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Medicaid Access & Coverage in 2019

Results from the Institute for Medicaid Innovation's 2020 Annual Medicaid Managed Care Survey

INSTITUTE FOR MEDICAID INNOVATION

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Preface

Distribution of the Institute for Medicaid Innovation's (IMI's) 2020 Annual Medicaid Managed Care Survey to the health plans coincided with reports of the first COVID-19 cases in the United States. Nevertheless, despite the pivot of health plans to focus their energy on responding to their members' needs during the pandemic, the plans found time to complete this year's survey. We are grateful to them for their ongoing support of this project and for their recognition that the IMI's work has a direct and meaningful impact on the Medicaid population.

Executive Summary

This third 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 (IMI's) founding executive director, Dr. Jennifer Moore, the annual 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. Each year, this team of experts evaluates and refines the survey to capture the national landscape of Medicaid managed care and to inform salient policy issues. Our intention is that the survey findings contained in this report will equip Medicaid stakeholders with the information they need to accurately articulate the national narrative about Medicaid managed care.

For the 2020 survey, representing coverage in 2019, the IMI invited all Medicaid MCOs to participate, including, but not limited to, 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 67 percent of all covered lives in Medicaid managed care across almost every state with Medicaid managed care. The 74-page survey report provides a comprehensive look into Medicaid managed care in 2019 and longitudinally over a three-year period. Longitudinal data presented in the report include sample characteristics, notable changes, and responses that remained consistent over time. 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 2019, 80 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, address; 93%), difficulty reaching a member (93%), and lack of member's willingness to participate in a needs assessment (80%). The most common barriers cited by Medicaid MCOs in providing high-risk care coordination were members' willingness to engage (100%), ability to contact member (93%), members' unmet social needs (80%), and availability of social supports (67%). Across all three years of the survey, members' willingness to engage and MCOs' ability to contact members were the top-two barriers to providing high-risk care coordination. 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 or sometimes provided these core functions to members.

"Members' willingness to engage" and "MCOs' ability to contact members" remained the top two barriers to providing high-risk care coordination across all three years of the survey.

Value-Based Purchasing (VBP)

Approximately 93 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 2019. Half of the health plans 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. An increase in establishing VBP arrangements with dentists was seen from 2017 to 2019, while a decrease was seen in implementation of arrangements with home and community-based services providers, long-term care facilities, and orthopedics. Furthermore, 43 percent of health plans indicated that the percentage of payments to hospitals through alternative mechanisms was less than 15 percent. The most common operational barrier to implementing value-based agreements, as reported by the health plans, was data reporting to providers (86%). The most common external factors influencing adoption and innovation were providers' readiness and willingness (100%) and providers' information technology (IT) capabilities (79%). Longitudinally, almost all external factors, except providers' readiness and willingness, which influence adoption and innovation in VBP/APMs, decreased over time, from 2017 to 2019. The percentage of Medicaid MCOs that selected state requirements limiting VBP/APM models, uncertain or shifting federal policy requirements/priorities, and the impact of 42 CFR Part 2 on limiting access to behavioral health data decreased by over 50 percent from 2017 to 2019.

From 2017 to 2019, there was a 14 percentage-point increase in the establishment of VBP arrangements with a majority of dentists.

Pharmacy

The majority of Medicaid MCO respondents (93%) reported being at-risk for pharmacy benefits in at least one of their markets during 2019. 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 (85%); an increase in the number of specialty pharmacy medications (77%); and pharmacy benefits or subsets of benefits carved out of managed care (69%). From 2017 to 2019, responses changed in how states addressed high-cost drugs, with decreases seen in capitation rate adjustments as part of regular rate adjustments, carving-out drug costs completely/paying fee-for-service for certain drugs, and stop-loss provisions to cap the plan's cost for the drug.

The percentage of MCOs at-risk for pharmacy benefits increased by 24 percentage points from 2017 to 2019.

Behavioral Health

In 2019, 73 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 that fragmentation in program funding and contracting for physical and behavioral health services (92%), provider capacity to provide integrated physical and behavioral health at point of care (92%), and access to data between care management and behavioral health teams (67%) were common barriers to care. The top operational, network, and policy barriers across all three years of the survey are listed below:

Operational Barriers:

- Access to data between care management and behavioral health teams

Network Barriers:

- Provider capacity to provide integrated physical and behavioral health at point of care
- Access to behavioral health providers in select regions (e.g., rural, underserved)

Policy Barriers:

- Fragmentation in program funding and contracting for physical and behavioral health services
- 42 CFR Part 2 limitations on SUD treatment information being shared

Women's Health

Approximately 93 percent of health plans provided targeted women's health programs for Medicaid members in 2019. Consistent with Medicaid's role in providing coverage for people who are pregnant, 100 percent of health plans indicated that prenatal and postpartum care was a priority women's health topic, with 100 percent also indicating that they had targeted programs and engagement strategies to address this priority. Additional common priority topics included general behavioral health (93%) and cancer screening and treatment (79%). Churn remains a concern for health plans working to address the long-term health of women enrolled in Medicaid. The top-three barriers to addressing the long-term health of women enrollees as a result of churn across all three years of the survey were (1) clinical care disruption and care management continuity, (2) completeness of patient/member history, and (3) maintaining access to providers and care.

"Clinical care disruption" and "care management continuity" remained the top barriers associated with churn for addressing the long-term health of women enrollees from 2017 to 2019.

Child and Adolescent Health

All Medicaid MCOs offered targeted child health programs in 2019. Furthermore, over 93 percent of health plans, regardless of size, contracted with the state Medicaid agency to provide coverage for children with special healthcare needs (CSHCN). The survey 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 CSHCN (93%), attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD; 87%), behavioral health screening and treatment (80%), and asthma (80%). Similarly, the most common targeted programs and engagement strategies were focused on CSHCN (87%), asthma (80%), behavioral health screening and treatment (67%), and ADHD/ADD (67%). The most common barriers to serving children and adolescents in 2019 included identifying and coordinating with schools (67%), churn (67%), and policies or program structures that create barriers if the parent(s) has/have more than one child (60%). Based on responses from health plans from 2017 to 2019, there has been a decrease in each of the five identified barriers.

The survey found 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 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 (100%), supported and encouraged adherence to care plan (100%), and care coordination (100%). However, barriers persisted, including carved-out services, which created inefficiencies in services for families (73%); poor communication among multiple providers to families (60%); and carved-out services, which created an increased risk for duplication and costs (53%).

Managed Long-Term Services and Supports (MLTSS)

In 2019, over half of survey respondents indicated that they were at risk for needing long-term services and supports (LTSS). With the growing interest of state Medicaid agencies in providing 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, while 33 percent of medium-size plans (i.e., 250,001 to 1 million covered lives) and 40 percent of small-size plans (i.e., 250,000 or fewer covered lives) are at risk for MLTSS. Of the health plans at risk, regardless of size, 100 percent assigned a care coordinator for more than 75 percent of their MLTSS members.

Three-quarters of Medicaid MCOs reported completing the enrollment and assessment process for their new members in fewer than 30 days, and all reported completing the member's plan of care within 90 days of enrollment. Across all three years of the survey, 100 percent of health plans indicated completing a comprehensive list of core functions for their members, including conducted risk assessments, engaging a care team of professionals, and developing a care plan. Furthermore, 100 percent of Medicaid MCOs utilized care teams for their MLTSS members in 2019.

In 2019, the most common approaches for innovation in MLTSS were member-centric.

When designing MLTSS programs, health plans indicated two common barriers: misalignment between Medicaid and Medicare (75%) and state program requirements that limit the effectiveness of managed care strategies (e.g., any-willing-provider provisions, continuity-of-care provisions; 63%). Finally, the most common approaches for innovation in MLTSS that were led by health plans in 2019 were member-centric, including self-advocacy (88%) and innovative approaches for caregiver supports and services (63%). Furthermore, health plans commonly offered innovative approaches for partnerships with community-based organizations (50%), wellness initiatives (50%), and "money follows the person" community transition programs (50%).

Social Determinants of Health (SDOH)

In 2019, all respondents indicated that they offer targeted social determinants of health (SDOH) programs. The most common populations that were targeted for SDOH programs were homeless/housing insecure (87%), people who were pregnant (73%), and adults with serious mental illness (67%). A comprehensive table on page 61 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).

Most health plans (50%) indicated using an internally developed or adapted SDOH screening tool in 2019.

It was notable in the survey findings that plans used multiple SDOH screening tools and not just one, across all Medicaid MCO respondents. Half of the health plans indicated utilizing an internally developed or adapted tool, with 13 percent not using any tool.

Efforts to Support Sexual and Gender Minority Health and Reduce Health Disparities

A new set of questions was added to the 2020 survey to capture Medicaid MCO efforts to address sexual and gender minority health. The survey findings showed that in 2019, 60 percent of Medicaid MCO respondents indicated that they offered targeted programs to address sexual and gender minority health, while 20 percent were considering offering targeted programs for their members. It was found that the majority of respondents (60%) covered gender-affirming treatment, including hormone therapies and surgical procedures for their members. Twenty percent of respondents indicated that health disparities affecting sexual and gender minority children and adolescents were a priority in 2019, and 13 percent offered targeted programs and engagement strategies to address these disparities. Almost half (43%) of respondents covered gender-affirming care for transgender and gender-nonconforming children with special health care needs (CSHCN). Seven percent of respondents provided targeted social determinants of health programs for members who identify as sexual and gender minorities.

Overall, findings from the survey highlight the continued value of the managed care model in Medicaid. However, existing barriers could inhibit continued success and growth. This report presents the findings from data collected on these challenges and potential solutions. A companion report, "2020 Medicaid MCO Best Practices and Innovative Initiatives," highlights innovative initiatives and best practices led by Medicaid MCOs in 2019.

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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 2020 survey, capturing 2019 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 allows us to provide critical trend data, representing three years, and analysis to evaluate the impact of state and federal policies on the Medicaid program and managed care.

Background

Included in this report are descriptive statistics for each survey item, representing de-identified, aggregated 2019 data provided to the IMI from Medicaid MCOs. The survey was emailed in February 2020 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 with more than 500,000 covered lives and without an affiliation to either trade association. The Medicaid MCOs that responded to the survey represented 67 percent of all covered lives in Medicaid managed care across almost 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, 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. A companion report, *2020 Medicaid MCO Best Practices and Innovative Initiatives*, provides a summary of the innovative initiatives and best practices led by Medicaid MCOs in 2019.

Characteristics of Survey Respondents: Medicaid Managed Care Organizations

Survey respondents indicated initiating participation in Medicaid programs as a managed care organization as early as 1981 and as late as 2013. Respondents were 47 percent private, non-profit organizations; 27 percent private, for-profit organizations; and 27 percent either public or government organizations (total does not add up to 100 due to rounding). The majority of respondents (80%) indicated that they provided coverage in a single state in 2019, with 20 percent providing coverage in multiple states (Table 1).

The Medicaid MCO survey respondents were categorized based on the number of lives they covered, with 33 percent covering fewer than 250,000 Medicaid managed lives, 40 percent covering 250,001 to 1 million lives, and 27 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 (93%), pharmacy (93%), behavioral health (80%), institutional care (67%), dental care (67%), home and community-based waiver services (60%), and gender-affirming treatment, including hormone therapies and surgical procedures (60%). Further, Medicaid MCOs reported participating in a number of health benefit programs, including the Children's Health Insurance Program (CHIP; 67%), Medicare Advantage Dual Special Needs Plan (DSNP; 67%), Medicare Advantage (53%), health insurance marketplace/exchange (47%), employer markets (40%), other programs (40%), and individual markets (27%). Figure 1. highlights that among the 40 percent of Medicaid MCOs that do not offer gender-affirming treatment, 20 percent are considering offering these programs.

In 2019, 67 percent of survey respondents indicated that they contracted with an Accountable Care Organization (ACO), as highlighted in Figure 2. Approximately 43 percent contracted with an integrated health system that was not an ACO (Figure 3). Almost half (43%) of health plan respondents indicated that more than 50 percent of their members received services through a patient-centered medical home (Figure 4). Medicaid MCOs also indicated that they had at least one contract with federally qualified health centers (FQHCs), rural health centers, substance use disorder agencies, and skilled nursing facilities. The majority of respondents indicated having contracts with a variety of provider types ranging from local/county health departments (67%) to public hospitals (93%). From 2018 to 2019, the percentage of respondents who indicated having contracts with family planning (Title X) and Planned Parenthood clinics increased from 67 percent to 73 percent.

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

Table 1. Trends and Overview of Medicaid Managed Care Survey Respondents' Characteristics, 2017-2019

Survey Sample Characteristics			
Medicaid Managed Care Organization (MCO) Tax Status			
	2017	2018	2019
Private, non-profit	38%	45%	47%
Private, for-profit	39%	33%	27%
Government or Other	23%	22%	27%
Parent Organization			
	2017	2018	2019
Provider owned	23%	22%	33%
Not provider owned	77%	78%	67%
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
2017	15%	54%	31%
2018	39%	28%	33%
2019	33%	40%	27%
Medicaid MCO Markets in 2019			
	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%	75%
Single state	100%	100%	25%
Benefits Managed at Full Risk			
	2017	2018	2019
Physical Health	85%	100%	93%
Pharmacy*	85%	95%	93%
Behavioral Health	92%	95%	80%
Institutional Care	85%	78%	67%
Dental	62%	73%	67%
Home and Community-Based Waiver Services	92%	78%	60%
Gender-affirming treatment, including hormone therapies and surgical procedures	N/A	N/A	60%
MCO Program Participation			
	2017	2018	2019
Children's Health Insurance Program (CHIP)	62%	67%	67%
Medicare Advantage Dual Special Needs Plan (DSNP)	62%	62%	67%
Medicare Advantage	77%	62%	53%
Health Insurance Marketplace/Exchange	62%	39%	47%
Employer market (small and/or large group)	54%	34%	40%
Other	39%	28%	40%
Individual market	39%	34%	27%

*In at least one market

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 2. Comparison of Elements of Medicaid Managed Care Organization Coverage by Health Plan Size, 2019

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	80%	100%	100%	93%
Pharmacy	100%	83%	100%	93%
Behavioral Health	80%	67%	75%	73%
Women's Health	100%	83%	100%	93%
Child and Adolescent Health	100%	100%	100%	100%
Long-Term Services and Supports	40%	33%	100%	53%
Social Determinants of Health	100%	100%	100%	100%

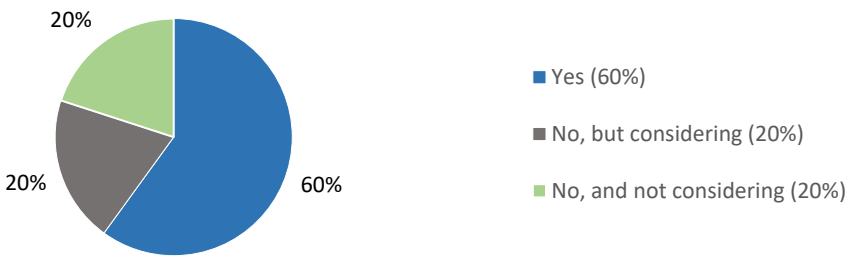
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 3. Percentage of Medicaid Managed Care Organizations Serving Specific Populations, 2019

Population Served by Medicaid MCOs	Percentage of Medicaid MCOs
Children	100%
Children with Special Healthcare Needs	100%
Medicare and Medicaid Enrollees (Duals)	100%
Individuals with Serious Mental Illness (SMI)	87%
Aged, Blind, Disabled	87%
Children and Youth in Foster Care	80%
Childless Adults	73%
Individuals with Intellectual and Developmental Disabilities (I/DD)	73%
Adult Caregivers	53%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 1. Percentage of Medicaid Managed Care Organizations Offering Targeted Programs to Address Sexual and Gender Minority Health, 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 4. Percentage of Medicaid Managed Care Organizations with Specific Provider Contracts, 2019

Type of Provider Contract	Percentage of Medicaid MCOs
Public hospitals	93%
Behavioral health centers	93%
Community health centers	93%
Urgent care clinics	93%
School-based clinics	87%
Methadone and other MAT clinics	87%
Academic medical centers	80%
Maternal and child health clinics	80%
HIV/AIDS services organizations	73%
Family planning clinics (Title X)	73%
Planned Parenthood	73%
Retail clinics	73%
Local/County health departments	67%
Indian Health Service providers or tribal health clinics	40%
Other (e.g., FQHCs, rural health clinics, skilled nursing facilities)	13%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 5. Percentage of Medicaid Managed Care Organizations Contracting with Planned Parenthood and/or Family Planning Clinics (Title X), 2018-2019

Type of Provider Contract	2018	2019
Planned Parenthood	67%	73%
Family planning clinics (Title X)	67%	73%

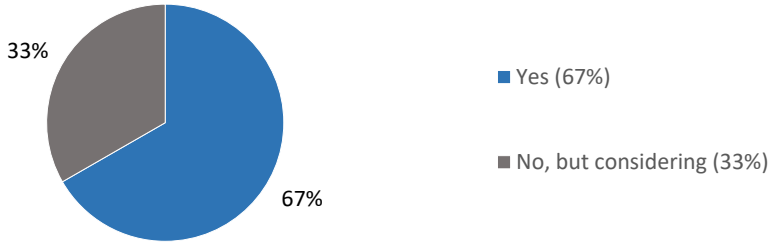
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 6. Most Common Strategies Used by Medicaid Managed Care Organizations to Recruit and Retain Providers in Medicaid Managed Care, 2019

Medicaid MCO Strategy	Percentage of Medicaid MCOs
In-person outreach to providers	100%
Financial incentives	93%
Streamlined referral and authorization practices	93%
Use of technology	73%
Dedicated provider hotline for questions, problems, and needs	73%
Automatic assignment of members to primary care providers	73%
Prompt payment policies	67%
Streamlined credentialing and re-credentialing processes	60%
Reduced administrative burdens	60%
Pay rates comparable to Medicare or commercial rates	53%
Debt repayment	13%
Other (e.g., value-based care incentives, dedicated provider relations staff)	13%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

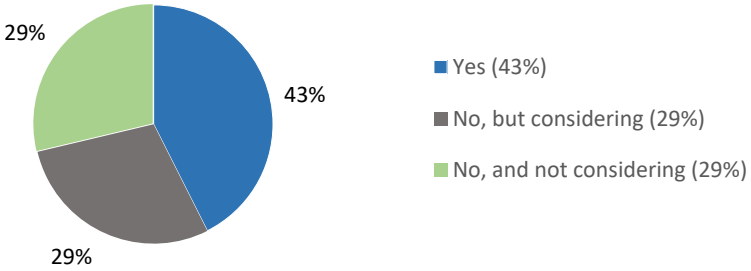
Figure 2. Percentage of Medicaid Managed Care Organizations Contracting with an Accountable Care Organization (ACO) or Integrated Health System (IHS), 2019



Note: None of the survey respondents selected "No, and not considering" as an answer for this item.

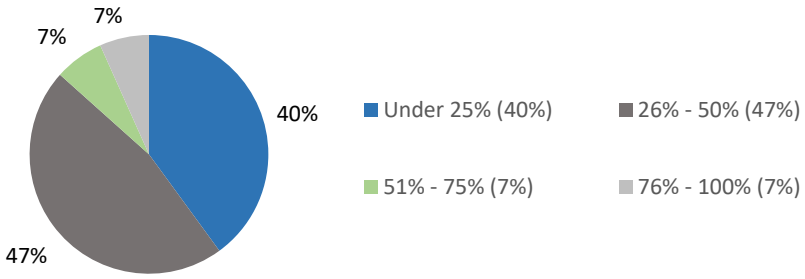
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 3. Percentage of Medicaid Managed Care Organizations Contracting with an Integrated Health System That Is Not an ACO, 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 4. Percentage of Medicaid Members Receiving Services through a Patient-Centered Medical Home (PCMH), 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

In 2019, 80 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 by Medicaid MCOs in providing high-risk care coordination were members' willingness to engage (100%), ability to contact member (93%), members' unmet social needs (80%), and availability of social supports (67%). Across all three years of the survey, 100 percent of Medicaid MCOs indicated that members' willingness to engage was a barrier to providing high-risk care management. The most common barriers cited in completing an individual health risk assessment were inaccurate member information (e.g., phone number, address; 93%), difficulty reaching member (93%), and lack of members' willingness to participate in needs assessments (80%). Respondents indicated additional barriers including: challenges to providing efficient and comprehensive care coordination as a result of carved-out services, such as behavioral health; perceived disconnects between state contract expectations and understanding of what services are delivered; the availability of real-time data; and engaging members in programs. An innovative suggestion provided in the write-in section was to use proprietary risk-scoring algorithms to identify members who need case management.

93 percent of MCOs measured the effectiveness of high-risk care coordination in 2019.

Approximately 53 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 or sometimes 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 (93%) measured the effectiveness of their high-risk care coordination efforts in 2019, with the most common forms of measurement being emergency room utilization (100%), inpatient utilization (93%), patient experience survey (79%), and preventive care (71%).

As part of the 2020 survey, Medicaid MCOs were asked to identify the types of data that would support targeted high-risk care coordination. The following represents the write-in responses that we received. Several suggestions were noted by multiple health plans that fit into the following two categories:

<u>Additional demographic data and contact information, including:</u>

- Secondary phone numbers and email addresses
- Durable Power of Attorney or legal guardian and documentation
- Copy of advanced directives
- Social needs data
- Engagement in other state programs (e.g., Head Start, WIC, etc.)
- Reason for loss of enrollment (e.g., financial, paperwork not completed, etc.)

Claims and clinical encounter data shared through state databases, such as:

- Historical claims data and detailed information on clinical encounters, including case management, social work, and behavioral health services
- Data on health indicators (e.g., tobacco use, special healthcare needs indicators, earlier identification of someone who is pregnant)
- State Medicaid utilization benchmark statistics (e.g., emergency department utilization, rate of hospital admissions, average length-of-stay, and rate of readmission)

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

Table 7. Most Common Assessment Barriers in Completing Individual Health Risk Assessments for Members, 2019

Assessment Barriers Medicaid MCOs Encounter	Percentage of Medicaid MCOs
Inaccurate member information (e.g., phone number, address)	93%
Difficulty reaching members	93%
Lack of member's willingness to participate in a needs assessment	80%
Lack of confirmed member record	27%
State deadline to complete assessments within timeframe	13%
Dispute in resolving the identity of members	13%
Overlapping assessments tied to eligibility	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 8. Top Five Barriers to Completing Individual Health Risk Assessments for Members, 2017-2019

Barriers
Difficulty reaching members
Inaccurate member information
Member's unwillingness to participate in a needs assessment
Lack of confirmed member record
State deadline to complete assessments within timeframe

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 9. Most Common Management Barriers to Effective High-Risk Care Coordination, 2019

Management Barriers Medicaid MCOs Encounter	Percentage of Medicaid MCOs
Member's willingness to engage	100%
Ability to contact member	93%
Member's unmet social needs	80%
Availability of social supports	67%
Provider's willingness to engage with health plan	53%
Ability to connect individuals to necessary non-clinical social supports	53%
Obtaining consent	53%
Access to information from previous providers	53%
Coordination with multiple care coordinators from health systems, provider practices, clinics, etc.	53%
Churn (member or eligibility-related)	53%
Ability to share information with service providers	40%
Member's access to primary care	33%
Member's access to specialty care	33%
Other (e.g., housing instability)	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 10. Trends in Top-Five Barriers to Effective High-Risk Care Management, 2017-2019

Percentage of Medicaid MCOs in 2017		Percentage of Medicaid MCOs in 2018		Percentage of Medicaid MCOs in 2019	
Ability to contact member	85%	Member's willingness to engage	100%	Member's willingness to engage	100%
Member's willingness to engage	39%	Ability to contact member	95%	Ability to contact member	93%
Access to information from previous providers	31%	Member's unmet social needs	78%	Member's unmet social needs	80%
Obtaining consent	23%	Availability of social supports	78%	Availability of social supports	67%
Ability to share information with service providers	23%	Provider's willingness to engage with health plan	62%	Provider's willingness to engage with health plan	53%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 11. Most Common Methods by Medicaid Managed Care Organizations for Sharing Members' Risk Assessments, 2019

Method of Sharing	Percentage of Medicaid MCOs
Health plan to care coordinator	100%
Health plan to member	80%
Health plan to member's guardian or responsible party	73%
Health plan to member's preferred provider	73%
Health plan to network providers	53%
Health plan to community-based organization	40%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 12. Core High-Risk Care Coordination Functions Performed by Medicaid Managed Care Organizations, 2019

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	47%	53%	0%	0%
Engaged a care team of professionals to address the needs of the member	60%	40%	0%	0%
Developed a plan of care	87%	13%	0%	0%
Supported adherence to plans of care	80%	20%	0%	0%
In addition to supplying the provider directory, supported the member in identifying and connecting with providers	33%	67%	0%	0%
Coordinated in-home services	27%	67%	7%	0%
Prepared the member for appointments	13%	73%	13%	0%
Arranged transportation for appointments	13%	80%	7%	0%
Provided information on other types of social services (e.g., faith based, non-profit, other government programs)	7%	73%	0%	0%
Provided guided referrals or "hand-offs" to other needed social services (e.g., faith- based, non-profit, other government programs)	7%	80%	13%	0%
Coordinated with social services (i.e., housing providers, nutrition programs) as part of care plan development and adherence	7%	80%	13%	0%
Shared data with social services	7%	40%	27%	27%
Coordinated with multiple care coordinators from health systems, provider practices, clinics, etc.	13%	87%	0%	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 13. Trends in Core Functions Performed by Medicaid Managed Care Organizations under High-Risk Care Coordination, 2017-2019

Core Function	Frequency of Function	Direction of Change, 2017 -2019
Served as a single point of contact for the member	Always	↓
	Sometimes	↑
	Limited	↓
Engaged a care team of professionals to address the needs of the member	Always	↓
	Sometimes	↑
	Limited	-
In addition to supplying the provider directory, supported the member in identifying and connecting with providers	Always	↓
	Sometimes	↑
	Limited	↑
Coordinated in-home services	Always	↓
	Sometimes	↑
	Limited	↑
Prepared the member for appointments	Always	↓
	Sometimes	↑
	Limited	↑
Provided guided referrals or "handoffs" to other needed social services (e.g., faith- based, non-profit, other government programs)	Always	↓
	Sometimes	↑
	Limited	↑
Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence	Always	↓
	Sometimes	↑
	Limited	↑

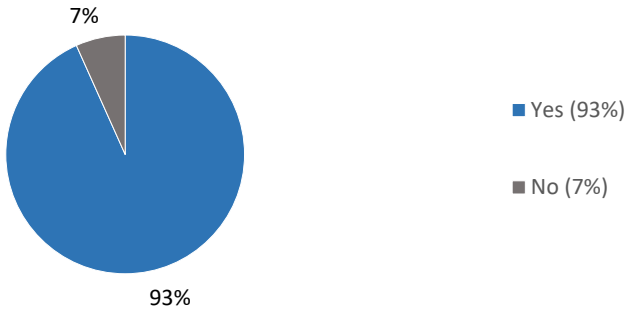
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 14. Frequency of Participation with Medicaid Managed Care Organization Care Teams, 2019

	Always	Sometimes	Never
Individual member	33%	67%	0%
Family member	0%	100%	0%
Guardian	7%	93%	0%
Member's Primary Care Provider	13%	87%	0%
Representative from Primary Care Provider office	7%	87%	7%
Other healthcare professional not employed by health plan	0%	100%	0%
Natural/community supports (other than guardian)	7%	87%	7%
Care coordinator within health plan	87%	13%	0%
Behavioral health specialist within health plan	20%	67%	13%
Pharmacist within health plan	13%	80%	7%
Community worker within health plan	0%	87%	13%
Peer-support specialist within health plan	7%	60%	33%
Non-health plan care coordinators (e.g., from health system, provider practices, clinics, etc.)	0%	100%	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 5. Percentage of Medicaid Health Plans Measuring Effectiveness of High-Risk Care Coordination, 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 15. Most Common Measures of Effectiveness Used in High-Risk Care Coordination, 2019

Measures Utilized by Medicaid MCOs	Percentage of Medicaid MCOs
Emergency Department utilization	100%
Inpatient utilization	93%
Patient experience survey results	79%
Preventive care	71%
Impact on HEDIS measures	64%
Total spending	64%
Provider experience survey results	43%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

The survey findings show that as the number of state Medicaid agencies that required value-based purchasing agreements increased, the percentage of state-required contracts between health plans and providers increased also. Approximately 93 percent of all Medicaid MCO respondents utilized an alternative payment model or a 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 2019.

Half of the 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. Health plans reported piloting various population-specific VBP arrangements with obstetrics/gynecology, behavioral health, skilled nursing facilities, and for members with specific conditions that spend more than a specific financial threshold. Across three years of the survey, there were no trends in VBP implementation within specific populations.

The most common strategies were payment incentives based on performance measures related to access to care (64%) and payment incentives for availability of same-day or after-hours appointments (43%). Additional APMs used between providers and Medicaid MCOs included per member per month payments for care coordination, payments for care coordination for members who misuse services/medications, and owner risk-based arrangements. Furthermore, 43 percent of health plans indicated that use of alternative payments to hospitals was less than 15 percent.

The most common operational barrier to implementing VBP in 2019 was "data reporting to providers."

However, the most common operational barrier as reported by the health plans was data reporting to providers (86%). The most common external factors influencing adoption and innovation were providers' readiness and willingness (100%) and providers' information technology (IT) capabilities (79%).

As part of the write-in option of the VBP section of the survey, the respondents indicated the following state and federal barriers to VBP and/or APMs, including:

- State and federal restrictions on data sharing and lack of consistency in reported metrics
- State requirements that limit VBP/APM model development by Medicaid MCOs

The respondents indicated that the following state opportunities supported effective implementation of VBP and/or APMs:

- Improved state communication around VBP expectations to increase awareness of shared goals
- State assistance in educating providers to understand expectations of Medicaid MCOs for VBP agreements
- State development of realistic, multi-pronged VBP strategies, with performance targets for specific populations and geographic locations

Health plans also wrote-in that increased provider involvement (e.g., number of providers who have value-based agreements; total number of members under a provider with value-based agreement) would assist them in more effectively implementing VBP and/or APMs.

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

Table 16. Percentage of Medicaid Managed Care Organizations Using APM or VBP Structures, by Health Plan Size, 2017-2019

	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
2017	100%	86%	100%	92%
2018	86%	100%	100%	95%
2019	80%	100%	100%	93%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 17. Level of Engagement by Medicaid Managed Care Organizations in HCP-LAN APM Categories, 2019

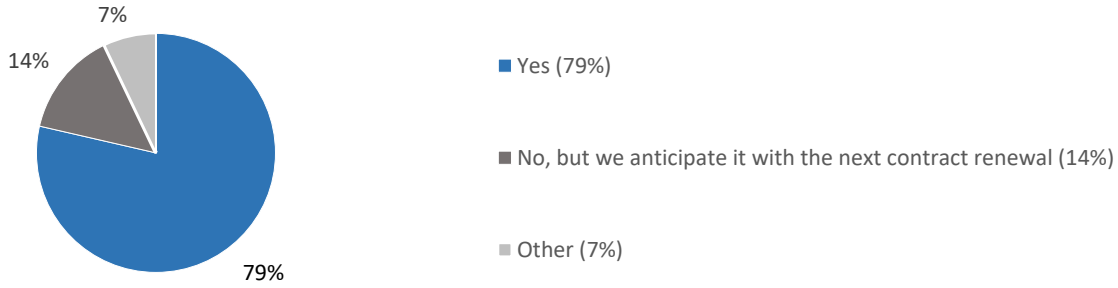
HCP-LAN APM Category	Percentage of Medicaid MCOs Engaged
Category 1: FFS, No Link to Quality or Value	79%
Category 2: FFS, Link to Quality and Value	79%
Sub-Category A: Foundational Payments for Infrastructure & Operations	73%*
Sub-Category B: Pays for Reporting	46%*
Sub-Category C: Rewards for Performance	100%*
Sub-Category D: Rewards and Penalties for Performance	27%*
Category 3: APMs Built on FFS architecture	86%
Sub-Category A: APMs with Upside Gainsharing	92%*
Sub-Category B: APMs with Upside Gainsharing/Downside Risk	42%*
Category 4: Population-Based Payment	50%
Sub-Category A: Condition-Specific Population-Based Payment	57%*
Sub-Category B: Comprehensive Population-Based Payment	57%*

*This number represents the percentage of respondents who engage in the overall category that also engage in this specific sub-category.

Note: Under each category, respondents selected all sub-categories that were applicable; therefore, the total subcategory responses may exceed 100%.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

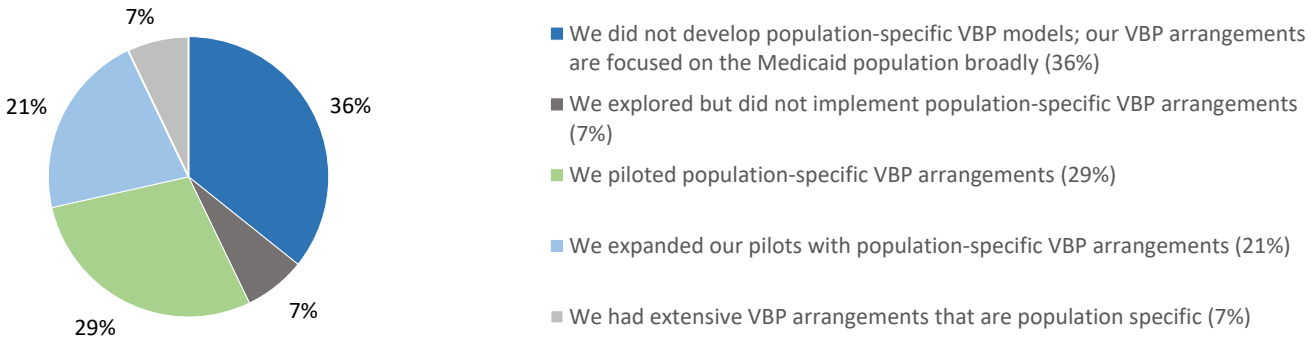
Figure 6. Percentage of State Contracts Requiring Medicaid Managed Care Organizations to Implement VBP or APM Contracting between Medicaid Managed Care Organizations and Providers, 2019



Note: None of the survey respondents selected "No, and not planned with next contract renewal" as an answer for this item.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 7. Percentage of VBP Implementation within Specific Populations, 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 18. VBP Implementation within Specific Provider Categories (Hospitals Excluded), 2019

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%	43%	57%
Dentists	14%	7%	79%
Home and Community-Based Service Providers	0%	21%	79%
Long-Term Care Facilities	0%	21%	79%
Nurse-Midwives	0%	14%	86%
Obstetricians/ Gynecologists	7%	57%	36%
Orthopedics	7%	14%	79%
Primary Care Providers (i.e., Physicians, Advanced Practice Nurses, Physician Assistants)	50%	36%	14%
Other Specialists	7%	29%	64%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 19. Trends in VBP Implementation within Specific Provider Categories (Hospitals Excluded), 2017-2019

Provider Type	Frequency of Working with Provider Type	Direction of Change, 2017 - 2019
Dentists	Worked with a Majority of This Type of Provider	↑
	Worked with Select Providers	↑
	Did Not Work with This Type of Provider	↓
Home and Community-Based Service Providers	Worked with a Majority of This Type of Provider	↓
	Worked with Select Providers	↓
	Did Not Work with This Type of Provider	↑
Long-Term Care Facilities	Worked with a Majority of This Type of Provider	↓
	Worked with Select Providers	↓
	Did Not Work with This Type of Provider	↑
Orthopedics	Worked with a Majority of This Type of Provider	↓
	Worked with Select Providers	↓
	Did Not Work with This Type of Provider	↑

Note: Table presents provider types with notable changes over time.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 20. Most Common Medicaid Managed Care Organization Payment Strategies, 2019

Payment Strategy	Percentage of Medicaid MCOs
Payment incentives based on performance measures related to access to care	64%
Payment incentives for availability of same-day or after-hours appointments	43%
Enhanced payment rates for hard-to-recruit provider types	29%
Other*	29%
Enhanced payment rates for providers in rural or frontier areas	21%
We did not use any payment strategies	14%

* Including enhanced payments to providers for a specific health outcome for reimbursement parity and to promote access, care coordination for members with mis-utilization of services and/or medications, quality-incentive based arrangements for primary and obstetrical care providers, and strategies that support the integration of behavioral health care into primary care.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 21. Most Common Types of APMs Used between Providers and Medicaid Managed Care Organizations, 2019

Type of Alternative Payment Model	Percentage of Medicaid MCOs
Incentive/bonus payments tied to specific performance measures	93%
Shared savings	64%
Global or capitated payments to primary care providers or integrated provider entities	50%
Bundled or episode-based payments	43%
Shared savings and risk	43%
Payment withholds tied to performance	36%
Other*	14%
Non-payment or reduced payment for patient safety issues	7%
Non-payment or reduced payment for 39-week elective delivery	7%

* Including per member per month (PMPM) payments for care coordination, payments for care coordination of members who mis-utilize services or medication, and owner risk-based arrangements.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 22. Percentage of Payments through APMs to Primary Care Providers, by Health Plan Size, 2019

Percentage of Payment	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
1-15%	50%	33%	50%	43%
16-30%	0%	33%	0%	14%
More than 30%	50%	33%	0%	43%
None	0%	0%	0%	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 23. Percentage of Payments through APMs to Hospitals, by Health Plan Size, 2019

Percentage of Payment	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
1-15%	25%	50%	50%	43%
16-30%	0%	17%	25%	14%
More than 30%	25%	17%	0%	14%
None	50%	17%	25%	29%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 24. Most Common Operational Barriers in VBP/APMs, as Reported by Medicaid Managed Care Organizations, 2019

Operational Barriers	Percentage of Medicaid MCOs
Data reporting to providers	86%
IT system preparedness	71%
Support to providers to make determinations on VBP/APM	71%
Tracking quality and reporting within new structure	71%
Contract requirements on VBP/APM approaches	50%
Pricing VBP/APM	43%
Other (e.g., development of an online, secure document exchange portal, delivery model readiness)	14%
None	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 25. Trends in the Most Common External Factors Influencing Adoption and Innovation in VBP/APMs, as Reported by Medicaid Managed Care Organizations, 2017-2019

External Factors	Percentage of Medicaid MCOs in 2019	Direction of Change, 2017-2019
Provider readiness and willingness	100%	-
Provider IT capabilities	79%	⬇
Medicaid payment rates	57%	⬇
Uncertain or shifting state policy requirements/ priorities	43%	⬇
Uncertain or shifting federal policy requirements/priorities	29%	⬇
Impact of 42 CFR Part 2 on limiting access to behavioral health data	21%	⬇
State requirements limiting VBP/APM models	14%	⬇
Other	7%	N/A*

* We are unable to present trend data for this data point as it was not an answer option for all three years of the survey.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Pharmacy

The majority of Medicaid MCO respondents (93%) reported being at risk for pharmacy benefits in at least one of their markets in 2019. 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 (85%); an increase in the number of specialty pharmacy medications (77%); and pharmacy benefits or a subset of benefits carved out of managed care (69%). Others also noted additional challenges, including members' comprehension of and engagement in programs and states' 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 (62%) and completely carved-out drug costs or payment based on fee-for-service for certain drugs (46%). Medicaid MCOs identified the following strategies to address new or high-cost drugs:

- Value-based arrangements
- State-mandated drug list
- Reallocation of revenue
- Risk sharing
- State reimbursement
- Risk corridor for high-cost medication
- Using a small pot of funds for one-time coverage of high-cost drugs

In the pharmacy write-in section of the survey, a few Medicaid MCOs shared that carving-out the pharmacy benefit is an issue they encounter similar to when state programs choose not to incorporate behavioral health and substance use disorder services into managed care. One Medicaid MCO shared, "When MCOs have responsibility for both medical and pharmacy benefits, Medicaid MCOs can coordinate clinical programs, benefits, and communication, ensuring timely, cohesive messaging, with better cost control and improved quality of care." Health plans also cited states' moving to a single, statewide preferred drug list as well as lack of transparency and inconsistency in pricing as challenges. Furthermore, respondents said that Medicaid best price distorts efforts for transparent drug pricing, and they expressed frustrations at not being able to negotiate prices.

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

Table 26. Percentage of Medicaid Managed Care Organizations Fully at Risk for Pharmacy Benefits, by Health Plan Size, 2017-2019

	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
2017	100%	57%	75%	69%
2018	86%	80%	100%	89%
2019	100%	83%	100%	93%

Note: Percentages in this table reflect MCOs that were fully at-risk for pharmacy benefits in at least one market. Percentages do not include MCOs that were at-risk for a portion of the pharmacy spending in at least one market.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 27. Percentage of Medicaid MCOs Utilizing Pharmacists for Medication Therapy Management, by Health Plan Size, 2019

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
80%	100%	75%	85%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 28. Pharmacists' Most Common Approaches to Medication Therapy Management, 2019

Approaches	In-person	Over-the-phone	Utilized Other Telecommunication Technology
Medication therapy reviews	55%	100%	9%
Medication-related action plans	45%	91%	9%
Intervention and/or referrals	45%	100%	9%
Documentation and follow-up	36%	100%	9%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 29. Pharmacists' Most Common Approaches to Using Community-Based Contracts, 2019

Types of Community-Based Contracts	Percentage of Medicaid MCOs
Drug Utilization Rate (e.g. duplicative therapies)	46%
None	46%
Pharmacotherapy consults	31%
Medication adherence rate	31%
Identification of lower-cost medication alternatives	31%
Other*	15%
Hospital readmissions	0%
Emergency Department visits	0%

*Including providing comprehensive medication management services for individuals and addressing care gaps.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 30. Trends in Most Common Challenges in Managing Medicaid Prescription Drug Benefits, 2017-2019

Challenges	Percentage of Medicaid MCOs in 2019	Direction of Change, 2017-2019
Utilization and cost history unknown for new drugs entering a market; impacting capitation rates and pricing	85%	↓
Increase in number of specialty pharmacy medications	77%	N/A*
Pharmacy benefits or subset of benefits carved out of managed care	69%	↓
Member comprehension and engagement of programs	62%	↑
Single preferred drug list/formulary requirements	62%	N/A*
Differences between plan formularies and methodologies and state requirements	54%	↑
Formulary notification requirements as part of Medicaid Managed Care Organization Final Rule	31%	↑
Pharmacy network requirements	23%	↓
Other+	15%	N/A*

* We are unable to present trend data for this data point as it was not an answer option for all three years of the survey.

+Including independent pharmacy advocacy on reimbursements and subsequent political activity, members' adherence to medication, and multiple co-morbidities and multiple drugs for members.

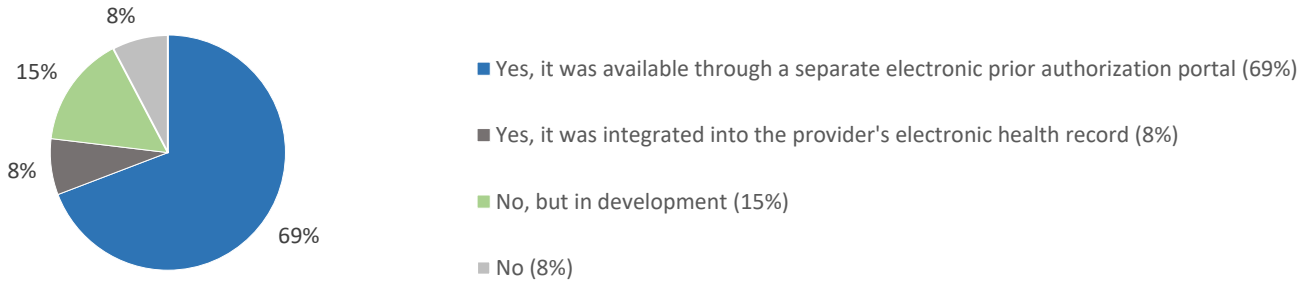
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 31. Percentage of Medicaid Managed Care Organizations Supporting E-Prescribing through Pharmacy Benefit Managers (PBMs), by Health Plan Size, 2019

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%	25%	100%	76.9%

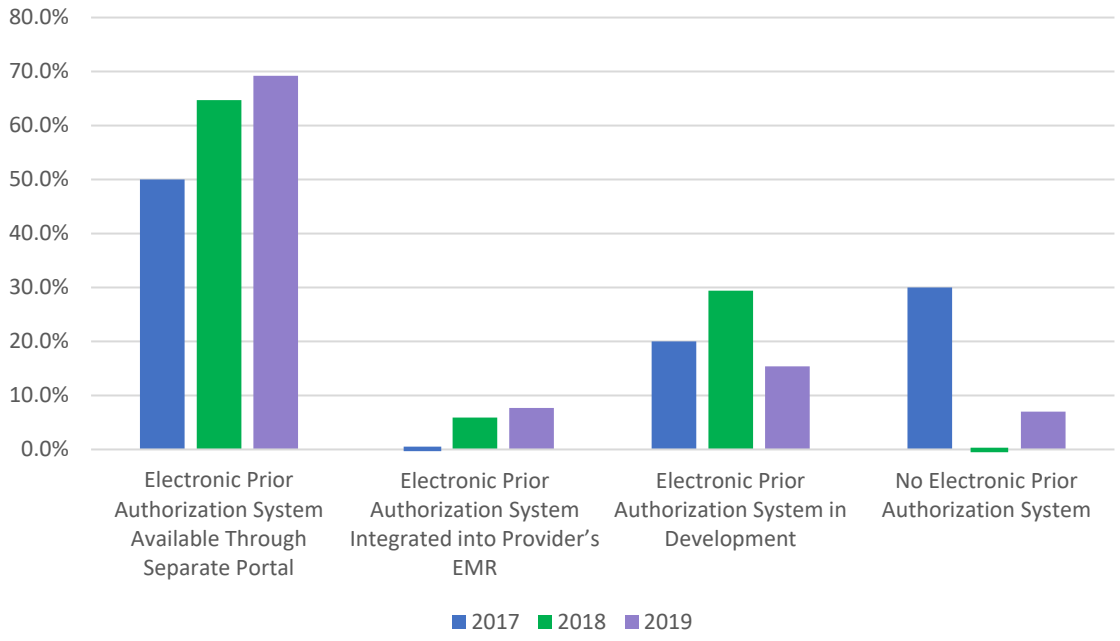
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 8. Utilization of Electronic Prior Authorization Systems with Contracted Pharmacy Benefit Managers (PBMs), 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey

Figure 9. Trends in Utilization of Electronic Prior Authorization Systems with Contracted Pharmacy Benefit Managers (PBMs), 2017-2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 32. Trends in Most Common Approaches by States to Addressing New or High-Cost Drugs, 2017-2019

State Approaches	Percentage of Medicaid MCOs Impacted in 2019	Direction of Change, 2017-2019
Capitation rate adjustment as part of regular rate adjustments	62%	↓
Carved-out the drug costs completely/pay fee-for-service for certain drug(s)	46%	↓
Other[+]	46%	N/A*
States have not addressed the cost	39%	N/A*
Stop-loss provision to cap the plan's cost for the drug	31%	↓
Transition period in which drug(s) are offered in fee-for-service to get claims data then rolled into contracts	23%	↑
Capitation rate adjustments made off the normal rate cycle	23%	↓
None	8%	↑

* We are unable to present trend data for this data point as it was not an answer option for all three years of the survey.

[+]Including risk corridor for high-cost medications, small amount of funds available for one-time coverage of high-cost drugs, value-based arrangements for high-cost and/or specialty drugs, state-mandated preferred drug list that controlled the majority of the pharmacy benefit, reallocation of revenue, risk sharing, and state reimbursement.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

The majority (73%) of health plan respondents indicated being at risk for behavioral health services for their Medicaid members in 2019. Medicaid MCOs reported operational, network, and policy barriers when integrating behavioral and physical health. The majority of health plans indicated that fragmentation in program funding and contracting for physical and behavioral health services (92%), provider capacity to provide integrated physical and behavioral health at point of care (92%), and access to data between care management and behavioral health teams (67%) were common barriers. Barriers that health plans experienced when integrating behavioral and physical health persisted across all three years of the survey. The top operational, network, and policy barriers across all three years of the survey are listed below:

Operational:

- Access to data between care management and behavioral health teams

Network Barriers:

- Provider capacity to provide integrated physical and behavioral health at point of care
- Access to behavioral health providers in select regions (e.g., rural, underserved)

Policy Barriers:

- Fragmentation in program funding and contracting for physical and behavioral health services
- 42 CFR Part 2 limitations on SUD treatment information being shared

A majority of health plans shared additional information in the behavioral health write-in section regarding barriers and challenges to behavioral and physical health integration. Multiple plans mentioned that carve-outs of behavioral health, including specific populations (e.g., SMI, SUD) and a lack of data sharing (e.g. lack of shared HIPAA compliant EHRs, increased privacy around SUD, lack of global informed consent platform, outcomes of therapy and medication adherence), lead to fragmented service delivery and difficulty coordinating care.

In this section of the report, we highlight additional behavioral health findings.

Table 33. Percentage of Medicaid Managed Care Organizations at Risk for Behavioral Health Benefits, by Health Plan Size, 2017-2019

	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
2017	50%	71%	100%	77%
2018	72%	80%	100%	84%
2019	80%	67%	75%	73%

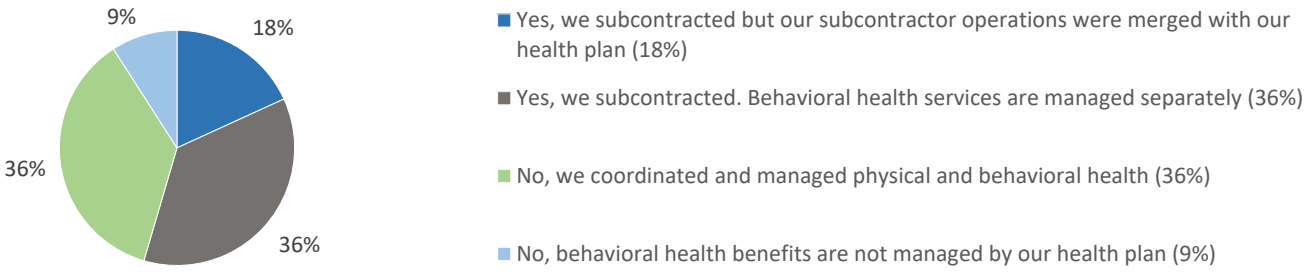
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 34. Percentage of Medicaid Managed Care Organizations with Access to Review Medical Records, Inclusive of Physical and Behavioral Health, 2019

	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	25%	80%	33%	50%
Yes, in some markets	75%	20%	67%	50%
No	0%	0%	0%	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 10. Percentage of Medicaid Managed Care Organizations Subcontracting for Behavioral Health Management, 2019



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 35. Most Common Strategies to Work with Providers to Address Physical and Behavioral Health Needs, 2019

Worked with behavioral health providers to address physical health needs by…	
Information/data sharing on behavioral health	83%
Education	75%
Making screening tools available	50%
Allowing payment for multiple services at the same location and date of service	50%
Embedding physical/behavioral health specialists in medical practices	41%
Helped providers to get paid for case management of behavioral health	41%
Value-based contracting across physical and behavioral health	33%
Other (e.g., integrated care plan, plan only manages mild-to-moderate diagnoses, CMEs for providers)	25%
Worked with physical health providers to address behavioral health needs by…	
Making screening tools available	92%
Education	92%
Information/data sharing on behavioral health	75%
Allowing payment for multiple services at the same location and date of service	58%
Embedding physical/behavioral specialists in medical practices	50%
Helped providers to get paid for case management of behavioral health	50%
Value-based contracting across physical and behavioral health	42%
Other (e.g., integrated care plan, SUD provider toolkit, CMEs for providers)	25%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 36. Most Common Barriers Medicaid Managed Care Organizations Experienced when Integrating Behavioral and Physical Health, 2019

Operational Barriers	Percentage of Medicaid MCOs
Access to data between care management and behavioral health teams	67%
System differences with subcontractor	67%
Communication between care management and behavioral health	50%
Staffing in care management to align skills sets with integrated care needs	42%
Other*	33%
Network Barriers	**Percentage of Medicaid MCOs**
Provider capacity to provide integrated physical and behavioral health at point of care	92%
Behavioral health provider readiness for managed care	58%
Behavioral health provider adoption of electronic health records	58%
Other+	17%
Policy Barriers	**Percentage of Medicaid MCOs**
Fragmentation in program funding and contracting for physical and behavioral health services	92%
42 CFR Part 2 limitations on SUD treatment information being shared	83%
Institutions for Mental Disease (IMD) exclusion	50%
State-specific substance use confidentiality laws	33%
State-specific behavioral health confidentiality laws	33%
Other#	17%

*Including behavioral health carve-out, state carving out benefit to another plan, subcontractor managing the benefit, and being a new plan in the market.

+Including limited network for some specialties and providers not being in-network as part of carve-out.

#Including state-specific bifurcation of mental health care continuum services and SMI being managed by the county system of care.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 37. State-Contracted Behavioral Health Services Included for Medicaid Members, 2019

	Yes, managed by our Medicaid MCO	Yes, subcontracted to a vendor	Varies by population	No
Behavioral health assessment/screening	75%	8%	17%	0%
Outpatient mental health Services	67%	17%	8%	8%
Inpatient mental health Services	50%	17%	8%	25%
Outpatient substance use treatment services	58%	8%	17%	17%
Inpatient/residential substance use treatment services	50%	8%	17%	25%
Detox services (outpatient or residential)	50%	8%	17%	25%
Outpatient substance use treatment services	58%	17%	8%	17%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

The majority (93%) of health plans provided targeted women's health programs for Medicaid members in 2019. Consistent with Medicaid's role in providing coverage for people who are pregnant, 100 percent of health plans indicated that prenatal and postpartum care was a priority women's health topic, with 100 percent also indicating that they had targeted programs and engagement strategies. Additional common priority topics included general behavioral health (93%) and cancer screening and treatment (79%). The majority of health plans reported that aged, blind, and disabled (ABD) women maintained their coverage for at least one year, and dually-eligible women maintained their coverage for two or more years. Pregnant individuals, parents, and childless adults were enrolled for time-limited periods before losing eligibility or qualifying for another program.

Common challenges that the respondents continue to address fell into three primary categories:

Care delivery, including:

- Lack of access to long-acting reversible contraception during inpatient stay for delivery
- Lack of member participation in care management programs
- Understanding how racial disparities affect pregnancy and birth outcomes
- High prevalence of substance use/opioid use disorder among pregnant people
- Members' social needs (e.g., accessing care, child care difficulties, and food insecurity)
- Shifting focus on women's health before and outside of pregnancy

Data, including:

- Lack of access to accurate contact information
- Lack of timely access to out-of-network hospital delivery information to follow up with postpartum members
- Early identification of pregnant people

Regulations, including:

- State regulations limiting system capacity to provide innovative models of care at birth centers with midwifery models and doula support
- Medicaid provider requirements and network adequacy
- Loss of eligibility for mothers 60 days postpartum

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

Table 38. Percentage of Medicaid Managed Care Organizations with Targeted Women's Health Programs, by Health Plan Size, 2017-2019

	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
2017	100%	86%	100%	92%
2018	86%	80%	100%	89%
2019	100%	83%	100%	93%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 39. Women's Health Priorities Identified by Medicaid Managed Care Organizations Compared to Targeted Health Plan Programs & Engagement Strategies across the Lifespan, 2019

Priorities	Percentage of Medicaid MCOs Indicating a Priority	Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies on Priority Topic
Prenatal and postpartum care	100%	100%
Behavioral health, generally	93%	57%
Cancer screening and treatment	79%	71%
Substance use disorder	71%	50%
Family planning	71%	57%
Depression/Anxiety	71%	64%
Diabetes	71%	71%
Heart disease	50%	43%
Sexual health	50%	43%
Obesity	43%	36%
Other (e.g., oral health, rural health)	14%	7%
Eating disorders	7%	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 40. Average Duration of Enrollment among Female Medicaid Managed Care Organization Members, 2019

	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%	39%	46%	15%	0%
Female parents	0%	8%	25%	50%	17%
Female adults (Expansion population)	8%	0%	17%	58%	17%
Female aged, blind, and disabled	0%	0%	0%	83%	17%
Female Medicare and Medicaid eligible (Duals)	0%	0%	8%	67%	25%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 41. Top-Five Issues Associated with Churn for Women Enrolled in Medicaid Managed Care Organizations, 2019

Issues	Percentage of Medicaid MCOs
Clinical care disruption and care management continuity	77%
Completeness of patient/member history	62%
Maintaining access to providers and care	62%
Quality measure disruption	54%
Repeated member on-boarding	23%
None	8%

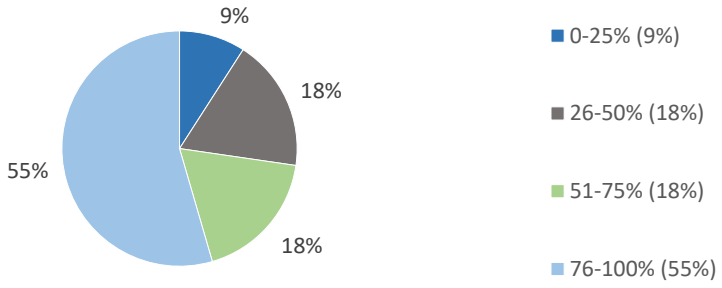
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 42. Providers Serving as a Primary Care Provider for Women, 2019

Provider Type	Percentage of Medicaid MCOs
Family physicians	100%
Obstetricians/Gynecologists	92%
Pediatricians	92%
Internists	85%
Nurse Practitioners	69%
Geriatricians	54%
Nurse-Midwives	31%
Other (e.g., maternal health homes for pregnant members with SUD, FQHCs, physician assistants)	15%
School-based health centers	15%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 11. Percentage of Women across All Markets Enrolled in a Medicaid Managed Care Organization with an Established Primary Care Provider, 2019



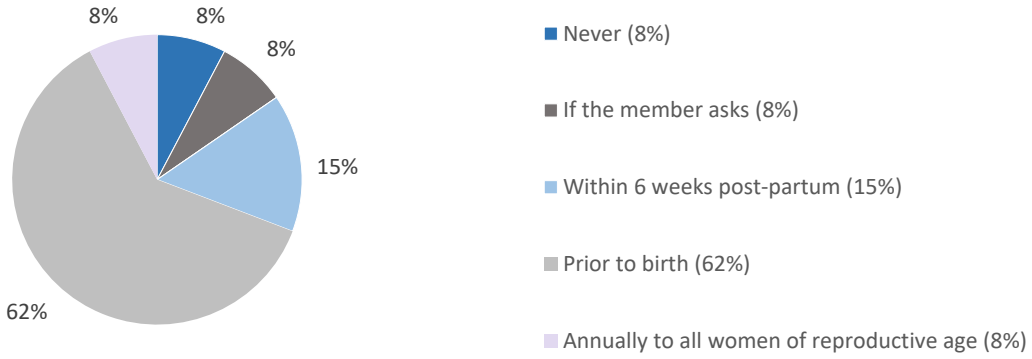
Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 43. Providers Offering Members Contraception Counseling and Services, 2019

Provider Type	Percentage of Medicaid MCOs
Freestanding family planning clinics	100%
Planned Parenthood clinics	100%
Federally Qualified Health Centers (FQHCs)	100%
Hospital-based clinics	100%
State or local health departments	92%
Community health/Rural health centers	92%
School-based clinics	39%
Other (e.g., primary care practices, safety-net clinics, hospitals)	23%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Figure 12. Timing of Post-Partum Contraception or Sterilization Information Provided by Medicaid Managed Care Organizations, 2019



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. 2020 Annual Medicaid MCO Survey.

All health plans offered targeted child health programs in 2019. Furthermore, over 93 percent of health plans, regardless of size, contracted with the state Medicaid agency to provide coverage for children with special healthcare needs (CSHCN). The survey respondents identified an array of child and adolescent health priority topics specific to health and social needs. The most common priority topics identified were CSHCN (93%), ADHD/ADD (87%), behavioral health screening and treatment (80%), and asthma (80%). Similarly, the most common targeted programs and engagement strategies were focused on CSHCN (87%), asthma (80%), behavioral health screening and treatment (67%), and ADHD/ADD (67%). The survey found 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 providing information and coordinating with other needed social service organizations (e.g., faith-based, housing, nutrition, non-profit, etc.) as part of care plan development and adherence (100%), supported and encouraged adherence to care plan (100%), and care coordination (100%). However, barriers persisted, including carved-out services creating inefficiencies in services for families (73%), poor communication among multiple providers to families (60%), and carved-out services creating an increased risk for duplication and costs (53%).

Table 44. Percentage of Medicaid Managed Care Organizations Offering Targeted Child Health Programs, by Health Plan Size, 2017-2019

	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
2017	100%	86%	100%	92%
2018	86%	100%	100%	95%
2019	100%	100%	100%	100%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 45. Child & Adolescent Health Priorities Identified by Medicaid Managed Care Organizations Compared to Targeted Health Plan Programs & Engagement Strategies, 2019

Priorities	Percentage of Medicaid MCOs Indicating a Priority	Percentage of Medicaid MCOs with Targeted Programs & Engagement Strategies for Priority Issue
CSHCN	93%	87%
ADHD/ADD	87%	67%
Behavioral health screening and treatment	80%	67%
Asthma	80%	80%
Diabetes	67%	60%
Autism spectrum disorder	67%	53%
Depression/Anxiety	67%	47%
Obesity	60%	60%
Dental health	60%	53%
Adverse Childhood Experiences	60%	40%
Substance use disorder	60%	60%
Teen pregnancy	60%	40%
Transitioning to adulthood and independence	53%	33%
Tobacco use	47%	33%
Sex education	20%	20%
Other (e.g., lead screenings, immunizations, and well-care visits)	20%	27%
Health disparities impacting sexual and gender minorities	20%	13%
Success in school	13%	7%
Readiness to start school	7%	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 46. Trends in the Most Common Barriers for Medicaid Managed Care Organizations Serving Child and Adolescent Members, 2017-2019

Barrier	Percentage of Medicaid MCOs in 2019	Direction of Change, 2017-2019
Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)	67%	↓
Churn (member or eligibility-related)	67%	N/A*
Policies or program structures that create barriers if the parent(s) have more than one child (e.g. transportation policies)	60%	↓
Engaging family members who are not enrolled in the same plan to address social determinants of health	47%	↓
Language barriers within families	47%	↓
Program fragmentation	23%	↓
None	20%	↑
Other[+]	13%	N/A*

* We are unable to present trend data for this data point as it was not an answer option for all three years of the survey.

[+]Including inaccurate mailing addresses, parents unaware of annual renewal requirement, coordination of care for infants with Neonatal Abstinence Syndrome (NAS).

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 47. Percentage of Medicaid Managed Care Organizations Contracting with State Medicaid Agencies for Children with Special Healthcare Needs (CSHCN), by Health Plan Size, 2019

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
100%	83%	100%	93%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 48. Most Common Benefits Managed by Medicaid Managed Care Organizations for CSHCN, 2019

Benefits	Percentage of Medicaid MCOs
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	100%
Supported and encouraged adherence to care plan	100%
Care coordination	100%
Supported the member in identifying and connecting with providers (in addition to supplying the provider directory)	93%
Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential)	93%
Helped in making appointments with providers	86%
Arranged transportation for appointments	86%
Supported members' preparedness for appointments	86%
Engaged a care team of professionals to address members' needs	86%
Vaccines	86%
Caregiver support	86%
Coordinated behavioral health services	79%
Developed a comprehensive plan of care with the family/caregivers	79%
Conducted risk assessments	79%
Coordinated in-home services	79%
Served as a single point of contact for the member	79%
Transition planning (e.g., acute care to residential care, residential care to the community)	79%
Medication management	79%
Transportation to and from medical appointments	79%
Equipment and supplies	71%
Parent education	71%
Lab testing	64%
Nutrition education	64%
Family transportation and lodging for out-of-town/state specialist visits	50%
Pre-Exposure Prophylaxis (PrEP)	43%
Gender-affirming care for transgender/gender-nonconforming children and adolescents	43%
School-based healthcare services	36%
Shared data with social services	29%
Screened for social isolation	29%
Other	7%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 49. Trends in the Most Common Barriers Experienced by Medicaid Managed Care Organizations when Serving CSHCN, 2017-2019

Barrier	Percentage of Medicaid MCOs in 2019	Direction of Change, 2017-2019
Carved-out services created inefficient services for families (e.g., too many coordinators)	73%	↑
Poor communication among multiple providers to families	60%	↑
Carved-out services created an increased risk for duplication and costs	53%	↓
Misinformation about managed care value to CSHCN	33%	↓
Lack of consistent quality measures specific to unique needs of CSHCN	27%	↓
Consistency in identification parameters	27%	↓
Insufficient information regarding the goals and preferences of CSHCN and their families	27%	N/A*
None	13%	↑
Other+	7%	N/A*

* We are unable to present trend data for this data point as it was not an answer option for all three years of the survey.

+Including having an all or none care model or a whole person care model that can be confusing.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

In 2019, over half (53%) of survey 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, compared to less than half of medium and small health plans (i.e. between 250,001 and 1 million covered lives and less than 250,000 covered lives, respectively). Of the health plans at risk, regardless of size, 100 percent assigned a care coordinator for more than 75 percent of their MLTSS members.

Three-quarters of health plans reported completing the enrollment and assessment process for the new member in less than 30 days, and all Medicaid MCOs 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 (100%).

Across all three years of the survey, 100 percent of Medicaid MCOs indicated performing the following core functions within MLTSS care coordination models:

- Conducted risk assessments
- Engaged a care team of professionals to address the needs of the member
- Developed a plan of care
- Supported and encouraged adherence to care plan
- In addition to supplying the provider directory, supported the member in identifying and connecting with providers
- Coordinated in-home services
- Coordinated home and community-based services
- Transition planning (e.g., acute care to residential care; residential care to the community).

Furthermore, 100 percent of Medicaid MCOs utilized care teams for their MLTSS members in 2019. Across all three years of the survey, 100 percent of Medicaid MCOs noted that individual members, family members, and health plan care coordinators were included in MLTSS care teams.

From 2017 to 2019, 100% of Medicaid MCOs indicated inclusion of the following care plan and medical components:

Care Plan Components:

- Caregiver information and status
- Goals – personal and care goals
- Primary care provider
- Emergency (crisis) plan

Medical Components:

- Community transition plan
- Durable medical equipment use, hearing aids and vision impairments
- Activities of daily living (i.e., feeding, dressing, toileting, ambulating, sleep)

When designing MLTSS programs, health plans indicated two common barriers: misalignment between Medicaid and Medicare (75%) and state program requirements that limit effectiveness of managed care strategies (e.g., any willing provider provisions, continuity of care provisions) (63%). Health plans also reported that duplication of assessments between health plans and other agencies/providers along with adequacy of the HCBS network when entering a new MLTSS market were important considerations that affected the plan's ability to manage MLTSS. Finally, the most common approaches for innovation in MLTSS that were led by health plans in 2019 were member-centric, including self-advocacy (88%) and innovative approaches for caregiver supports and services (63%). Furthermore, health plans commonly offered innovative approaches for partnerships with community-based organizations (50%), wellness initiatives (50%), and "money follows the person" community transition programs (50%).

Table 50. Percentage of Medicaid Managed Care Organizations At-Risk for MLTSS, by Health Plan Size, 2017-2019

	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
2017	50%	86%	100%	85%
2018	43%	60%	100%	67%
2019	40%	33%	100%	53%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 51. Percentage of Medicaid Managed Care Organizations Utilizing a Different Clinical Model of Care for MLTSS Members, by Health Plan Size, 2019

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%	75%	75%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 52. Most Common Core Functions Performed by Medicaid Managed Care Organizations for MLTSS Care Coordination Models, 2019

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 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	100%
Coordinated behavioral health services	100%
Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence	100%
Helped in making appointments with providers	100%
Provided guided referrals or "hand-offs" to other needed social services (e.g., faith-based, non-profit, or other government programs)	100%
Provided information on other needed social services (e.g., faith-based, nonprofit, other government programs)	100%
Served as a single point of contact for the member	100%
Supported the member preparedness for appointments	100%
Screened for social isolation	100%
Caregiver support	88%
Shared data with social services	84%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 53. Most Common Individuals in Care Team Composition for MLTSS, 2019

Individuals	Percentage of Medicaid MCOs
Care coordinator within the health plan	100%
Family member	100%
Individual member	100%
Guardian	88%
Member's primary care provider	88%
Behavioral health specialist within the health plan	75%
Natural/community supports other than guardian	75%
Other health care professional not employed by the health plan	75%
Representative from primary care clinician office	63%
Pharmacist within the health plan	63%
Community health worker within the health plan	50%
Peer support specialist within the health plan	50%
Other (e.g., MLTSS member advocate or medical director, individual the member wanted to invite)	25%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 54. Most Common Components Included in MLTSS Care Plans Offered by Medicaid Managed Care Organizations, 2019

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	88%
Other+	50%
Medical Components	**Percentage of Medicaid MCOs**
Activities of daily living (i.e., feeding, dressing, toileting, ambulating, sleep)*	100%
Community transition plan*	100%
Current health/medical status	100%
Durable medical equipment use, hearing aids, and vision impairments*	100%
Medication list	100%
Safety screening (i.e., feeling safe and secure)	100%
Behavioral health status/condition (i.e., depression, anxiety, stress, drug, alcohol screening)	88%
Recent hospitalizations or emergency department visits	88%

* Note: 100% of Medicaid MCOs indicated including this component in MLTSS care plans across the past three years (2017-2019) of the survey.

+Including communication preferred language, assessed and unmet needs, services, special instructions, frequency and any type of HCBS, community services, risk and protective factors, cultural consideration, and back-up plans.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 55. Most Common Program Design Considerations to Manage LTSS, 2019

Program Design Considerations	Percentage of Medicaid MCOs
Medicare and Medicaid misalignment creates challenges and financial disincentives	75%
State program requirements that limit effectiveness of managed care strategies (e.g., any willing provider provisions, continuity of care provisions)	63%
State requirements for health plans to contract with specific organizations or providers for care coordination	50%
Waiver waitlists	50%
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)	50%
Appropriate benefit and program design to allow for community transitions and long-term sustainability	50%
Member churn	50%
Fragmented Medicaid benefit design – behavioral health and/or physical health benefits – limits ability to serve the whole individual	38%
Other (e.g., adequacy of HCBS network, duplication of assessments)	25%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 56. Frequency of Innovations Leveraged by Medicaid Managed Care Organizations for LTSS, 2019

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	13%	25%	38%	25%
Telehealth other than remote monitoring that is specific to the MLTSS population	0%	25%	38%	38%
Care coordination communication tools with caregivers, direct services workers, and other in-home providers or support organizations	38%	38%	25%	0%
Partnerships with community-based organizations (e.g. AAAs, CILs)	50%	38%	25%	0%
Electronic visit verification	13%	25%	25%	38%
Value-based payment arrangements with MLTSS providers	13%	0%	38%	50%
Caregiver supports and services (outside of administering benefits required by state plan)	63%	25%	0%	13%
Wellness initiatives	50%	38%	0%	13%
Healthy eating or nutrition pro-grams outside of administering benefits required by state plan	38%	25%	13%	25%
Unique housing strategies outside of administering benefits required by state plan	25%	63%	13%	0%
Money follows the person or community transition programs	50%	38%	13%	0%
Self-advocacy	88%	13%	0%	0%
Employment initiatives outside of administering benefits required by state plan	13%	38%	38%	13%
Tools for self-direction	38%	50%	13%	0%
Transportation innovations	25%	38%	38%	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

In 2019, all respondents indicated offering targeted SDOH programs. The most common populations that were targeted for SDOH programs were homeless/housing insecure (87%), people who were pregnant (73%), and adults with serious mental illness (67%). A comprehensive table on page 61 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 prevention).

100 percent of respondents offered targeted SDOH programs in 2019.

It was noticeable in the survey findings that there were multiple screening tools being used but not one across all Medicaid MCO respondents. Most of the health plans (50%) indicated utilizing an internally developed or adapted tool, with 13 percent not using any tool.

Health plans shared ways that the state supported their SDOH initiatives for their Medicaid members, including:

- Approved a plan to pay for a non-covered SDOH benefit (i.e., housing navigation support);
- Participated in trainings (i.e., trauma-informed care);
- Created a common referral tool;
- Started a pilot to address food security for members who have congestive heart failure.

Health plans shared the following ways they supported providers to screen, refer, and/or follow-up on SDOH needs:

- Provided a screening tool and educated providers on social needs services in the local area;
- Provided access to a repository of community agencies and supports;
- Included value-added incentives for screening/assessment completion;
- Secured a grant to build capacity to capture SDOH data electronically in the EHR.

SDOH were assessed and evaluated with a variety of metrics including cost utilization (67%), cost savings (67%), and access to care (60%). A few plans also mentioned they used market capacity (i.e., amount of food available in food banks), and one plan mentioned using the percentage of eligible populations impacted by social needs services that were offered as their metrics to assess and evaluate SDOH initiatives. Of the 53 percent of respondents who mentioned that performance measures were used to assess and evaluate SDOH initiatives, the most common were HEDIS scores (prenatal visit, postpartum visit, well-child visit), number of members engaged and participating in programs, referrals completed, incomplete/pending referrals, community-based organization capacity (completed vs. denied referrals), denied referrals, utilization metrics including inpatient, emergency department, and unnecessary care, risk-stratification-level changes, and housing stability.

Multiple Medicaid MCOs shared that community-based organization (CBO) capacity to serve members' needs continues to be a significant barrier for all stakeholders. They are also looking for ongoing and sustainable resources to address their members' social needs. Health plans frequently cited housing resources along with access to healthy foods as social needs that are affected by limited capacity.

CBO capacity to serve members' needs remains a significant barrier for health plans.

Table 57. Percentage of Medicaid Managed Care Organizations with Targeted SDOH Programs, by Health Plan Size, 2019

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%	100%	100%	100%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 58. Percentage of Medicaid Managed Care Organizations Providing Targeted Social Determinants of Health Programs, by Population, 2019

Population	Percentage of Medicaid MCOs
Homeless/housing insecure	87%
Pregnant women	73%
Adults with serious mental illness	67%
Adults with substance use disorder	53%
Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)	53%
Expansion members	47%
Adults with disabilities (e.g., physical, intellectual, developmental)	40%
Children with Special Healthcare Needs (CSHCN)	40%
Medicare and Medicaid enrollees (Duals)	40%
Geographic location	40%
Criminal justice involved	33%
Child welfare/Child protective services involving families	27%
Foster care youth/Youth transitioning to adulthood	27%
Other*	27%
HIV/AIDS	20%
Residential institution/Facility-placed individuals	13%
Individuals in Institutions for Mental Diseases (IMD)	7%
Sexual and gender minorities	7%

*Including available to any member based on needs assessment; members with chronic diseases or elevated blood lead levels; high school seniors; and members with cognitive issues such as dementia, Alzheimer's, or autism.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 59. Most Common Social Needs Identified by Medicaid Managed Care Organizations for Their Members, 2019

Social Need	Percentage of Medicaid MCOs
Nutrition food security	100%
Housing	93%
Employment, job placement, and/or skills training	93%
Non-emergency medical transportation (NEMT)	93%
Non-medical transportation	87%
Application assistance (e.g., TANF, SNAP, Special Supplemental Nutrition Program for WIC)	87%
Utilities	80%
Financial literacy (i.e., assistance with household budgets and finances)	80%
Social isolation/Sense of belonging	73%
Education	73%
Environmental health (e.g., lead abatement)	67%
Violence/Interpersonal violence	53%
Trauma	40%
Not assessed/No information collected	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Key for Table 60

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 60. Percentage of Medicaid Managed Care Organizations Providing Targeted Strategies to Address Social Needs, 2019

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	73%	73%	53%	73%	60%	53%	73%	73%	67%	53%	60%	60%
Assessed/Screened for member needs	93%	93%	73%	80%	53%	67%	73%	67%	73%	60%	60%	47%
Provided application assistance	60%	80%	13%	47%	40%	13%	33%	40%	7%	33%	13%	7%
Provided caregiver support	53%	33%	33%	20%	20%	27%	40%	27%	27%	20%	33%	20%
Utilized peers	47%	53%	60%	40%	20%	27%	27%	27%	20%	27%	27%	33%
Used community health workers	60%	60%	40%	53%	33%	60%	60%	53%	53%	47%	27%	27%
Engaged interdisciplinary community care team including CBOs	67%	47%	27%	33%	13%	40%	33%	33%	27%	20%	27%	27%
Identified and coordinated with CBOs to link members with needed social services	93%	80%	47%	67%	40%	47%	60%	73%	67%	67%	53%	40%
Provided guided referrals or "hand-offs" to other needed social services	93%	80%	53%	47%	33%	60%	53%	67%	47%	47%	47%	40%
Engaged in direct community investment and capacity building	73%	73%	47%	60%	40%	33%	33%	20%	47%	40%	27%	33%
Worked with local health departments to address challenges or coordination of services	53%	33%	20%	27%	20%	7%	7%	13%	20%	60%	20%	20%
Coordinated with schools to provide IEP services	0%	0%	0%	33%	7%	0%	0%	0%	13%	13%	0%	7%
Coordinated with social services as part of care plan development and adherence	60%	40%	47%	33%	27%	27%	20%	13%	33%	33%	27%	27%
Established agreement for data sharing with social services and community partners	40%	20%	0%	13%	0%	13%	7%	7%	0%	13%	20%	13%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 61. Most Common Programs Led by Medicaid Managed Care Organizations to Assist with Homelessness or Housing Instability, 2019

Program	Percentage of Medicaid MCOs
Case management or care coordination for homeless or housing-insecure individuals	93%
Outreach to members or potential members who were homeless or housing insecure to help them access health care coverage and services	80%
Partnership with state or local housing agencies or organizations	73%
Respite, palliative, or recuperative care for homeless or housing-insecure individuals	67%
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	60%
Participation in a state-level, Medicaid-housing initiative	33%
Payment for Medicaid-covered, housing-related services	27%
Other*	27%
None	7%

*Including hired a housing specialist, worked with CBOs and NGOs to address housing needs, provided outreach and coordination for homeless members, invested in permanent housing and supportive services for members, and planned for a housing partnership.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 62. Most Common Social Determinant of Health Screening Tools Used by Medicaid Managed Care Organizations, 2019

Screening Tool	Percentage of Medicaid MCOs
Other (e.g., internally developed, adapted versions of other tools)	50%
Internally developed tool that is not based on one of the tools listed	47%
Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)	27%
Adaption of one or more of the tools listed	27%
Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Health-Related Social Needs Screening Tool	20%
Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)	20%
State mandated tool	20%
American Community Survey	13%
None	13%
Tool(s) embedded in provider EHR	13%
Social Determinants Screening Tool, AccessHealth Spartanburg, CHCS version	7%
Social Needs Screening Toolkit, HealthLeads USA	7%
Arizona Self Sufficiency Matrix	0%
Self-Sufficiency Outcomes Matrix, OneCare Vermont, CHCS version	0%
The EveryOne project: Advancing health equity in every community, Toolkit by American Academy of Family Physicians (AAFP)	0%

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 63. Most Common Approaches Used by States to Support the Efforts of Medicaid Managed Care Organizations to Address Social Needs, 2019

State Approaches to Support Medicaid MCOs	Percentage of Medicaid MCOs
Made policy/regulatory changes to support SDOH initiatives	47%
Submitted/received approval for a Medicaid waiver(s) that included support of SDOH initiatives	40%
Other*	33%
Provided financial support	27%
States did not support social needs initiatives	20%
Allowed or improved data sharing	20%
Provided screening tools	20%
Provided administrative assistance	13%
Provided support for cultural and linguistic competency	13%
Improved analytic capacity	0%

*Including state approval for health plan to pay for non-covered SDOH benefits, participation in trainings, creation of a common referral tool, and pilot with state to address food security for members with congestive heart failure.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 64. Most Common Approaches Used by Medicaid Managed Care Organizations to Support Provider Efforts to Address Social Needs, 2019

Medicaid MCO Approaches to Support Providers	Percentage of Medicaid MCOs
Member stratification	60%
Data or information sharing	53%
Staff	53%
Pay-per-performance incentives	40%
Other*	33%
Ability to bill for multiple codes, joint billing	33%
No incentives/supports were provided	20%

*Including access to repository of agencies and community supports, value-added incentive for screening/assessment completion, training, provided screening tool, education on SDOH services in local area, and capacity building to capture SDOH data in the EHR.

Source: Institute for Medicaid Innovation. 2020 Annual Medicaid MCO Survey.

Table 65. Most Common Metrics Used by Medicaid Managed Care Organizations to Assess and Evaluate Social Determinants of Health Initiatives, 2019

Metrics Used by Medicaid MCOs	Percentage of Medicaid MCOs
Cost utilization	67%
Cost savings	67%
Access to care	60%
Performance measures	53%
Other*	27%
No performance metrics were used	20%

*Including market capacity, return on investment, measurement of needs versus capacity to serve, percentage of eligible population impacted by SDOH services, and ability to capture SDOH data.

Source: Institute for Medicaid Innovation. 2020 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 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 2020 survey captured key characteristics across almost every state with Medicaid managed care, with survey respondents representing 67 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 2020 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 14, 2020, with a completion deadline of March 13, 2020. To accommodate shifting priorities during this time because of COVID-19, extensions were granted to health plans in need of extra time through May 8th. The IMI strongly encouraged each Medicaid health plan to identify a primary person within its 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 2019; otherwise, there were no exclusion criteria. The survey captured key characteristics across almost every state with Medicaid managed care, with survey respondents representing 67 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 2019 data from Health Management Associates (HMA).

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 and ACAP 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.

In the 2020 survey, we clarified for each question that we were seeking information across all markets. In consultation with experts, we added additional questions about programs to address sexual and gender minority health care as well as the provision of gender-affirming care for transgender and gender-nonconforming members. We also updated our SDOH section to gain deeper insight into the use of SDOH screening tools and barriers that a state could mitigate for Medicaid managed care organizations to better address SDOH.

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 that 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. These include High-Risk Care Coordination, Value-Based Purchasing, Pharmacy, Behavioral Health, Women's Health, Child and Adolescent Health, Managed Long-Term Services and Supports, 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 might not generalize to all Medicaid-covered lives. However, the survey was able to capture data representing 67 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 or 2020 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 that completed the survey for the purpose of this annual report.

Appendix B: Survey Acronyms and Definitions

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

AAA: Area Agency on Aging.

ACO: Accountable Care Organization.

ADHD/ADD: Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder.

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.

DSNP: Dual Special Needs Plan.

DUR: Drug Utilization Review.

EHR: Electronic Health Record.

FFS: Fee-for-service.

FQHC: Federally qualified health center.

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 Treatment.

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

MLTSS: Managed 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.