September 2019

# Medicaid Access & Coverage to Care in 2018

## Results from the Institute for Medicaid Innovation's 2019 Annual Medicaid Managed Care Survey

INSTITUTE FOR MEDICAID INNOVATION

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# Executive Summary

This second Annual Medicaid Managed Care Survey represents the first-of-its-kind comprehensive effort to collect robust, longitudinal data on Medicaid managed care organizations (MCOs). Under the leadership and vision of the Institute for Medicaid Innovation's founding executive director, Dr. Jennifer Moore, the annual Medicaid managed care organization survey was developed through the contribution of national experts in Medicaid. The experts, representing knowledge in managed care operations, survey methodology, health services research, policy, and clinical care, were engaged throughout the process to design, test, refine, and finalize the survey while utilizing rigorous scientific methods. The survey findings contained in this report are intended to equip Medicaid stakeholders with the information they need to accurately articulate the national narrative about Medicaid managed care.

For the 2019 survey, representing coverage in 2018, all Medicaid MCOs were invited to participate, including, but not limited to, the members of the two leading Medicaid trade associations, Medicaid Health Plans of America (MHPA) and Association for Community Affiliated Plans (ACAP). Overall, the Medicaid MCOs that responded to the survey represented 69 percent of all covered lives in Medicaid managed care across every state with Medicaid managed care. The 46-page survey provides a comprehensive look into Medicaid managed care. Highlighted in this report are findings specific to critical elements of the Medicaid program, including the following:

- High-Risk Care Coordination
- Value-Based Purchasing
- Pharmacy
- Behavioral Health
- Women's Health
- Child and Adolescent Health
- Managed Long-Term Services and Supports
- Social Determinants of Health

## High-Risk Care Coordination

In 2018, 56 percent of Medicaid MCO respondents indicated that less than 6 percent of their members received high-risk care coordination services. The most common barriers cited in completing an individual health risk assessment were inaccurate member information (e.g., phone number) (95%), difficulty reaching a member (95%), and lack of member's willingness to participate in a needs assessment (95%). The most common barriers cited by Medicaid MCOs in providing high-risk care management were members' willingness to engage (100%), ability to contact member (95%), availability of social

supports (78%), and members' unmet social needs (78%). Of the state-mandated core functions of high-risk care coordination (e.g., served as a single point of contact for the member, developed a plan of care), the majority of health plans always provided these core functions to members.

## Value-Based Purchasing

Approximately 95 percent of all Medicaid MCO respondents utilized an alternative payment model, or value-based purchasing arrangement, with 100 percent of medium (i.e., 250,001 to 1 million covered lives) and large (over 1 million covered lives) health plans reporting engagement in 2018. The majority of health plans (82%) implemented value-based purchasing arrangements with primary care providers (i.e., physicians, advance practice nurses), while very few established similar arrangements with behavioral health providers, dentists, home and community-based service providers, and long-term care facilities. Furthermore, more than 66 percent of health plans indicated that the percentage of payments to hospitals through alternative mechanisms was less than 15 percent, which indicates Medicaid MCOs' clear preference to work directly with primary care providers over hospitals to establish value-based purchasing arrangements. However, the most common operational barrier to implementing value-based agreements, as reported by the health plans, was data reporting to providers (53%). The most common external factors influencing adoption and innovation were providers' readiness and willingness (89%) and provider information technology (IT) capabilities (83%). Although the data indicate a preference to work with primary care providers, common barriers specific to providers exist that are hindering adoption and innovation in value-based purchasing as well.

## Pharmacy

The majority of Medicaid MCO respondents (89%) reported being at-risk for pharmacy benefits in their contracts during 2018. The most common challenges noted by health plans in managing prescription drug benefits included (1) unknown utilization and cost history for new drugs entering a market, which affects capitation rates and pricing (89%), (2) members' comprehension of and engagement in programs (65%), and (3) pharmacy benefits carved out of managed care (59%).

## Behavioral Health

In 2018, 84 percent of health plan respondents indicated being at risk for behavioral health services for their Medicaid members. Medicaid MCOs reported operational, network, and policy barriers when integrating behavioral and physical health. The majority of health plans indicated common barriers, including 42 CFR Part 2 limitations on substance use disorder treatment information being shared between behavioral and physical health providers (88%), provider capacity to provide integrated physical and behavioral health at point of care (82%), fragmentation in program funding and contracting for physical and behavioral health services (63%), and access to data between care management and behavioral health teams (63%). As was noted in the findings on value-based purchasing, access to data and provider readiness are barriers to behavioral and physical health integration.

## Women's Health

Approximately 89 percent of health plans were providing targeted women's health programs for Medicaid members in 2018. Consistent with Medicaid's role in providing coverage for pregnant women, 95 percent of health plans indicated that prenatal and postpartum care was a priority women's health topic, with 95 percent also indicating that they had targeted programs and engagement strategies to address this priority. Approximately 50 percent of health plans also identified depression/anxiety, diabetes, and heart disease as priority topics and also had programs and strategies across the lifespan. Common challenges that health plans continued to address in women's health in 2018 included the high prevalence of substance use/opioid use disorder among pregnant women, with lack of access to medication-assisted treatment, lack of adoption of long-acting reversible contraception, early identification of pregnancy before 12 weeks gestation, access to family planning services, and loss of Medicaid eligibility after pregnancy.

## Child and Adolescent Health

The majority of health plans (95%) offered targeted child health programs in 2018, with 100 percent of all medium and large-size health plans (greater than 250,001 covered lives) indicating that they have such programs. Furthermore, over 80 percent of health plans, regardless of size, contracted with the state Medicaid agency to provide coverage for children with special healthcare needs (CSHCN). The Medicaid MCO respondents identified an array of child and adolescent health priority topics specific to their health and social needs. The most common priority topics identified were diabetes (64%) and obesity (56%). However, the most common targeted programs and engagement strategies were focused on CSHCN (82%), behavioral health screening and treatment (71%), and asthma (71%).

The survey findings identified that the majority of Medicaid MCOs provided a comprehensive list of covered health and social services to support children with special healthcare needs such as supporting the member in identifying and connecting with providers, including outside of the provider directory (100%); developing a comprehensive plan of care with the family/caregivers (93%); and providing information and coordination with other needed social service organizations (e.g., faith-based, housing, nutrition, non-profit, etc.) as part of care plan development and adherence (93%). However, barriers persisted, including poor communication among multiple providers to families (77%); carved-out services, which created inefficiencies in services for families (71%); and carved-out services, which created an increased risk for duplication and costs (53%). To address the common barriers that health plans encountered, the benefits they provided often began while the child was at home and not at the point of hospitalization or as part of discharge planning.

## Managed Long-Term Services and Supports (MLTSS)

In 2018, 67 percent of Medicaid MCO respondents indicated being at-risk for long-term services and supports (LTSS). With the growing interest of state Medicaid agencies to provide managed long-term services and supports (MLTSS) through health plans, we anticipate that this number will increase. Currently, 100 percent of large health plans (i.e., greater than 1 million covered lives) are at-risk for MLTSS in at least one of their markets. Of the health plans at-risk, regardless of size, 100 percent assigned a care coordinator for more than 75 percent of their members.

More than 66 percent of health plans reported completing the enrollment and assessment process for the new member in less than 30 days, and almost 100 percent reported completing the member's plan of care within 90 days of enrollment. The overwhelming majority of health plans indicated completing a comprehensive list of core functions for their members, especially in the areas of care coordination (100%), transition planning (100%), and social needs support (92%). Furthermore, in 2018, 100 percent of Medicaid MCOs utilized care teams for their MLTSS members.

When designing MLTSS programs, health plans indicated two common barriers: fragmented Medicaid benefit design (42%) and misalignment between Medicaid and Medicare (42%). Finally, the most common approaches for innovation in MLTSS that were led by health plans in 2018 were member-centric, including self-advocacy (84%) and tools for self-direction (59%). Furthermore, health plans commonly offered innovative approaches for caregiver support and services (59%), care coordination (59%), partnerships with community-based organizations (59%), and "money follows the person" community transition programs (50%).

## Social Determinants of Health (SDOH)

In 2018, 78 percent of all Medicaid MCO respondents indicated that they offer targeted social determinant of health (SDOH) programs, with 100 percent of large health plans (more than one million covered lives) having such programs. The most common populations that were targeted for SDOH programs were pregnant women (86%), homeless/housing insecure (79%), and adults with substance use disorders (72%). A very comprehensive table on page 52 provides detailed information on the types and percentages of health plans offering targeted SDOH strategies (e.g., maintained a database of community and social service resources) for specific social needs (e.g., housing, social isolation, and violence).

It was noticeable in the survey findings that there were multiple screening tools being used and not one across all Medicaid MCO respondents. Most of the health plans (50%) indicated utilizing an internally developed or adapted tool, with 15 percent not using any tool.

Finally, the write-in portion of the SDOH section of the survey generated the highest number of comments out of the entire survey, with every health plan offering insight into the barriers that they experience when coordinating and covering services to address social needs. The most common barriers that states could address to support efforts included data sharing (i.e., availability, access to Homeless Management Information System [HMIS], accuracy, timeliness, completeness), increased resources (i.e., financial and human), standardization of the 834 enrollment file to include social needs information, and contracting (i.e., challenges with community-based organizations).

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.

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Graphic Design by Lydia Tonkonow

# Overview and Sample Characteristics

The Institute for Medicaid Innovation's (IMI's) annual Medicaid managed care organization (MCO) survey was developed 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 2019 survey, capturing 2018 Medicaid managed care data, 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 survey's longitudinal design 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 2018 data provided to the IMI from Medicaid MCOs. The survey was emailed in February 2019 to all members of the two leading trade associations for Medicaid health plans, Medicaid Health Plans of America (MHPA) and Association for Community Affiliated Plans (ACAP), and individually to health plans greater than 500,000 covered lives without an affiliation with either trade association. The Medicaid MCOs that responded to the survey represented **69 percent of all covered lives in Medicaid managed care** across **every state with Medicaid managed care**.

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 eight core areas of Medicaid managed care coverage: high-risk care coordination, value-based payment, pharmacy, women's health, behavioral health, child and adolescent health, managed long-term services and supports (MLTSS), and social determinants of health. 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.

## Characteristics of Survey Respondents: Medicaid Managed Care Organizations

Health plan survey respondents indicated participating in Medicaid programs as a managed care organization as early as 1981 and as late as 2016. Respondents were 34 percent private, non-profit organizations; 45 percent private, for-profit organizations; and 23 percent either public or government organizations. The majority of respondents (73%) indicated that they provided coverage in a single state or a single region within a single state in 2018, with 28 percent providing coverage in multiple states (Table 1). The increase in the number of single-state health plan respondents from 2017 is due to the addition of ACAP member health plans participating in this year's survey, who oftentimes only operate in a single state or area of a state.

There was almost equal distribution of covered lives among the Medicaid MCO survey respondents, with 39 percent covering fewer than 250,000 Medicaid managed lives, 28 percent covering 250,001 to 1 million lives, and 34 percent covering more than 1 million lives (Table 1). Table 2 highlights the percentage of health plans, stratified by health plan size, offering coverage in the core areas in Medicaid managed care. The majority of Medicaid MCOs provided coverage in all areas (i.e., value-based purchasing, pharmacy benefits, women's health, etc.). Health plans reported managing a number of benefits at full risk, including physical health (100%), behavioral health (95%), institutional care (78%), home and community-based waiver services (78%), pharmacy (95%), and dental (73%). Further, Medicaid MCOs reported participating in a number of health benefit programs, including the Children's Health Insurance Program (CHIP; 67%), Medicare Advantage (62%), Medicare Special Needs Plan (62%), Health Insurance Marketplace/Exchange (39%), individual markets (34%), employer markets (34%), and other programs (28%).

In 2018, 44 percent of Medicaid MCO survey respondents indicated that they contracted with an Accountable Care Organization (ACO), as highlighted in Figure 1. Approximately 72 percent contracted with an integrated health system that was not an ACO (Figure 2). A little over three-quarters of health plan respondents indicated that more than 50 percent of their members received services through a patient-centered medical home.

Additional characteristics of the Medicaid MCO survey respondents are highlighted in this section of the report.

## Table 1. Overview of Medicaid Managed Care Survey Respondents' Characteristics, 2018

| Survey Sample Characteristics (Representing 69% of all covered lives in Medicaid MCOs.) | | | |
|---|---|---|---|
| **Medicaid Managed Care Organization (MCO) Tax Status** | | | |
| Private, non-profit | | | 45% |
| Private, for-profit | | | 33% |
| Other (public or government) | | | 22% |
| **Parent Organization** | | | |
| Provider owned | | | 22% |
| Not provider owned | | | 78% |
| **Number of Covered Lives** | | | |
| Medicaid MCOs with fewer than 250,000 covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | |
| 39% | 28% | 33% | |
| **Medicaid MCO Markets** | | | |
| | Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives |
| Multiple states | 0% | 0% | 83% |
| Single state | 100% | 100% | 17% |
| **Benefits Managed at Full Risk** | | | |
| Physical Health | | | 100% |
| Behavioral Health | | | 95% |
| Pharmacy | | | 95% |
| Institutional Care | | | 78% |
| Home and Community-Based Waiver Services | | | 78% |
| Dental | | | 73% |
| **MCO Program Participation** | | | |
| Children's Health Insurance Program (CHIP) | | | 67% |
| Medicare Advantage | | | 62% |
| Medicare Special Needs Plan | | | 62% |
| Health Insurance Marketplace/Exchange | | | 39% |
| Individual market | | | 34% |
| Employer market (small and/or large group) | | | 34% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 2. Comparison of Elements of Medicaid Managed Care Organization Coverage by Health Plan Size, 2018

| Elements of Medicaid MCO Coverage | Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|---|
| High-Risk Care Coordination | 100% | 100% | 100% | 100% |
| Value-Based Purchasing | 86% | 100% | 100% | 95% |
| Pharmacy | 86% | 80% | 100% | 89% |
| Behavioral Health | 72% | 80% | 100% | 84% |
| Women's Health | 86% | 80% | 100% | 89% |
| Child and Adolescent Health | 86% | 100% | 100% | 95% |
| Long-Term Services and Supports | 43% | 60% | 100% | 67% |
| Social Determinants of Health | 58% | 80% | 100% | 78% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 3. Percentage of Medicaid Managed Care Organizations Serving Specific Populations, 2018

| Population Served by Medicaid MCOs | Percentage of Medicaid MCOs |
|---|---|
| Individuals with Serious Mental Illness (SMI) | 100% |
| Aged, Blind, Disabled | 95% |
| Children | 95% |
| Childless Adults | 89% |
| Children with Special Healthcare Needs | 89% |
| Individuals with I/DD | 89% |
| Medicare and Medicaid Enrollees | 89% |
| Children and Youth in Foster Care | 78% |
| Adult Caregivers | 67% |
| Medicare Only | 50% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 4. Percentage of Medicaid Managed Care Organizations with Specific Provider Contracts, 2018

| Type of Provider Contract | Percentage of Medicaid MCOs |
|---|---|
| Public hospitals | 95% |
| Academic medical centers | 89% |
| Behavioral health centers | 89% |
| Community health centers | 89% |
| Urgent care clinics | 89% |
| Maternal and child health clinics | 84% |
| HIV/AIDS services organizations | 78% |
| Local/County health departments | 78% |
| School-based clinics | 78% |
| Methadone and other MAT clinics | 73% |
| Family planning clinics (Title X) | 67% |
| Planned Parenthood | 67% |
| Indian Health Service providers or tribal health clinics | 62% |
| Retail clinics | 56% |
| Other | 17% |

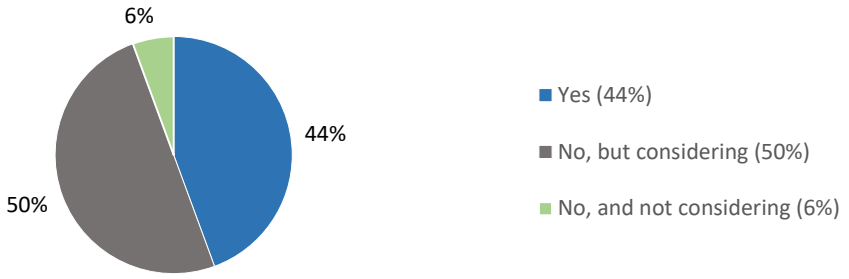
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 5. Most Common Strategies Used by Medicaid Managed Care Organizations to Recruit and Retain Providers in Medicaid Managed Care, 2018

| Medicaid MCO Strategy | Percentage of Medicaid MCOs |
|---|---|
| Financial incentives | 95% |
| In-person outreach to providers | 89% |
| Use of technology | 89% |
| Dedicated provider hotline for questions, problems, and needs | 84% |
| Prompt payment policies | 78% |
| Streamlined referral and authorization practices | 73% |
| Automatic assignment of members to primary care providers | 67% |
| Pay rates comparable to Medicare or commercial rates | 67% |
| Streamlined credentialing and re-credentialing processes | 67% |
| Reduced administrative burdens | 56% |
| Debt repayment | 17% |
| Other | 12% |

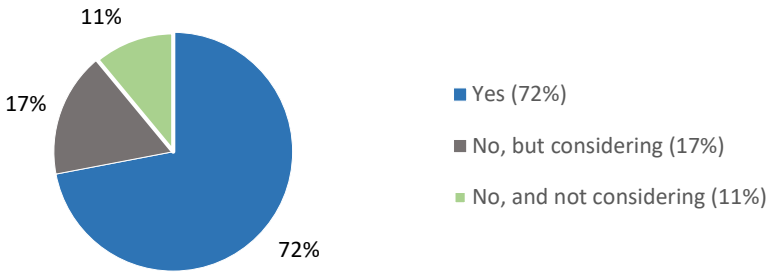
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 1. Percentage of Medicaid Managed Care Organizations Contracting with an Accountable Care Organization (ACO), 2018




Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 2. Percentage of Medicaid Managed Care Organizations Contracting with an Integrated Health System That Is Not an ACO, 2018




Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

In 2018, 56 percent of Medicaid MCO respondents indicated that less than 6 percent of their members received high-risk care coordination services. The most common barriers cited in completing an individual health risk assessment were inaccurate member information (e.g., phone number) (95%), difficulty reaching member (95%), and lack of member's willingness to participate in a needs assessment (95%). The most common barriers cited by Medicaid MCOs in providing high-risk care management were member's willingness to engage (100%), ability to contact member (95%), availability of social supports (78%), and member's unmet social needs (78%). Approximately 95 percent of health plans reported utilizing care teams. Of the state-mandated core functions of high-risk care coordination (e.g., served as a single point of contact for the member, developed a plan of care), the majority of health plans always provided these core functions to members. In addition, the majority of health plans sometimes provided other non-state mandated core functions (e.g., coordinated in-home services, prepared member for appointment). Almost all Medicaid MCO respondents (95%) measured the effectiveness of their high-risk care coordination efforts in 2018, with the most common forms of measurement being emergency room utilization (95%), inpatient utilization (89%), preventative care (77%), and patient experience survey (77%).

Additional high-risk care coordination findings are highlighted in this section of the report.

## Table 6. Most Common Barriers in Completing Individual Health Risk Assessments for Members, 2018

| Assessment Barriers Medicaid MCOs Encounter | Percentage of Medicaid MCOs |
|---|---|
| Inaccurate member information (e.g., phone number, address) | 95% |
| Difficulty reaching members | 95% |
| Lack of member's willingness to participate in a needs assessment | 95% |
| Lack of confirmed member record | 34% |
| State deadline to complete assessments within timeframe | 34% |
| Dispute in resolving the identity of members | 23% |
| Overlapping assessments tied to eligibility | 23% |
| Other | 6% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 7. Most Common Barriers to Effective High-Risk Care Management, 2018

| Management Barriers Medicaid MCOs Encounter | Percentage of Medicaid MCOs |
|---|---|
| Member's willingness to engage | 100% |
| Ability to contact member | 95% |
| Availability of social supports | 78% |
| Member's unmet social needs | 78% |
| Provider's willingness to engage with health plan | 62% |
| Ability to connect individuals to necessary non-clinical social supports | 62% |
| Obtaining consent | 56% |
| Access to information from previous providers | 56% |
| Coordination with multiple care coordinators from health systems, provider practices, clinics, etc. | 56% |
| Member's access to primary care | 45% |
| Member's access to specialty care | 45% |
| Ability to share information with service providers | 45% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 8. Most Common Methods by Medicaid Managed Care Organizations for Sharing Members' Risk Assessments, 2018

| Method of Sharing | Percentage of Medicaid MCOs |
|---|---|
| Health plan to care coordinator | 84% |
| Health plan to member | 73% |
| Health plan to member's guardian or responsible party | 73% |
| Health plan to network providers | 62% |
| Health plan to member's preferred provider | 62% |
| Health plan to community-based organization | 56% |
| Network provider to health plan | 34% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 9. Core Functions Performed by Medicaid Managed Care Organizations under High-Risk Care Coordination, 2018

| Core Function | Always (i.e., Required for care coordination.) | Sometimes (i.e., Based on member needs.) | Limited (i.e., Small pilot program or case-by-case.) | Did Not Provide |
|---|---|---|---|---|
| Served as a single point of contact for the member | 56% | 44% | 0% | 0% |
| Engaged a care team of professionals to address the needs of the member | 67% | 33% | 0% | 0% |
| Developed a plan of care | 77% | 23% | 0% | 0% |
| Supported adherence to plans of care | 77% | 23% | 0% | 0% |
| In addition to supplying the provider directory, supported the member in identifying and connecting with providers | 45% | 55% | 0% | 0% |
| Coordinated in-home services | 33% | 67% | 0% | 0% |
| Prepared the member for appointments | 17% | 73% | 12% | 0% |
| Arranged transportation for appointments | 11% | 89% | 0% | 0% |
| Provided information on other types of social services (e.g., faith based, non-profit, other government programs) | 27% | 73% | 0% | 0% |
| Provided guided referrals or "hand-offs" to other needed social services (e.g., faith- based, non-profit, other government programs) | 17% | 78% | 5% | 0% |
| Coordinated with social services (i.e., housing providers, nutrition programs) as part of care plan development and adherence | 17% | 78% | 5% | 0% |
| Shared data with social services | 17% | 44% | 22% | 17% |
| Coordinated with multiple care coordinators from health systems, provider practices, clinics, etc. | 33% | 67% | 0% | 0% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 10. Frequency of Participation with Medicaid Managed Care Organization Care Teams, 2018

| | Always | Sometimes | Never |
|---|---|---|---|
| Individual member | 30% | 70% | 0% |
| Family member | 6% | 94% | 0% |
| Guardian | 6% | 94% | 0% |
| Member's Primary Care Provider | 94% | 6% | 0% |
| Representative from Primary Care Provider office | 12% | 82% | 6% |
| Other healthcare professional not employed by health plan | 6% | 88% | 6% |
| Natural/community supports (other than guardian) | 6% | 82% | 12% |
| Care coordinator within health plan | 77% | 23% | 0% |
| Behavioral health specialist within health plan | 24% | 70% | 6% |
| Pharmacist within health plan | 24% | 64% | 12% |
| Community worker within health plan | 6% | 82% | 12% |
| Peer-support specialist within health plan | 12% | 70% | 18% |
| Non-health plan care coordinators (e.g., from health system, provider practices, clinics, etc.) | 12% | 82% | 6% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 11. Most Common Measures of Effectiveness Used in High-Risk Care Coordination, 2018

| Measures Utilized by Medicaid MCOs | Percentage of Medicaid MCOs |
|---|---|
| Emergency Department utilization | 95% |
| Inpatient utilization | 89% |
| Preventative care | 77% |
| Patient experience survey results | 77% |
| Impact on HEDIS measures | 70% |
| Total spending | 65% |
| Provider experience survey results | 59% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

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 12. HCP-LAN Alternative Payment Model Framework

| Category 1 | Category 2 | Category 3 | Category 4 |
|---|---|---|---|
| Fee for Service – No Link to Quality & Value | Fee for Service – Link to Quality &Value | APMs Built on Fee-for-Service Architecture | Population-Based Payment |
| | **A** Foundational Payments for Infrastructure & Operations<br>**B** Pays for Reporting<br>**C** Rewards for Performance<br>**D** Rewards and Penalties for Performance | **A** APMs with Upside Gainsharing<br>**B** APMs with Upside Gainsharing/ Downside Risk | **A** Condition-Specific Population-Based Payment<br>**B** Comprehensive Population-Based Payment |

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

The survey findings show that as the number of state Medicaid agencies that require value-based purchasing agreements increases, the percentage of state-required contracts between health plans and providers increases also. Approximately 95 percent of all Medicaid MCO respondents utilized an alternative payment model or value-based purchasing arrangement, with 100 percent of medium-size (i.e., 250,001 to 1 million covered lives) and large-size (over 1 million covered lives) health plans reporting engagement in 2018.

The majority of health plans implemented value-based purchasing arrangements with primary care providers (i.e., physicians, advance practice nurses), while very few health plans established similar arrangements with behavioral health providers, dentists, home and community-based service providers, and long-term care facilities. Furthermore, over 66 percent of health plans indicated that the percentage of alternative payments to hospitals was less than 15 percent, which highlights Medicaid MCOs' clear preference to work directly with primary care providers rather than hospitals to establish value-based purchasing arrangements.

However, the most common operational barrier as reported by the health plans was data reporting to providers (53%). The most common external factors influencing adoption and innovation were providers' readiness and willingness (89%) and provider information technology (IT) capabilities (83%). Although the data indicate a preference to work with primary care providers, common barriers specific to providers exist that are hindering adoption and innovation in value-based purchasing as well.

Additional value-based purchasing findings are highlighted in this section of the report.

## Table 13. Percentage of Medicaid Managed Care Organizations Using APM or VBP Structures, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 86% | 100% | 100% | 95% |

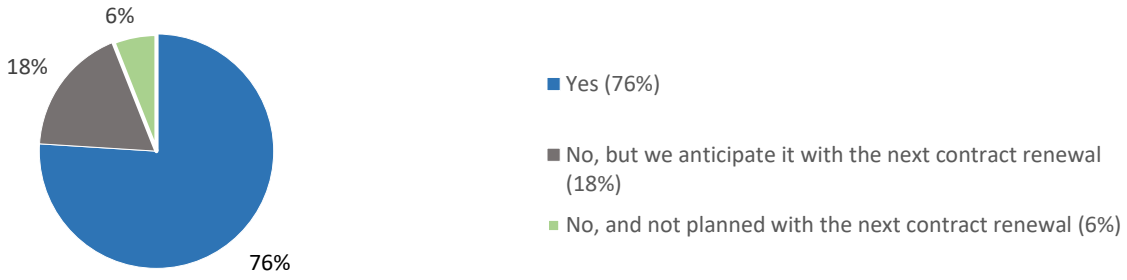
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 14. Level of Engagement by Medicaid Managed Care Organizations in HCP-LAN APM Categories, 2018

| HCP-LAN APM Category | Percentage of Medicaid MCOs Engaged |
|---|---|
| Category 1: FFS, no link to quality or value | 65% |
| Category 2: FFS, link to quality and value | 71% |
| Category 3: APMs built on FFS architecture | 89% |
| Category 4: Population-based payment | 48% |

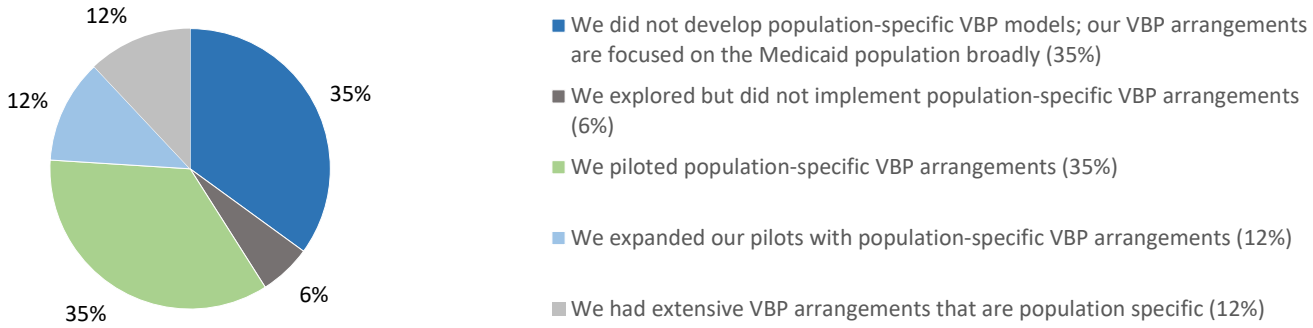
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 3. Percentage of State Contracts Requiring Medicaid Managed Care Organizations to Implement VBP or APM Contracting between Medicaid Managed Care Organizations and Providers, 2018




Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 4. Percentage of VBP Implementation Within Specific Populations, 2018




Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 15. Value-Based Purchasing (VBP) Implementation within Specific Provider Categories (Hospitals Excluded), 2018

| Provider Type | Worked with a Majority of This Type of Provider | Worked with Select Providers | Did Not Work with This Type of Provider |
|---|---|---|---|
| Behavioral Health Providers | 0% | 53% | 47% |
| Dentists | 6% | 12% | 82% |
| Home and Community-Based Service Providers | 6% | 35% | 59% |
| Long-Term Care Facilities | 6% | 23% | 71% |
| Nurse -Midwives | 6% | 6% | 88% |
| OBGYNs | 12% | 53% | 35% |
| Orthopedics | 6% | 23% | 71% |
| Primary Care Providers (i.e., Physicians, Advanced Practice Nurses, Physician Assistants) | 59% | 23% | 18% |
| Other Specialists | 12% | 50% | 38% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 16. Most Common Medicaid Managed Care Organization Payment Strategies, 2018

| Payment Strategy | Percentage of Medicaid MCOs |
|---|---|
| Payment incentives based on performance measures related to access to care | 59% |
| Enhanced payment rates for hard-to-recruit provider types | 42% |
| Payment incentives for availability of same-day or after-hours appointments | 38% |
| Other | 36% |
| Enhanced payment rates for providers in rural or frontier areas | 24% |
| Medicaid MCO did not implement any of these strategies within the past 12 months | 12% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 17. Most Common Types of Alternative Payment Models (APMs) Used between Providers and Medicaid Managed Care Organizations, 2018

| Type of Alternative Payment Model | Percentage of Medicaid MCOs |
|---|---|
| Incentive/bonus payments tied to specific performance measures | 95% |
| Shared savings | 71% |
| Global or capitated payments to primary care providers or integrated provider entities | 59% |
| Bundled or episode-based payments | 53% |
| Shared savings and risk | 48% |
| Non-payment or reduced payment for patient safety issues | 30% |
| Payment withholds tied to performance | 30% |
| Non-payment or reduced payment for 39-week elective delivery | 18% |
| Other | 12% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 18. Percentage of Payments through APMs to Primary Care Providers, by Health Plan Size, 2018

| Percentage of Payment | Medicaid MCOs with 250,000 or less covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|---|
| 1-15% | 43% | 40% | 17% | 36% |
| 16-30% | 0% | 0% | 34% | 12% |
| More than 30% | 29% | 60% | 50% | 48% |
| None | 15% | 0% | 0% | 6% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 19. Percentage of Payments through APMs to Hospitals, by Health Plan Size, 2018

| Percentage of Payment | Medicaid MCOs with 250,000 or less covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|---|
| 1-15% | 0% | 60% | 67% | 67% |
| 16-30% | 0% | 0% | 34% | 34% |
| More than 30% | 43% | 20% | 0% | 0% |
| None | 43% | 20% | 0% | 0% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 20. Most Common Operational Barriers in VBP/APMs, as Reported by Medicaid Managed Care Organizations, 2018

| Operational Barriers | Percentage of Medicaid MCOs |
|---|---|
| Data reporting to providers | 53% |
| IT system preparedness | 48% |
| Support to providers to make determinations on VBP/APM | 42% |
| Pricing VBP/APM | 42% |
| Tracking quality and reporting within new structure | 36% |
| Contract requirements on VBP/APM approaches | 24% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 21. Most Common External Factors Influencing Adoption and Innovation in VBP/APMs, as Reported by Medicaid Managed Care Organizations, 2018

| External Factors | Percentage of Medicaid MCOs |
|---|---|
| Provider readiness and willingness | 89% |
| Provider IT capabilities | 83% |
| Medicaid payment rates | 65% |
| State requirements limiting VBP/APM models | 42% |
| Uncertain or shifting state policy requirements/priorities | 36% |
| Uncertain or shifting federal policy requirements/priorities | 30% |
| Impact of 42 CFR Part 2 on limiting access to behavioral health data | 24% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

# Pharmacy

The majority of Medicaid MCO respondents (89%) reported being at risk for pharmacy benefits in 2018. The most common challenges noted by health plans in managing prescription drug benefits included unknown utilization and cost history for new drugs entering a market, which affects capitation rates and pricing (89%); members' comprehension of and engagement in programs (65%), and pharmacy benefits or set of benefits carved out of managed care (59%). Others also noted additional challenges, including an increase in specialty pharmacy medication cost and utilization and state single preferred drug list/formulary requirements. Health plans reported approaches that states are utilizing to address new or high-cost drugs, including capitation rate adjustment as part of regular rate adjustments (59%) and completely carved-out drug costs or payment based on fee-for-service for certain drugs (53%). Survey respondents noted that changes in pharmacy benefit managers are evolving and affecting pharmacy benefits for Medicaid members. For instance, one health plan noted that they transitioned from a plan-managed drug formulary to a single preferred drug list managed by the state health care authority. This change occurred mid-year.

Additional pharmacy findings are highlighted in this section of the report.

## Table 22. Percentage of Medicaid Managed Care Organizations At-Risk for Pharmacy Benefits, by Health Plan Size, 2018

| | Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|---|
| Yes | 86% | 80% | 100% | 89% |
| Yes, but only a portion of the pharmacy spend | 0% | 20% | 0% | 6% |
| No | 15% | 0% | 0% | 6% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 23. Percentage of Medicaid MCOs Utilizing Pharmacists for Medication Therapy Management, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 50% | 100% | 84% | 77% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 24. Most Common Ways Used by Pharmacists for Medication Therapy Management, 2018

| Approaches | In-person | Over-the-phone | Both | Utilized Other Telecommunication Technology |
|---|---|---|---|---|
| Medication therapy reviews | 22% | 58% | 34% | 22% |
| Medication-related action plans | 24% | 54% | 34% | 24% |
| Intervention and/or referrals | 22% | 58% | 34% | 22% |
| Documentation and follow-up | 22% | 58% | 34% | 22% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 25. Most Common Ways Community-Based Contracts Were Used with Pharmacists, 2018

| Types of Community-Based Contracts | Percentage of Medicaid MCOs |
|---|---|
| Drug Utilization Rate (e.g. duplicative therapies) | 42% |
| Pharmacotherapy consults | 42% |
| Medication adherence rate | 23% |
| Identification of lower-cost medication alternatives | 30% |
| Hospital readmissions | 12% |
| Emergency Department visits | 12% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 26. Most Common Challenges in Managing Medicaid Prescription Drug Benefits, 2018

| Challenges | Percentage of Medicaid MCOs |
|---|---|
| Utilization and cost history unknown for new drugs entering a market; impacting capitation rates and pricing | 89% |
| Member comprehension and engagement of programs | 65% |
| Pharmacy benefits or subset of benefits carved out of managed care | 59% |
| Differences between plan formularies and methodologies and state requirements | 48% |
| Pharmacy network requirements | 36% |
| Formulary notification requirements as part of Medicaid Managed Care Organization Final Rule | 30% |

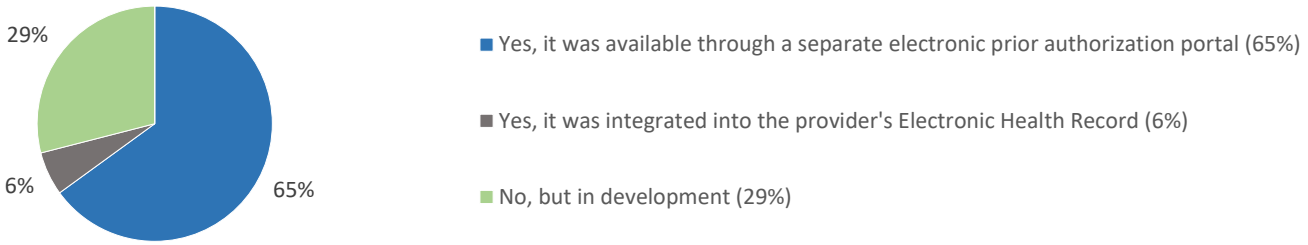
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 27. Percentage of Medicaid Managed Care Organizations Supporting E-Prescribing through Pharmacy Benefit Managers (PBMs), by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 100% | 60% | 84% | 83% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 5. Utilization of Electronic Prior Authorization Systems with Contracted Pharmacy Benefit Managers (PBMs), 2018




Note: None of the survey respondents selected "no" for this item.

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey

## Table 28. Most Common Approaches by States to Address New or High-Cost Drugs, 2018

| State Approaches | Percentage of Medicaid MCOs Impacted |
|---|---|
| Capitation rate adjustment as part of regular rate adjustments | 59% |
| Carved-out the drug costs completely/pay fee-for-service for certain drug(s) | 53% |
| Transition period where drug(s) are offered in fee-for-service to get claims data then rolled into contracts | 36% |
| Stop-loss provision to cap the plan's cost for the drug | 24% |
| Capitation rate adjustments made off the normal rate cycle | 24% |
| States have not addressed the cost | 24% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

# Behavioral Health

The majority (84%) of health plan respondents indicated being at risk for behavioral health services for their Medicaid members in 2018. Medicaid MCOs reported operational, network, and policy barriers when integrating behavioral and physical health. The majority of health plans indicated common barriers, including 42 CFR Part 2 limitations on substance use disorder treatment information being shared (88%), provider capacity to provide integrated physical and behavioral health at point of care (82%), fragmentation in program funding and contracting for physical and behavioral health services (63%), and access to data between care management and behavioral health teams (63%). Similar to the findings on value-based purchasing, access to data and provider readiness are barriers to behavioral and physical health integration.

Additional behavioral health findings are highlighted in this section of the report.

## Table 29. Percentage of Medicaid Managed Care Organizations At Risk for Behavioral Health Services, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO respondents |
|---|---|---|---|
| 72% | 80% | 100% | 84% |

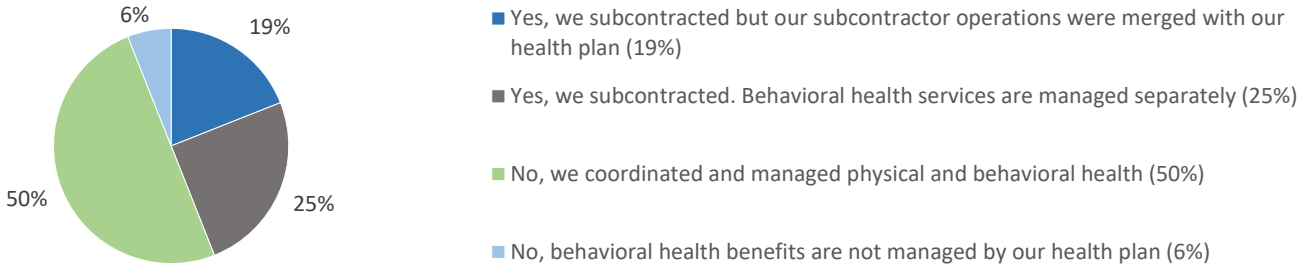
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 30. Percentage of Medicaid Managed Care Organizations with Access to Review Medical Records Inclusive of Physical and Behavioral Health, 2018

| | Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO respondents |
|---|---|---|---|---|
| Yes | 66% | 25% | 50% | 50% |
| Yes, in some markets | 17% | 75% | 50% | 44% |
| No | 17% | 0% | 0% | 6% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 6. Percentage of Medicaid Managed Care Organizations Subcontracting for Behavioral Health Management, 2018




Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 31. Most Common Strategies to Work with Providers to Address Physical and Behavioral Health Needs, 2018

| Worked with behavioral health providers to address physical health needs by… | |
|---|---|
| Information/data sharing on behavioral health | 82% |
| Making screening tools available | 63% |
| Education | 63% |
| Allowing payment for multiple services at the same location and date of service | 57% |
| Embedding physical/behavioral health specialists in medical practices | 50% |
| Value-based contracting across physical and behavioral health | 38% |
| Specialized programs or offerings | 38% |
| **Worked with physical health providers to address behavioral health needs by…** | |
| Making screening tools available | 88% |
| Information/data sharing on behavioral health | 88% |
| Education | 82% |
| Embedding physical/behavioral specialists in medical practices | 69% |
| Allowing payment for multiple services at the same location and date of service | 69% |
| Specialized programs or offerings | 57% |
| Value-based contracting across physical and behavioral health | 44% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 32. Most Common Barriers Medicaid Managed Care Organizations Experienced when Integrating Behavioral and Physical Health, 2018

| Operational Barriers | |
|---|---|
| Access to data between care management and behavioral health teams | 63% |
| Communication between care management and behavioral health | 50% |
| System differences with subcontractor | 50% |
| Staffing in care management to align skills sets with integrated care needs | 38% |
| **Network Barriers** | |
| Provider capacity to provide integrated physical and behavioral health at point of care | 82% |
| Behavioral health provider readiness for managed care | 75% |
| Behavioral health provider adoption of electronic health records | 63% |
| **Policy Barriers** | |
| 42 CFR Part 2 limitations on SUD treatment information being shared | 88% |
| Fragmentation in program funding and contracting for physical and behavioral health services | 63% |
| Institutions for Mental Disease (IMD) exclusion | 44% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 33. State Contracted Behavioral Health Services Included for Medicaid Members, 2018

| | Yes, managed by our Medicaid MCO | Yes, subcontracted to a vendor | Varies by population | No |
|---|---|---|---|---|
| Behavioral health assessment/screening | 82% | 6% | 6% | 6% |
| Outpatient mental health services | 62% | 13% | 13% | 12% |
| Inpatient mental health services | 50% | 13% | 12% | 25% |
| Outpatient substance use treatment services | 50% | 6% | 19% | 25% |
| Inpatient/residential substance use treatment services | 50% | 6% | 19% | 25% |
| Detox services (outpatient or residential) | 44% | 6% | 19% | 31% |
| Outpatient substance use treatment services | 50% | 6% | 19% | 25% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

The majority (89%) of health plans were providing targeted women's health programs for Medicaid members in 2018. Consistent with Medicaid's role in providing coverage for pregnant women, 95 percent of health plans indicated that prenatal and postpartum care was a priority women's health topic, with 95 percent also indicating that they had targeted programs and engagement strategies. Approximately 50 percent of health plans identified depression/anxiety, diabetes, and heart disease as additional priority topics and also had programs and strategies across the lifespan. For women enrolled in Medicaid managed care, the majority of health plans reported that their members maintained coverage for at least one year with aged, blind, and disabled (ABD) and dual-eligible women maintaining coverage for two or more years. Pregnant women, parents, and childless adults were enrolled for time-limited periods before losing eligibility or qualifying for another program. As noted in the qualitative portion of the survey, common challenges that health plans continued to address in 2018 included the high prevalence of substance use/opioid use disorder among pregnant women with lack of access to medication-assisted treatment, lack of adoption of long-acting reversible contraception, early identification of pregnancy before 12 weeks gestation, access to family planning services, and loss of Medicaid eligibility after pregnancy.

Additional women's health findings are highlighted in this section of the report.

## Table 34. Percentage of Medicaid Managed Care Organizations with Targeted Women's Health Programs, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 86% | 80% | 100% | 89% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 35. Women's Health Priorities Identified by Medicaid Managed Care Organizations Compared to Targeted Health Plan Programs & Engagement Strategies Across the Lifespan, 2018

| Priorities | Percentage of Medicaid MCOs Indicating a Priority | Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies on Priority Topic |
|---|---|---|
| Prenatal and postpartum care | 95% | 95% |
| Cancer screening and treatment | 83% | 65% |
| Behavioral health, generally | 71% | 65% |
| Substance use disorder | 65% | 77% |
| Family planning | 59% | 42% |
| Depression/Anxiety | 59% | 59% |
| Diabetes | 53% | 59% |
| Heart disease | 42% | 48% |
| Obesity | 36% | 24% |
| Sexual health | 36% | 24% |
| Eating disorders | 18% | 0% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 36. Average Duration of Enrollment among Female Medicaid Managed Care Organization Members, 2018

| | Enrolled for less than 6 months | Enrolled for 6-12 months | Enrolled for more than 1 but less than 2 years | Enrolled for 2 or more years | Not applicable. We do not enroll this population. |
|---|---|---|---|---|---|
| Pregnant women | 0% | 33% | 40% | 27% | 0% |
| Parents | 0% | 14% | 29% | 43% | 14% |
| Childless adults | 0% | 0% | 38% | 54% | 8% |
| Aged, blind, and disabled | 0% | 0% | 14% | 86% | 0% |
| Medicare and Medicaid eligible | 0% | 0% | 21% | 72% | 7% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 37. Top 5 Issues Associated with Churn for Women Enrolled in Medicaid Managed Care Organizations, 2018

| Issues | Percentage of Medicaid MCOs |
|---|---|
| Clinical care disruption and care management continuity | 82% |
| Completeness of patient/member history | 63% |
| Maintaining access to providers and care | 50% |
| Quality measure disruption | 50% |
| Repeated member on-boarding | 44% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 38. Providers Serving as a Medical Home or Primary Care Provider for Women, 2018

| Provider Type | Percentage of Medicaid MCOs |
|---|---|
| Family physicians | 100% |
| Obstetricians/Gynecologists | 89% |
| Nurse Practitioners | 83% |
| Internists | 71% |
| Pediatricians | 65% |
| Nurse-Midwives | 48% |
| Geriatricians | 48% |
| Other | 18% |
| School-based health centers | 12% |

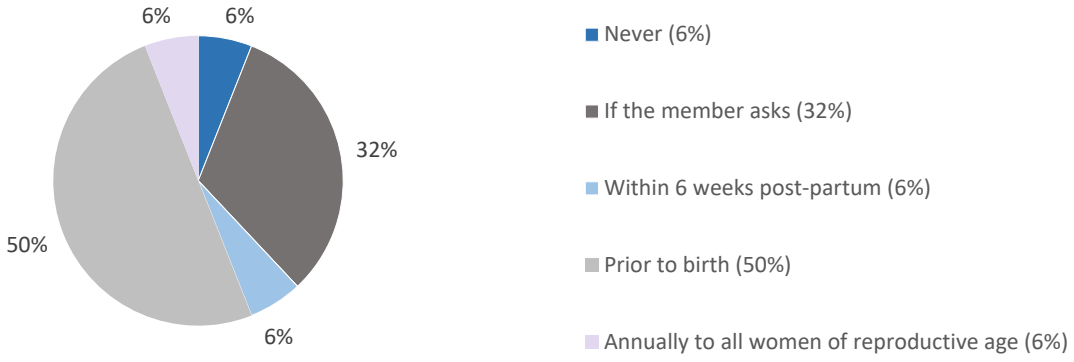
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 39. Providers Offering Members with Contraception Counseling and Services, 2018

| Provider Type | Percentage of Medicaid MCOs |
|---|---|
| Freestanding family planning clinics | 100% |
| Planned Parenthood clinics | 100% |
| Federally Qualified Health Centers | 95% |
| State or local health departments | 95% |
| Community health/Rural health centers | 89% |
| Hospital-based clinics | 89% |
| School-based clinics | 42% |
| Other | 12% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 7. Timing of Post-Partum Contraception or Sterilization Information Provided by Medicaid Managed Care Organizations, 2018




Note: None of the survey respondents selected "immediate post-partum (i.e., during inpatient stay for delivery)" as an answer for this item.

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

The vast majority of health plans (95%) offered targeted child health programs in 2018, with 100 percent of all medium and large-size health plans (greater than 250,001 covered lives) indicating that they have such programs. Furthermore, over 80 percent of health plans, regardless of size, contracted with the state Medicaid agency to provide coverage for children with special healthcare needs (CSHCN). The Medicaid MCO respondents identified an array of child and adolescent health priority topics specific to health and social needs. The most common priority topics identified were diabetes (64%) and obesity (56%). However, the most common targeted programs and engagement strategies were focused on CSHCN (82%), behavioral health screening and treatment (71%), and asthma (71%). The survey findings identified that the majority of Medicaid MCOs provided a comprehensive list of covered health and social services to support children with special healthcare needs, such as supporting the member in identifying and connecting with providers including outside of the provider directory (100%), developing a comprehensive plan of care with the family/caregivers (93%), and providing information and coordination with other needed social service organizations (e.g., faith-based, housing, nutrition, non-profit, etc.) as part of care plan development and adherence (93%). However, barriers persisted, including poor communication among multiple providers to families (77%), carved-out services creating inefficiencies in services for families (71%), and carved-out services creating an increased risk for duplication and costs (53%). To address the common barriers, health plans began providing benefits while the child was at home and not at the point of hospitalization or as part of discharge planning.

## Table 40. Percentage of Medicaid Managed Care Organizations Offering Targeted Child Health Programs, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 86% | 100% | 100% | 95% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 41. Child & Adolescent Health Priorities Identified by Medicaid Managed Care Organizations Compared to Targeted Health Plan Programs & Engagement Strategies, 2018

| Priorities | Percentage of Medicaid MCOs Indicating a Priority | Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies for Priority Issue |
|---|---|---|
| Diabetes | 64% | 48% |
| Obesity | 56% | 53% |
| CSHCN | 40% | 82% |
| Dental health | 40% | 48% |
| Transitioning to adulthood and independence | 40% | 36% |
| Readiness to start school | 40% | 0% |
| Adverse Childhood Experiences | 25% | 30% |
| Substance use disorder | 25% | 30% |
| Sex education | 25% | 6% |
| Teen pregnancy | 25% | 18% |
| Autism spectrum disorder | 24% | 36% |
| Behavioral health screening and treatment | 20% | 71% |
| Success in school | 20% | 0% |
| Tobacco use | 20% | 42% |
| Other | 20% | 24% |
| Depression/Anxiety | 17% | 53% |
| Asthma | 10% | 71% |
| ADHD/ADD | 10% | 53% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 42. Most Common Barriers for Medicaid Managed Care Organizations for Serving Child and Adolescent Members, 2018

| Barrier | Percentage of Medicaid MCOs |
|---|---|
| Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools) | 83% |
| Policies or program structures that create barriers if the parent(s) have more than one child (e.g. transportation policies) | 59% |
| Engaging family members who are not enrolled in the same plan to address social determinants of health | 59% |
| Program fragmentation | 53% |
| Language barriers within families | 48% |
| Other | 24% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 43. Percentage of Medicaid Managed Care Organizations Contracting with State Medicaid Agencies for Children with Special Healthcare Needs (CSHCN), by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or less covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 84% | 80% | 84% | 83% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 44. Most Common Benefits Managed by Medicaid Managed Care Organizations for CSHCN, 2018

| Benefits | Percentage of Medicaid MCOs |
|---|---|
| Supported the member in identifying and connecting with providers (in addition to supplying the provider directory) | 93% |
| Provided information and coordinated with other needed social service organizations (e.g., faith-based, housing, nutrition, non-profit, etc.) as part of care plan development and adherence | 93% |
| Developed a comprehensive plan of care with the family/caregivers | 86% |
| Helped in making appointments with providers | 86% |
| Conducted risk assessments | 86% |
| Supported and encouraged adherence to care plan | 86% |
| Coordinated in-home services | 86% |
| Arranged transportation for appointments | 86% |
| Lab testing | 85% |
| Supported the member preparedness for appointments | 79% |
| Engaged a care team of professionals to address the needs of the member | 79% |
| Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential) | 79% |
| Coordinated behavioral health services | 79% |
| Vaccines | 79% |
| Equipment and supplies | 79% |
| Served as a single point of contact for the member | 72% |
| Transition planning (e.g., acute care to residential care, residential care to the community) | 72% |
| Caregiver support | 72% |
| Medication management | 72% |
| Care coordination | 72% |
| Nutrition education | 72% |
| Parent education | 65% |
| School-based healthcare services | 58% |
| Shared data with social services | 50% |
| Transportation to and from medical appointments | 50% |
| Family transportation and lodging for out-of-town/state specialist visits | 43% |
| Screened for social isolation | 29% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 45. Most Common Barriers Experienced by Medicaid Managed Care Organizations when Serving CSHCN, 2018

| Barrier | Percentage of Medicaid MCOs |
|---|---|
| Poor communication among multiple providers to families | 77% |
| Carved-out services created inefficient services for families (e.g., too many coordinators) | 71% |
| Carved-out services created an increased risk for duplication and costs | 53% |
| Misinformation about managed care value to CSHCN | 48% |
| Lack of consistent quality measures specific to unique needs of CSHCN | 42% |
| Consistency in identification parameters | 36% |
| Insufficient information regarding the goals and preferences of children with special health care needs and their families | 36% |
| Other | 12% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

# Managed Long-Term Services and Supports

In 2018, 67 percent of Medicaid MCO respondents indicated being at risk for long-term services and supports (LTSS). With the growing interest of state Medicaid agencies to provide managed long-term services and supports (MLTSS) through health plans, we anticipate that this number will increase. Currently, 100 percent of large health plans (i.e., greater than 1 million covered lives) are at-risk for MLTSS in at least one of their markets. Of the health plans at-risk, regardless of size, 100 percent assigned a care coordinator for more than 75 percent of their members.

Over 66 percent of health plans reported completing the enrollment and assessment process for the new member in less than 30 days, and almost 100 percent reported completing the member's plan of care within 90 days of enrollment. The overwhelming majority of health plans indicated completing a comprehensive list of core functions for their members, especially in areas of care coordination (100%), transition planning (100%), and social needs support (92%). Furthermore, 100 percent of Medicaid MCOs utilized care teams for the MLTSS members in 2018.

When designing MLTSS programs, health plans indicated two common barriers: fragmented Medicaid benefit design (42%) and misalignment between Medicaid and Medicare (42%). Finally, the most common approaches for innovation in MLTSS that were led by health plans in 2018 were member centric, including self-advocacy (84%) and tools for self-direction (59%). Furthermore, health plans commonly offered innovative approaches for caregiver support and services (59%), care coordination (59%), partnerships with community-based organizations (59%), and "money follows the person" community transition programs (50%).

## Table 46. Percentage of Medicaid Managed Care Organizations at Risk for MLTSS, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 43% | 60% | 100% | 67% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 47. Percentage of Medicaid Managed Care Organizations Utilizing a Different Clinical Model of Care for MLTSS Members, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 34% | 100% | 100% | 84% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 48. Most Common Core Functions Performed by Medicaid Managed Care Organizations for MLTSS Care Coordination Models, 2018

| Core Functions | Percentage of Medicaid MCOs |
|---|---|
| Conducted risk assessments | 100% |
| Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential) | 100% |
| Coordinated in-home services | 100% |
| Developed a comprehensive plan of care | 100% |
| Engaged a care team of professionals to address the needs of the member | 100% |
| In addition to supplying the provider directory, supported the member in identifying and connecting with providers | 100% |
| Supported and encouraged adherence to care plan | 100% |
| Transition planning (e.g., acute care to residential care; residential care to the community) | 100% |
| Arranged transportation for appointments | 92% |
| Caregiver support | 92% |
| Coordinated behavioral health services | 92% |
| Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence | 92% |
| Helped in making appointments with providers | 92% |
| Provided guided referrals or "hand-offs" to other needed social services (e.g., faith-based, non-profit, or other government programs) | 92% |
| Provided information on other needed social services (e.g., faith-based, nonprofit, other government programs) | 92% |
| Served as a single point of contact for the member | 92% |
| Shared data with social services | 84% |
| Supported the member preparedness for appointments | 84% |
| Screened for social isolation | 75% |
| Other | 17% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 49. Most Common Individuals in Care Team Composition for MLTSS, 2018

| Individuals | Percentage of Medicaid MCOs |
|---|---|
| Care coordinator within the health plan | 100% |
| Family member | 100% |
| Individual member | 100% |
| Guardian | 92% |
| Behavioral health specialist within the health plan | 84% |
| Member's primary care provider | 75% |
| Community health worker within the health plan | 67% |
| Natural/community supports other than guardian | 67% |
| Other health care professional not employed by the health plan | 67% |
| Representative from primary care clinician office | 59% |
| Pharmacist within the health plan | 50% |
| Peer support specialist within the health plan | 34% |
| Other | 34% |

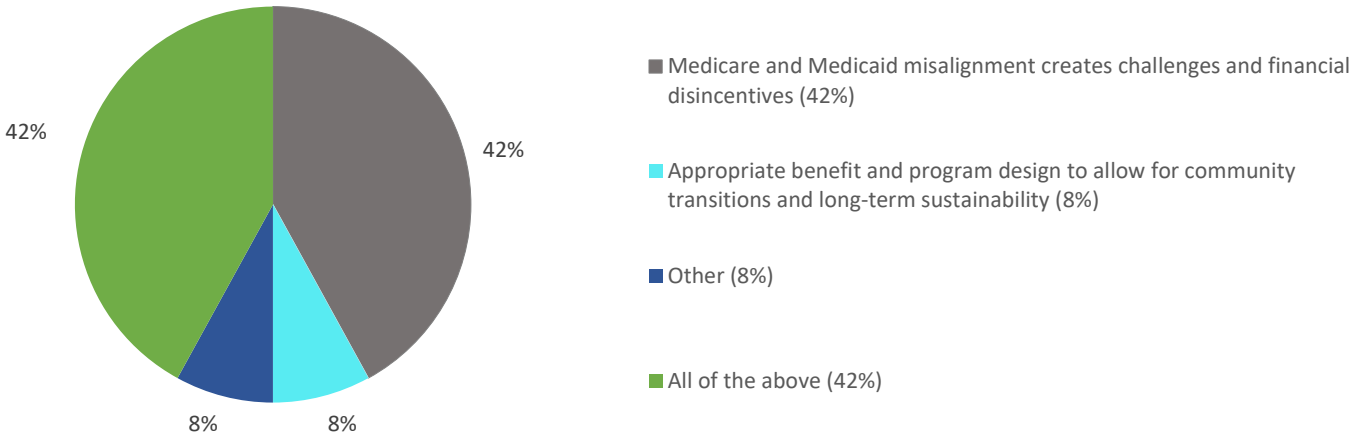
Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 50. Most Common Components Included in MLTSS Care Plans Offered by Medicaid Managed Care Organizations, 2018

| Care Plan Components | Percentage of Medicaid MCOs |
|---|---|
| Caregiver information and status | 100% |
| Demographic and social needs screening information (e.g., housing, financial, insurance, employment history) | 100% |
| Goals – personal and care goals | 100% |
| Primary care provider | 100% |
| Emergency (crisis) plan | 100% |
| End-of-life plan, including Medical Orders for Life-Sustaining Treatment (MOLST) and Durable Power of Attorney (DPOA)/Power of Attorney (POA)/Guardianship | 92% |
| Other | 34% |
| **Medical Components** | **Percentage of Medicaid MCOs** |
| Activities of daily living (i.e., feeding, dressing, toileting, ambulating, sleep) | 100% |
| Behavioral health status/condition (i.e., depression, anxiety, stress, drug, alcohol screening) | 100% |
| Community transition plan | 100% |
| Current health/medical status | 100% |
| Durable medical equipment use, hearing aids, and vision impairments | 100% |
| Medication list | 100% |
| Recent hospitalizations or Emergency Department visits | 100% |
| Safety screening (i.e., feeling safe and secure) | 100% |
| Other | 9% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Figure 8. Most Common Program Design Considerations to Manage LTSS, 2018




Note: None of the survey respondents selected the following answer options for this item: "Fragmented Medicaid benefit design - behavioral health and/or physical health benefits - limits ability to serve the whole individual," "State requirements for health plans to contract with specific organizations or providers for care coordination," "State program requirements that limit effectiveness of managed care strategies (e.g., any willing provider provisions, continuity of care provisions," and "Institutional level of care requirements that do not align with state goals (e.g. ADL/IADL requirements that are too low or too high to support appropriate utilization)."

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 51. Frequency of Innovations Leveraged by Medicaid Managed Care Organizations for LTSS, 2018

| Innovation | Always Provided (A required part of our approach to MLTSS.) | Sometimes (Based on member needs.) | Limited (Small pilot program or case-by-case.) | Not Provided |
|---|---|---|---|---|
| Remote monitoring | 17% | 17% | 41% | 25% |
| Telehealth other than remote monitoring that is specific to the MLTSS population | 17% | 50% | 33% | 0% |
| Care coordination communication tools with caregivers, direct services workers, and other in-home providers or support organizations | 58% | 17% | 17% | 8% |
| Partnerships with community based organizations (e.g. AAAs, CILs) | 58% | 34% | 8% | 0% |
| Electronic Visit Verification | 25% | 17% | 17% | 41% |
| Value-based payment arrangements with MLTSS providers | 8% | 17% | 33% | 42% |
| Caregiver supports and services (outside of administering benefits required by state plan) | 58% | 33% | 9% | 0% |
| Wellness initiatives | 58% | 42% | 0% | 0% |
| Healthy eating or nutrition programs outside of administering benefits required by state plan | 25% | 67% | 8% | 0% |
| Unique housing strategies outside of administering benefits required by state plan | 8% | 75% | 17% | 0% |
| Money follows the person or community transition programs | 50% | 33% | 8% | 8% |
| Self-advocacy | 83% | 17% | 0% | 0% |
| Employment initiatives outside of administering benefits required by state plan | 25% | 33% | 33% | 9% |
| Tools for self-direction | 58% | 33% | 9% | 0% |
| Transportation innovations | 17% | 50% | 25% | 8% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

As the social determinants of health (SDOH) gain recognition for the Medicaid population, health plans are finding new and innovative approaches to offer and coordinate needed social services. In 2018, 78 percent of all Medicaid MCO respondents indicated offering targeted SDOH programs, with 100 percent of large health plans (i.e., greater than 1 million covered lives) having programs. The most common populations that were targeted for SDOH programs were pregnant women (86%), homeless/housing insecure (79%), and adults with substance use disorder (72%). A comprehensive table on page 52 provides detailed information on the types and percentages of health plans offering targeted SDOH strategies (e.g., maintained a database of community and social service resources) for specific social needs (e.g., housing, social isolation, violence).

It was noticeable in the survey findings that there were multiple screening tools being used and not one across all Medicaid MCO respondents. Most of the health plans (50%) indicated utilizing an internally developed or adapted tool, with 15 percent not using any tool. As noted in the qualitative section of the survey, several of the health plans indicated that the Medicaid enrollment form could be standardized across states to include specific social needs questions as an initial assessment of member needs.

Finally, the write-in portion of the SDOH section of the survey generated the highest number of comments of the entire survey, with every health plan offering insight into the barriers that they experience when coordinating and covering services to address social needs. The most common barriers that states could address to support SDOH efforts included the following:

- **Data Sharing:** issues with data sharing (i.e., availability, access to Homeless Management Information System (HMIS), accuracy, timeliness, completeness) and consent between state Medicaid agencies and health plans and between health plans and community-based organizations;

- **Resources:** limited financial and human resources from the state to support social-need programs and coordination by health plans, providers, and community-based organizations;

- **Standardization:** limited information collected on the Medicaid enrollment form regarding social needs; and

- **Contracting:** barriers between health plans and community-based organizations to establish contracts and memorandums of understanding.

## Table 52. Percentage of Medicaid Managed Care Organizations with Targeted SDOH Programs, by Health Plan Size, 2018

| Medicaid MCOs with 250,000 or fewer covered lives | Medicaid MCOs with 250,001 to one million covered lives | Medicaid MCOs with over one million covered lives | All Medicaid MCO Respondents |
|---|---|---|---|
| 58% | 80% | 100% | 78% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 53. Percentage of Medicaid Managed Care Organizations Providing Targeted Social Determinants of Health Programs, by Population, 2018

| Population | Percentage of Medicaid MCOs |
|---|---|
| Pregnant women | 86% |
| Homeless/housing insecure | 79% |
| Adults with substance use disorder | 72% |
| Adults with serious mental illness | 65% |
| Criminal justice involved | 58% |
| Adults with disabilities (e.g., physical, intellectual, developmental) | 58% |
| Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation) | 50% |
| Expansion members | 50% |
| Children with Special Healthcare Needs (CSHCN) | 43% |
| Child welfare/Child protective services involving families | 43% |
| Foster care youth/ Youth transitioning to adulthood | 36% |
| HIV/AIDS | 29% |
| Other | 22% |
| Residential institution/Facility-placed individuals | 15% |
| Individuals in Institutions for Mental Diseases (IMD) | 8% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 54. Most Common Social Needs Identified by Medicaid Managed Care Organizations for Their Members, 2018

| Social Need | Percentage of Medicaid MCOs |
|---|---|
| Housing | 100% |
| Nutrition food security | 100% |
| Employment, job placement, and/or skills training | 100% |
| Non-medical transportation | 93% |
| Utilities | 93% |
| Application assistance (e.g., TANF, SNAP, Special Supplemental Nutrition Program for WIC) | 93% |
| Non-emergency medical transportation (NEMT) | 86% |
| Violence/Interpersonal violence | 86% |
| Financial literacy (i.e., assistance with household budgets and finances) | 79% |
| Environmental health (e.g., lead abatement) | 79% |
| Trauma | 79% |
| Social isolation/Sense of belonging | 72% |
| Education | 72% |
| Not assessed/No information collected | 8% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Key for Table 55

| Color | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percent Range | 0-9% | 10-19% | 20-29% | 30-39% | 40-49% | 50-59% | 60-69% | 70-79% | 80-89% | 90-99% | 100% |

## Table 55. Percentage of Medicaid Managed Care Organizations Providing Targeted Strategies to Address Social Needs, 2018

| Strategies | Housing/Supportive Housing (i.e. rent and utilities assistance, building housing for consumers) | Nutrition/Food Security/Food Access | Social Isolation/Sense of Belonging | Education | Financial Literacy | NEMT | Non-medical transportation | Utilities | Employment/Skills Training | Environmental Health | Violence | Trauma |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maintained a database of community and social service resources | 100% | 100% | 58% | 79% | 65% | 79% | 93% | 93% | 93% | 65% | 100% | 93% |
| Assessed/Screened for member needs | 100% | 100% | 58% | 72% | 36% | 86% | 86% | 79% | 72% | 65% | 86% | 58% |
| Provided application assistance | 50% | 72% | 24% | 29% | 29% | 43% | 29% | 58% | 43% | 36% | 22% | 22% |
| Provided caregiver support | 72% | 58% | 58% | 36% | 36% | 50% | 43% | 43% | 50% | 36% | 39% | 29% |
| Utilized peers | 58% | 50% | 72% | 43% | 36% | 58% | 58% | 43% | 34% | 29% | 50% | 50% |
| Used community health workers | 93% | 93% | 65% | 79% | 50% | 93% | 85% | 79% | 72% | 58% | 50% | 58% |
| Engaged interdisciplinary community care team including CBOs | 86% | 65% | 50% | 58% | 47% | 65% | 58% | 50% | 58% | 50% | 65% | 72% |
| Identified and coordinated with CBOs to link members with needed social services | 100% | 100% | 65% | 72% | 65% | 79% | 79% | 100% | 79% | 65% | 79% | 72% |
| Provided guided referrals or "hand-offs" to other needed social services | 93% | 93% | 79% | 65% | 58% | 86% | 86% | 86% | 72% | 79% | 85% | 79% |
| Engaged in direct community investment and capacity building | 75% | 86% | 36% | 50% | 36% | 36% | 43% | 36% | 36% | 22% | 29% | 36% |
| Worked with local health departments to address challenges or coordination of services | 65% | 43% | 22% | 36% | 22% | 35% | 34% | 29% | 29% | 58% | 36% | 36% |
| Coordinated with schools to provide IEP services | 15% | 36% | 8% | 43% | 8% | 15% | 15% | 8% | 15% | 15% | 15% | 15% |
| Coordinated with social services as part of care plan development and adherence | 77% | 72% | 65% | 58% | 58% | 50% | 50% | 65% | 65% | 65% | 65% | 50% |
| Established agreement for data sharing with social services and community partners | 79% | 65% | 29% | 36% | 15% | 29% | 36% | 15% | 36% | 29% | 24% | 22% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 56. Most Common Programs Led by Medicaid Managed Care Organizations to Assist with Homelessness or Housing Instability, 2018

| Program | Percentage of Medicaid MCOs |
|---|---|
| Case management or care coordination for homeless or housing-insecure individuals | 100% |
| Outreach to members or potential members who were homeless or housing insecure to help them access health care coverage and services | 93% |
| Partnership with state or local housing agencies or organizations | 85% |
| Respite, palliative, or recuperative care for homeless or housing-insecure individuals | 65% |
| Had a strategy for developing agreements and/or protocols with public housing agencies (PHAs) and/or continuum of care (COCs) programs to submit applications for housing assistance | 50% |
| Payment for Medicaid-covered, housing-related services | 43% |
| Participation in a state-level, Medicaid-housing initiative | 22% |
| Other | 15% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 57. Most Common Social Determinant of Health Screening Tools Used by Medicaid Managed Care Organizations, 2018

| Screening Tool | Percentage of Medicaid MCOs |
|---|---|
| Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE) | 36% |
| Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Health-Related Social Needs Screening Tool | 29% |
| Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) | 22% |
| American Community Survey | 15% |
| Arizona Self Sufficiency Matrix | 0% |
| Self-Sufficiency Outcomes Matrix, OneCare Vermont, CHCS version | 0% |
| Social Determinants Screening Tool, AccessHealth Spartanburg, CHCS version | 0% |
| Social Needs Screening Toolkit, HealthLeads USA | 0% |
| The EveryOne project: Advancing health equity in every community, Toolkit by American Academy of Family Physicians (AAFP) | 0% |
| Other (e.g., internally developed, adapted versions of other tools) | 50% |
| None | 15% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 58. Most Common Approaches Used by States to Support the Efforts of Medicaid Managed Care Organizations to Address Social Needs, 2018

| State Approaches to Support Medicaid MCOs | Percentage of Medicaid MCOs |
|---|---|
| Made policy/regulatory changes to support SDOH initiatives | 58% |
| Submitted/received approval for a Medicaid waiver(s) that included support of SDOH initiatives | 43% |
| Provided financial support | 22% |
| None | 22% |
| Allowed or improved data sharing | 15% |
| Other | 15% |
| Provided administrative assistance | 15% |
| Provided screening tools | 15% |
| Provided support for cultural and linguistic competency | 15% |
| Improved analytic capacity | 0% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 59. Most Common Approaches Used by Medicaid Managed Care Organizations to Support Provider Efforts to Address Social Needs, 2018

| Medicaid MCO Approaches to Support Providers | Percentage of Medicaid MCOs |
|---|---|
| Data or information sharing | 79% |
| Member stratification | 65% |
| Staff | 65% |
| Pay-per-performance incentives | 43% |
| Other | 29% |
| Ability to bill for multiple codes, joint billing | 22% |
| No incentives/supports were provided | 0% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

## Table 60. Most Common Metrics Used by Medicaid Managed Care Organizations to Assess and Evaluate Social Determinant of Health Initiatives, 2018

| Metrics Used by Medicaid MCOs | Percentage of Medicaid MCOs |
|---|---|
| Cost utilization | 65% |
| Cost savings | 58% |
| Access to care | 43% |
| No performance metrics were used | 31% |
| Performance measures | 29% |
| Other | 10% |

Source: Institute for Medicaid Innovation. 2019 Annual Medicaid MCO Survey.

# Appendix A: Methods

Under the leadership and vision of the Institute for Medicaid Innovation's (IMI's) founding executive director, Dr. Jennifer Moore, the annual Medicaid managed care organization survey was developed through the contribution of national experts who volunteered countless hours over three years reviewing, editing, and finalizing the survey instrument.

The IMI's Annual Medicaid MCO Survey was developed to address the paucity of national data on Medicaid managed care. The findings from the longitudinal 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 2019 survey captured key characteristics across every state with Medicaid managed care, with survey respondents representing 69 percent of all covered lives in Medicaid managed care. In addition, the survey 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 MLTSS).

## Sample Characteristics and Sample Representation

The 2019 survey was distributed to all Medicaid managed care organizations with membership in one of two leading national trade associations for Medicaid health plans: Medicaid Health Plans of America and the Association of Community Affiliated Plans. In addition, large health plans (i.e., with more than 500,000 covered lives), having no affiliation with either trade association, were individually contacted and encouraged to participate. All plans initially received the survey on February 21, 2019, with a completion deadline of March 22, 2019. The IMI 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 founding executive director. To be eligible to participate in the survey, health plans had to have participated in Medicaid managed care in 2018; otherwise, there were no exclusion criteria. The survey captured key characteristics across every state with Medicaid managed care, with survey respondents representing 69 percent of all covered lives in Medicaid managed care. Sample representation was determined by combining the number of covered lives for each survey respondent using November 2018 data from Health Management Associates (HMA). There were an equal number of health plans that were for-profit and non-profit. Also, there was equal distribution among the three categories of health plan size (i.e., fewer than 250,000, 250,001-1 million, and greater than 1 million), determined by the total number of covered lives in Medicaid managed care.

## Survey Development Process

All surveys that the IMI develops and implements are created in coordination with experts from Medicaid health plans, researchers, and clinicians. The development of the inaugural 2018 survey used a methodical, iterative, and collaborative approach over 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. 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 in order 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.
6. 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 additional questions in the women, children, and behavioral health sections.

7. Review by the MHPA Board of Directors, which led to the addition of a managed long-term services and supports (MLTSS) section on the survey.
8. Pilot testing the survey tool with Medicaid health plans, with further refinement by the workgroup before finalization.

The survey was pilot tested, refined, and finalized before it was released for its inaugural year in 2018. The 2018 survey respondents were then asked to participate in a series of interviews to provide feedback on the instrument. This led to further refinement and testing of the survey in preparation for the release of the 2019 annual Medicaid managed care organization survey. It also led to the development, testing, refinement, and finalization of a new category of questions focused on social determinants of health that debuted in the 2019 survey.

## 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 inaugural 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, MLTSS, and Social Determinants of Health.
- 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 the inaugural 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 69 percent of all covered Medicaid managed care lives, suggesting that the data presented are representative. The data provide a strong representation of the range of Medicaid MCOs.

Although the questions included in the survey were robust and created with input from a number of expert stakeholders, data from a few questions in the inaugural 2018 survey were dropped from the report because of confusion around the question wording, which was not uncovered during the pilot testing. These challenges were discussed with IMI's Data and Research Committee and the expert workgroup for refinement for the 2019 survey. After the edits were made, we did not experience any of these challenges as part of the 2019 survey, and no items were dropped from the report.

## 2015 – 2018 Medicaid Health Plan Representation for Inaugural 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
UnitedHealthcare Community & State
UPMC *For You*
Upper Peninsula Health Plan
Vaya Health

*The list of Medicaid health plan representatives who participated in the development, piloting, and refinement of the survey does not necessarily represent the health plans who 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.

**AAA:** Area Agency on Aging.

**ACO:** Accountable Care Organization.

**ADL/IADL:** Activities of Daily Living/Independent Activities of Daily Living.

**APM**: Alternative Payment Methodology.

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

**CBO**: Community-Based Organization.

**CSHCN: Children with Special Healthcare Needs**: Individuals (under age 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.

**CIL:** Centers for Independent Living.

**COC:** Continuum of Care.

**Complex population contracts**: Contracts that include Individuals with Intellectual and Developmental Disabilities (I/DD), Children with Special Healthcare Needs (CSHCN), Individuals with Serious Mental Illness (SMI), and Foster Care.

**DPOA**: Durable Power of Attorney.

**DUR:** Drug Utilization Review.

**EHR:** Electronic Health Record.

**FFS:** Fee-for-service.

**General Medicaid contract**: Medicaid contracts with managed care that primarily focus on Medicaid benefits outlined in the state's 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, and so forth.

**I/DD**: Individuals with Intellectual and Developmental Disabilities.

**IEP**: Individualized Education Plan.

**IMD**: Institution for Mental Diseases.

**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.

**MAT**: Medication-Assisted Therapy.

**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.

**MOLST**: Medical Orders for Life-Sustaining Treatment.

**MTM**: Medication Therapy Management.

**NEMT**: Non-Emergency Medical Transportation.

**PBM:** Pharmacy Benefit Manager.

**PCP**: Primary Care Provider.

**PCMH**: Patient-Centered Medical Home.

**PHA**: Public Housing Agencies.

**POA:** Power of Attorney.

**SDOH:** Social determinants of health, also referred to as social influences of health care conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functional, and quality-of-life outcomes and risks. Examples include housing, food, and public safety.

**SMI**: Serious Mental Illness.

**SNAP**: Supplemental Nutrition Assistance Program.

**SUD**: Substance Use Disorders.

**TANF**: Temporary Assistance for Needy Families.

**VBP**: Value-Based Payment.

**WIC**: Special supplemental nutrition program for women, infants, and children.