualify for long-term care based on functional need.

MCOs: Managed care organizations. For the purposes of this survey, we are exclusively interested in the Medicaid managed care organizations.

MLTSS: Medicaid Long-Term Supports and Services

PCP: Primary care provider.

SMI: Individuals with serious mental illness.

SUD: Substance use disorders.

VBP: Value-based payment.