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Medicaid Access & Care in 2020

Results from the Institute for Medicaid Innovation's 2021 Annual Medicaid Health Plan Survey

INSTITUTE FOR MEDICAID INNOVATION

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Table of Contents

Executive Summary

Since the launch of the Annual Medicaid Health Plan Survey, we have learned and shared a tremendous amount of information derived from Medicaid health plans' core services, experiences, and operations. This information was gleaned while each health plan supported millions of people covered under Medicaid. We have worked continuously to improve our survey, year after year, and, with the addition of trending data since the first publication of the results, our reports have improved dramatically.

Although we are excited about our fourth-year survey, like the entire nation, the Institute for Medicaid Innovation (IMI) had to pivot and respond to the events surrounding the COVID-19 pandemic. The deadline for the completed 2020 survey coincided with the week that the nation shut down. We pondered difficult decisions, including whether we could produce a report in 2020, recognizing the bandwidth of the health plans to complete the survey while faced with the urgent need to be responsive to their members' needs during the pandemic. However, to our great surprise, the Medicaid health plans were able to complete the survey with a three-month extension from the original deadline, and a report was released at the end of the year.

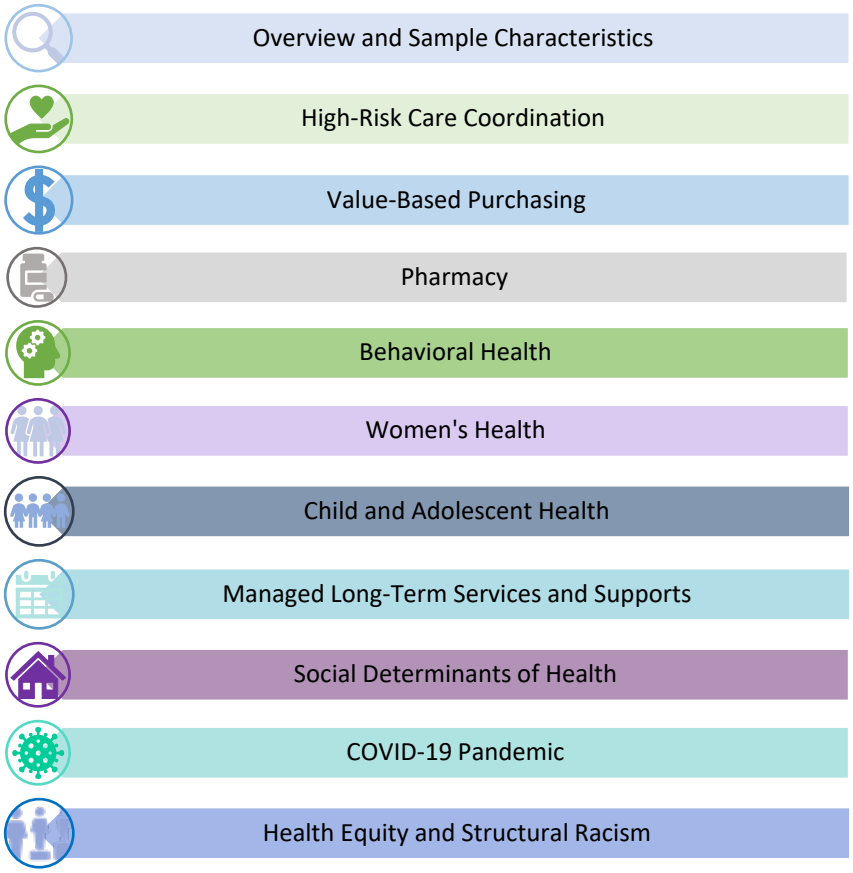
As we considered the role of the pandemic on the lives of those covered by Medicaid, we decided it would be best to focus on improvement and advancement of data and enhancing our core concepts and benchmarks. Readers will notice that this year's report has additional sections focused on the COVID-19 pandemic and health equity and structural racism. Health plans continue to serve a central role in curtailing the spread of COVID-19, managing the health of populations during unprecedented times, and leading efforts to address and properly resolve social problems necessary for survival. Paramount to the pandemic is a rigorous and appropriate space created to address inequities throughout the United States health system. The Annual Medicaid Health Plan Survey distills various common characteristics of health plans in order to provide accessible and useful insights into managed care across the country.

Development

This fourth survey continues to represent the first-of-its-kind comprehensive effort to collect robust, longitudinal data on Medicaid health plans. Under the leadership and vision of IMI's founding executive director, Dr. Jennifer Moore, the annual Medicaid health plan survey was developed through the contribution of national experts in Medicaid. The experts, representing knowledge in health plan 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 health plans and to inform salient policy issues. The survey findings contained in this report are intended to equip Medicaid stakeholders with the information they need to accurately articulate the national narrative about Medicaid managed care.

Domains

For the 2021 survey, representing coverage in 2020, all Medicaid health plans were invited 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 health plans 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 response rate for the survey is calculated by Health Management Associates (HMA) utilizing their proprietary data set. The denominator excludes covered lives who are in non-managed care health plans, state pilot health plans (e.g., Colorado), carved-out health plans (e.g., Medicaid behavioral health), and health plans with limited Medicaid coverage (e.g., only dually eligible members). The 68-page survey report provides a comprehensive look into Medicaid managed care in 2020 and longitudinally over a four-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

In 2020, 100 percent of health plan respondents provided high-risk care coordination for members, and 95 percent tracked the effectiveness of their efforts by monitoring metrics such as emergency department utilization (HEDIS measure; 95%), inpatient utilization (HEDIS measure; 95%), and patient experience survey results (79%). Across all four years of the survey, the ability to contact members and members' willingness to engage were the top two barriers for Medicaid health plans providing high-risk care coordination.

Across all four years of the survey, the ability to contact members and members' willingness to engage were the top two barriers.

Value-Based Purchasing (VBP)

Almost all Medicaid health plan respondents (90%) utilized an alternative payment model (APM) or value-based purchasing (VBP) arrangement in 2020, with 100 percent of medium (i.e., 250,001 to 1 million covered lives) and large (over 1 million covered lives) health plans reporting having an arrangement in place. Other key findings from 2020 included:

90% utilized an alternative payment model (APM) or value-based purchasing (VBP) arrangement in 2020.

- Most respondents (73%) implemented VBP arrangements with a majority of primary care providers.
- The majority of respondents did not implement VBP arrangements with dentists (89%), nurse-midwives (84%), or orthopedists (84%).
- Three-quarters (75%) of respondents were required by the state in which their plan operated to implement a VBP or APM contract with providers.
- Eighty-four percent (84%) of respondents used or considered Healthcare Effectiveness Data and Information Set (HEDIS) measures as part of their VBP models.
- The most frequently used payment strategies were payment incentives based on performance measures related to access to care (78%), payment incentives for the availability of same-day or after-hours appointments (56%), and enhanced payment rates for hard-to-recruit provider types (56%).
- From 2017 to 2020, all external factors impacting the adoption of and innovation in VBP/APMs decreased between 16 (provider readiness and willingness) and 83 (impact of 42 CFR Part 2 on limiting access to behavioral health data) percentage points.

Pharmacy

The majority of Medicaid health plan respondents (80%) were at-risk for pharmacy benefits in at least one market in 2020. The most common challenges noted by health plans in managing prescription drug benefits included utilization and cost history unknown for new drugs entering a market (75%) and an increase in the number of specialty pharmacy medications (69%).

A majority of health plan respondents (81%) used pharmacists for medication therapy management (MTM) in at least one market. Three-quarters (75%) of respondents supported an e-prescribing system through a contracted PBM. Over half of states that Medicaid health plan respondents had contracts with addressed the costs of new or high-cost drugs through carving out the drug costs completely (56%) or making capitation rate adjustments as part of regular rate adjustments (63%).

Behavioral Health

Eighty-five percent of Medicaid health plan respondents indicated being at-risk for behavioral health services in at least one market in 2020. Over half of respondents directly managed behavioral health assessments/screenings (61%) and outpatient mental health services (56%) for members. Health plans identified the following barriers to integrating physical and behavioral health services in 2020:

85% of Medicaid health plan respondents indicated being at-risk for behavioral health services in at least one market in 2020.

- **Operational Barrier:** Access to data between care management and behavioral health teams (61%)
- **Network Barrier:** Provider capacity to provide integrated physical and behavioral health at point of care (89%)
- **Policy Barrier:** 42 CFR Part 2 limitations on substance use disorder (SUD) treatment information being shared (89%)

Approximately one-third of respondents did not have contracts with state Medicaid agencies that included inpatient mental health services (33%), outpatient substance use treatment services (28%), inpatient/residential substance use treatment services (33%), or detox services (outpatient or residential, 28%).

Women's Health

Ninety-five percent of health plan respondents offered targeted programs to address women's health in 2020. More than three-fourths of respondents had specific targeted programs and engagement strategies for the following health priorities:

- Prenatal and postpartum care (90%)
- Behavioral health, generally (84%)
- Health disparities (84%)
- Social needs (79%)

In 2020, health plans addressed maternal health outcomes and the social needs of pregnant individuals in the following ways:

- Respondents led initiatives to improve maternal health outcomes and experiences (79%) and initiated new policies or programs to address the social needs of pregnant individuals (63%).
- Over half (58%) of health plan respondents contracted with vendors that provided additional or dedicated resources for meeting the social needs of pregnant individuals.

Child and Adolescent Health

Almost all Medicaid health plan respondents (95%) offered targeted programs to address the health of children and adolescents in 2020. The programs and engagement strategies specifically targeted the following health priorities:

- Asthma (84%)
- Behavioral health screening and treatment (68%)
- Attention Deficit Hyperactivity Disorder (ADHD/ADD) (68%)
- Depression/anxiety (63%)
- Children with special healthcare needs (CSHCN) (74%)

The top barriers to serving children enrolled in Medicaid were identifying and coordinating with schools (74%) and policies and program structures that create barriers if the parent(s) has/have more than one child (63%). The top barriers cited when serving CSHCN were uncoordinated communication among multiple providers to families (72%) and carved-out services that created inefficient services for families (56%).

Managed Long-Term Services and Supports (MLTSS)

Sixty percent of Medicaid health plan respondents were at risk for managed long-term services and supports in at least one market in 2020, and 58 percent of those at risk utilized a different clinical model of care for individuals enrolled in MLTSS programs than for those in general Medicaid managed care contracts.

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Key findings from the MLTSS category in 2020 included:

- Medicare and Medicaid misalignment resulting in challenges and financial disincentives was cited as the top program design challenge (75%) that affected a plan's ability to manage LTSS.
- Approximately half of Medicaid health plan respondents indicated always leveraging wellness initiatives (50%) and self-advocacy (58%) for MLTSS members.

Social Determinants of Health (SDOH)

Almost all Medicaid health plan respondents (95%) offered targeted programs to address social determinants of health in 2020. Respondents most frequently offered targeted SDOH programs for the following populations:

- Homeless/housing insecure (79%)
- Pregnant individuals (68%)
- Adults with serious mental illness (63%)

Housing and food security (100%) were identified as the number-one social need for members, and over half of respondents (53%) utilized an internally developed SDOH screening tool. Additional key findings included:

Housing and food security (100%) were identified as the number-one social need for members.

- Over half of respondents supported providers in screening, referral, and follow-up on social needs through data and information sharing (63%) and member stratification (58%).
- SDOH initiatives were most frequently evaluated using cost utilization (63%) and cost savings metrics (68%), as well as performance measures (63%).
- Almost two-thirds (63%) of Medicaid health plans indicated that Z code 59 (problems related to housing and economic circumstances) was clinicians' most commonly used Z code.

COVID-19 Pandemic

Medicaid health plans quickly responded to the COVID-19 pandemic by supporting the social and health-related needs of members in the following ways:

- Increased member outreach
- Contracted with and supported community-based organizations
- Deployed rapid-response teams to provide supplies such as food and durable medical equipment
- Supported transitional care for enrollees who were housing insecure and recovering from COVID-19

Ninety-five percent (95%) of Medicaid health plans made a commitment to transition to telehealth, 85% expanded coverage to new services, and 70% implemented payment parity between telehealth and equivalent in-person services. Reported telehealth related barriers included the following:

- Members' lack of access to technology, technology literacy, private locations for visits, or trust in health care providers;
- Limited clinician familiarity, capability, and capacity with telehealth and services;
- Outdated and inconsistent policies across states.

Health Equity and Structural Racism

Over two-thirds (70%) of health plans had a health equity plan in 2020. Of those, the majority of respondents had a dedicated person or team focused on addressing health disparities (100%), health equity (87%), racial equity (67%), and structural racism (60%).

Over two-thirds (70%) of health plans had a health equity plan in 2020.

Additional key takeaways included:

- Over half (53%) of respondents had a chief equity officer or equivalent role within their organization.
- The majority of respondents stratified outcomes (93%) and quality (80%) data by race and ethnicity.
- One-third (33%) of respondents worked with both Small Disadvantaged Businesses and Small and Diverse Businesses.
- All respondents that had a health equity plan in 2020 led programs or implemented policies for health plan internal staff to address racism and promote racial equity.

Overall, findings from the survey highlight the continued value of the managed care model in Medicaid. However, state and federal policies might inhibit continued success and growth. This report presents the findings from data collected on these challenges and potential solutions.

Support for this project is provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Graphic Design by Lydia Tonkonow

Overview and Sample Characteristics

The Institute for Medicaid Innovation's (IMI's) annual Medicaid health plan 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. The findings from the 2021 survey, capturing 2020 Medicaid managed care data, found in this report are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. The survey's longitudinal design allows us to provide critical trend data, representing four years, and analysis to evaluate the impact of state and federal policies on Medicaid and managed care.

Background

Included in this report are descriptive statistics for each survey item, representing de-identified, aggregated 2020 data provided to the IMI from Medicaid health plans. The survey was sent electronically in March 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 without an affiliation to either trade association. Overall, the Medicaid health plans 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 response rate for the survey is calculated by Health Management Associates (HMA) utilizing their proprietary data set. The denominator excludes covered lives who are in non-managed care health plans, state pilot health plans (e.g., Colorado), carved-out health plans (e.g., Medicaid behavioral health), and health plans with limited Medicaid coverage (e.g., only dually eligible members).

We provide details on the survey design and methods in Appendix A, with key definitions used for the survey in Appendix B.

We divided the survey findings highlighted in this report into the following ten 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, social determinants of health, the COVID-19 pandemic, and health equity and structural racism. For each section of the survey, the IMI provided open text boxes for Medicaid health plans to type in qualitative information that identified specific state and/or federal policy barriers, opportunities for innovation, and emerging or effective best practices that are addressing salient issues.

Characteristics of Survey Respondents: Health Plans

Survey respondents indicated that they initiated participation in Medicaid programs as a health plan as early as 1981 and as late as 2013. Respondents were 55 percent private, non-profit organizations; 25 percent private, for-profit organizations; and 20 percent either public or government organizations. The majority of respondents (85%) indicated that they provided coverage in a single state in 2020, with 15 percent providing coverage in multiple states (Table 1).

The survey respondents were categorized based on the number of lives they covered, with 50 percent covering fewer than 250,000 Medicaid managed care lives, 15 percent covering 250,001 to 1 million lives, and 35 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 health plans provided coverage in all areas (i.e., value-based purchasing, pharmacy, women's health, etc.). Health plans reported managing a number of benefits at full risk, including physical health (90%); pharmacy (85%); behavioral health (85%); vision (80%); gender-affirming treatment, including hormone therapies and surgical procedures (75%); institutional care (65%); dental (65%); and home and community-based waiver services (65%). Figure 1 highlights that among the 35 percent of Medicaid health plans that did not offer targeted programs to address the health of individuals with diverse sexual orientations and gender identities, 20 percent are considering offering these programs in the future.

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

Acronyms with accompanying definitions that are used in each section of this report can be found on the IMI website.

Table 1. Trends and Overview of Medicaid Health Plan Survey Respondents' Characteristics, 2017-2020

Survey Sample Characteristics				
Medicaid Health Plan Tax Status				
	2017	2018	2019	2020
Private, non-profit	38%	45%	47%	55%
Private, for-profit	39%	33%	27%	25%
Government or Other	23%	22%	27%	20%
Parent Organization				
	2017	2018	2019	2020
Provider-owned	23%	22%	33%	35%
Not-provider owned	77%	78%	67%	65%
Number of Covered Lives				
	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	
2017	15%	54%	31%	
2018	39%	28%	33%	
2019	33%	40%	27%	
2020	50%	15%	35%	
Medicaid Health Plan Markets in 2020				
	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	
Multiple states	0%	0%	43%	
Single state	100%	100%	57%	
Benefits Managed at Full Risk				
	2017	2018	2019	2020
Physical Health	85%	100%	93%	90%
Pharmacy	85%	95%	93%	85%
Behavioral Health	92%	95%	80%	85%
Institutional Care	85%	78%	67%	65%
Dental	62%	73%	67%	65%
Home and Community-Based Waiver Services	92%	78%	60%	65%
Gender-Affirming Treatment	N/A	N/A	60%	75%
Vision	N/A	N/A	N/A	80%

Note: Benefits were managed at full risk in at least one market.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 2. Comparison of Elements of Medicaid Health Plan Coverage by Health Plan Size, 2020

Elements of Medicaid Health Plan Coverage	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid Health Plan Respondents
High-Risk Care Coordination	100%	100%	100%	100%
Value-Based Purchasing	80%	100%	100%	90%
Pharmacy	70%	100%	86%	80%
Behavioral Health	90%	33%	100%	85%
Women's Health	90%	100%	100%	95%
Child and Adolescent Health	90%	100%	100%	95%
Long-Term Services and Supports	50%	33%	86%	60%
Social Determinants of Health	90%	100%	100%	95%

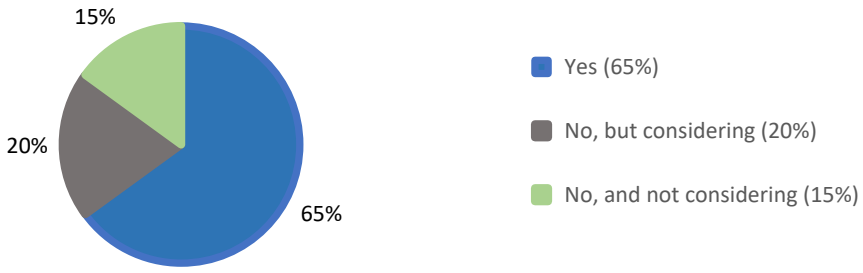
Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 3. Percentage of Medicaid Health Plans Serving Specific Populations, 2020

Population Served by Medicaid Health Plans	Percentage of Medicaid Health Plans
Children	95%
Children with Special Healthcare Needs	90%
Individuals with SUD/OUD	90%
Medicare and Medicaid Enrollees (Duals)	85%
Individuals with Serious Mental Illness (SMI)	85%
Aged, Blind, Disabled	85%
Childless Adults	85%
Pregnant Individuals	85%
Individuals with Diverse Sexual Orientations and Gender Identities	85%
Children and Youth in Foster Care	80%
Individuals with Intellectual and Developmental Disabilities (I/DD)	75%
Adult Caregivers	60%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Figure 1. Percentage of Medicaid Health Plans Offering Targeted Programs to Address the Health of Individuals with Diverse Sexual Orientations and Gender Identities, 2020



Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 4. Percentage of Medicaid Health Plans with Specific Provider Contracts, 2020

Type of Provider Contract	Percentage of Medicaid Health Plans
Urgent care clinics	95%
Community health centers	90%
Academic medical centers	90%
Behavioral health centers	85%
Skilled nursing facilities	85%
Public hospitals	80%
Safety-net hospitals	80%
School-based clinics	75%
Substance use disorder (SUD) agencies (e.g., methadone and other MAT clinics)	75%
Local/County health departments	75%
Maternal and child health clinics	65%
Planned Parenthood	65%
Rural health clinics	65%
HIV/AIDS services organizations	60%
Family planning clinics (Title X)	60%
Retail clinics	45%
Indian Health Service providers or tribal health clinics	45%
Other	10%

Note: "Other" included Behavioral Health Homes, Federally Qualified Health Centers (FQHCs), Integrated Community Wellness Centers (ICWCs).

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 5. Most Common Strategies Used by Medicaid Health Plans to Recruit and Retain Providers in Medicaid Managed Care, 2020

Medicaid Health Plan Strategy	Percentage of Medicaid Health Plans
Financial incentives	90%
In-person outreach to providers	85%
Use of technology	85%
Dedicated provider hotline for questions, problems, and needs	85%
Prompt payment policies	85%
Streamlined referral and authorization practices	80%
Automatic assignment of members to primary care providers	70%
Reduced administrative burdens	70%
Pay rates comparable to Medicare or commercial rates	60%
Streamlined credentialing and re-credentialing processes	50%
Debt repayment	15%
Other	15%

Note: "Other" included dedicated provider relations staff in the field, value-based care incentives.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 6. Most Common Assessment Barriers in Completing Individual Health Risk Assessments for Members, 2020

Assessment Barriers Medicaid Health Plans Encountered	Percentage of Medicaid Health Plans
Inaccurate member information (e.g., phone number, address)	100%
Difficulty reaching members	100%
Lack of member's willingness to participate in a needs assessment	90%
State deadline to complete assessments within timeframe	20%
Lack of confirmed member record	15%
Dispute in resolving the identity of members	10%
Other	10%
Overlapping assessments tied to eligibility	0%

Method of Sharing	Percentage of Medicaid Health Plans
Health plan to care coordinator	95%
Health plan to member	84%
Health plan to member's guardian or responsible party	79%
Health plan to network providers	79%
Health plan to member's preferred provider	74%
Health plan to community-based organization	48%
Health plan to other	11%

Note: "Other" included lack of member phone number, COVID-19.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 7. Frequency of Core High-Risk Care Coordination Functions Completed by Medicaid Health Plans, 2020

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)
Developed a plan of care	75%	25%	0%
Served as a single point of contact for the member	50%	50%	0%
Engaged a care team of professionals to address the needs of the member	45%	55%	0%
In addition to supplying the provider directory, supported the member in identifying and connecting with providers	40%	60%	0%
Coordinated with multiple care coordinators from health systems, provider practices, clinics, etc.	30%	70%	0%
Prepared the member for appointments	25%	75%	0%
Coordinated in-home services	20%	75%	5%
Arranged transportation for appointments	15%	80%	5%
Provided guided referrals or “hand-offs” to other needed social services (e.g., faith-based, non-profit, other government programs)	15%	80%	5%
Coordinated with social services (i.e., housing providers, nutrition programs) as part of care plan development and adherence	15%	80%	5%
Provided information on other types of social services (e.g., faith-based, non-profit, other government programs)	10%	90%	0%
Shared data with social services	10%	60%	20%

Notes: None of the survey respondents selected "did not provide" as an answer for any of the core functions. None of the survey respondents selected "not applicable" as an answer for any of the core functions, except for "Shared data with social services," for which 10 percent of respondents selected "not applicable."

Source: Institute for Medicaid Innovation. “2021 Annual Medicaid Health Plan Survey.”

Table 8. Most Common Measures of Effectiveness Used in High-Risk Care Coordination, 2020

Measures Utilized by Medicaid Health Plans	Percentage of Medicaid Health Plans
Emergency Department utilization (HEDIS measure)	95%
Inpatient utilization (HEDIS measure)	95%
Patient experience survey results (e.g., Consumer Assessment of Healthcare Providers and Systems)	79%
Preventive care	74%
Impact on other HEDIS measures	69%
Total spending	68%
Provider experience survey results	58%
Other	32%

Notes: "Other" included a care coordination management tool, asthma, heart failure, and diabetes admissions, care coordination complaints, quality measures specific to state contracts, member advisory meetings, and connection rates to the social determinants of health (SDOH).

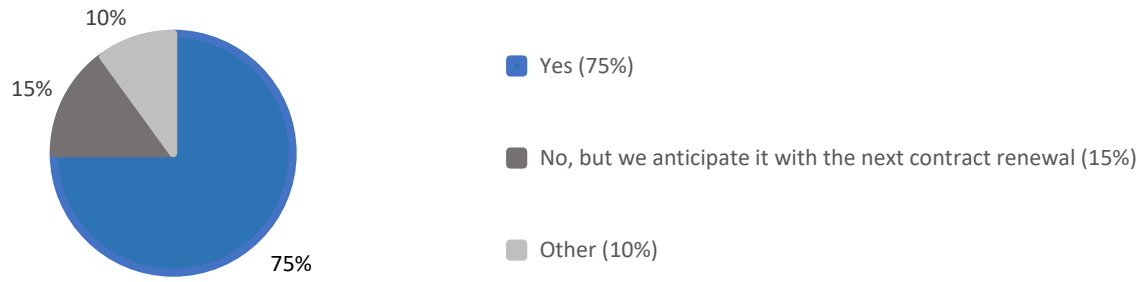
Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 9. Percentage of Medicaid Health Plans Using Value-Based Purchasing (VBP) or Alternative Payment Model (APM) Structures, by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	100%	86%	100%	92%
2018	86%	100%	100%	95%
2019	80%	100%	100%	93%
2020	70%	100%	71%	75%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

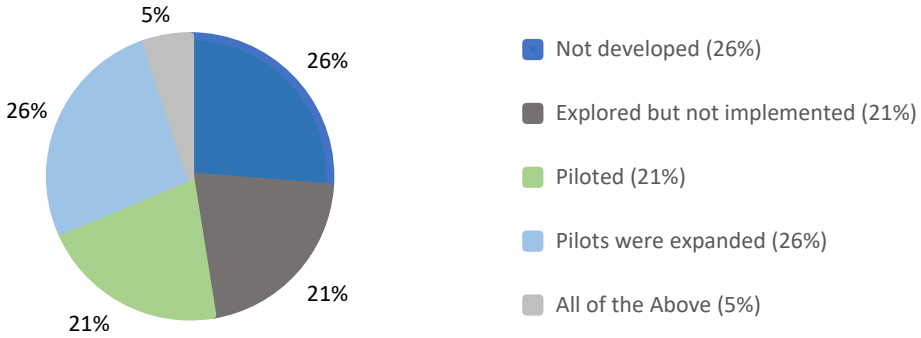
Figure 2. Percentage of State Contracts Requiring Medicaid Health Plans to Implement Value-Based Purchasing (VBP) or Alternative Payment Model (APM) Contracting between Medicaid Health Plans and Providers, 2020



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. "2021 Annual Medicaid Health Plan Survey."

Figure 3. Percentage of Value-Based Purchasing (VBP) Implementation within Specific Populations, 2020



Notes: None of the survey respondents selected "Had extensive arrangements" as an answer for this item. Numbers may not add up to 100 due to rounding.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 10. Provider Types Who Were Not Engaged in Value-Based Purchasing (VBP) Arrangements (Hospitals Excluded), 2020

Provider Type with which Health Plan Did Not Work	2017	2018	2019	2020
Behavioral Health Providers	54%	47%	57%	44%
Dentists	100%	82%	79%	89%
Home and Community-Based Service Providers	46%	59%	79%	78%
Long-Term Care Facilities	54%	71%	79%	78%
Nurse-Midwives	85%	88%	86%	84%
Obstetricians/Gynecologists	39%	35%	36%	53%
Orthopedists	67%	71%	79%	84%
Primary Care Providers (i.e., Physicians, Advanced Practice Nurses, Physician Assistants)	15%	18%	14%	21%
Other Specialists	39%	38%	64%	58%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 11. Most Common Medicaid Health Plan Payment Strategies, 2020

Payment Strategy	Percentage of Medicaid Health Plans
Payment incentives based on performance measures related to access to care	78%
Payment incentives for availability of same-day or after-hours appointments	56%
Enhanced payment rates for hard-to-recruit provider types	56%
Enhanced payment rates for providers in rural or frontier areas	50%
Strategies to support integrating behavioral health care into primary care	40%
Other	39%
Incentive payments for addressing health disparities	10%
Incentive payments for addressing health inequities	5%

Note: "Other" included capitation contracts, gap closure incentives, grant funds to address disparities, enhanced payments to providers, and payment incentives based on quality performance, care management, and health information exchange participation.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 12. Most Common Types of APMs Used between Providers and Medicaid Health Plans, 2020

Type of Alternative Payment Model	Percentage of Medicaid Health Plans
Incentive/bonus payments tied to specific performance measures	94%
Shared savings	78%
Global or capitated payments to primary care providers or integrated provider entities	67%
Bundled or episode-based payments	50%
Risk-based agreements	50%
Payment withholds tied to performance	33%
Other	11%
Non-payment or reduced payment for 39-week elective delivery	11%
Non-payment or reduced payment for patient safety issues	6%

Note: "Other" included per member per month payments for care management and payments tied to enrollment into care management program.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 13. Most Common Operational Barriers in VBP/APMs, 2020

Operational Barriers	Percentage of Medicaid Health Plans
Data reporting to providers	83%
IT system preparedness	50%
Tracking quality and reporting within new structure	50%
Contract requirements on VBP/APM approaches	44%
Support to providers to make determinations on VBP/APM	39%
Pricing VBP/APM	39%
None	11%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 14. Trends in Most Common External Factors Influencing Adoption and Innovation in VBP/APMs, 2017-2020

External Factors	2017	2018	2019	2020
Provider readiness and willingness	100%	88%	100%	94%
Provider IT capabilities	100%	82%	79%	72%
Medicaid payment rates	92%	65%	57%	67%
Uncertain or shifting state policy requirements/ priorities	92%	35%	43%	22%
Uncertain or shifting federal policy requirements/priorities	85%	29%	29%	11%
Impact of 42 CFR Part 2 on limiting access to behavioral health data	100%	24%	21%	17%
State requirements limiting VBP/APM models	85%	41%	14%	39%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 15. Percentage of Medicaid Health Plans Fully At Risk for Pharmacy Benefits, by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	100%	57%	75%	69%
2018	86%	80%	100%	89%
2019	100%	83%	100%	93%
2020	70%	100%	86%	80%

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

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 16. Percentage of Medicaid Health Plans Utilizing Pharmacists for Medication Therapy Management, by Health Plan Size, 2020

Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
57%	100%	100%	81%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 17. Most Common Ways Community-Based Contracts Were Used with Pharmacists, 2020

Types of Community-Based Contracts	Percentage of Medicaid Health Plans
Drug utilization rate (e.g., duplicative therapies)	63%
Medication adherence rate	63%
Pharmacotherapy consults	56%
Identification of lower-cost medication alternatives	38%
None	25%
Hospital readmissions	25%
Other	13%
Emergency Department visits	13%

Note: "Other" included payments to community pharmacists for chronic care management services.
Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 18. Trends in Most Common Challenges in Managing Medicaid Prescription Drug Benefits, 2017-2020

Challenges	2017	2018	2019	2020
Utilization and cost history unknown for new drugs entering a market, impacting capitation rates and pricing	100%	89%	85%	75%
Increase in number of specialty pharmacy medications	N/A	N/A	77%	69%
Pharmacy benefits or subset of benefits carved out of managed care	78%	59%	69%	58%
Member comprehension and engagement of programs	44%	65%	62%	56%
Single PDL/formulary requirements	N/A	N/A	62%	56%
Differences between plan formularies and methodologies and state requirements	56%	48%	54%	38%
Formulary notification requirements as part of Medicaid MCO Final Rule	11%	36%	31%	19%
Pharmacy network requirements	11%	36%	23%	19%
Other	N/A	N/A	15%	6%

Notes: We are unable to present trend data for some data points that were not answer options for all four years of the survey. "Other" included state interference with contracting. PDL is pregnancy disability leave. MCO is managed care organization.

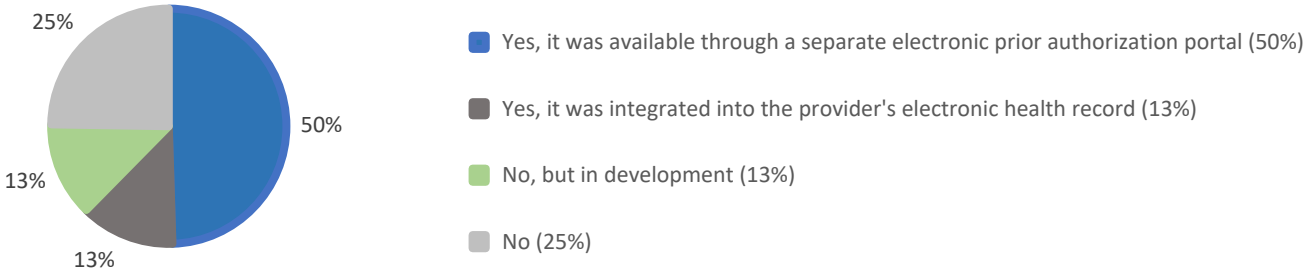
Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 19. Percentage of Medicaid Health Plans Supporting E-Prescribing through Pharmacy Benefit Managers (PBMs), by Health Plan Size, 2020

Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
100%	25%	100%	77%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

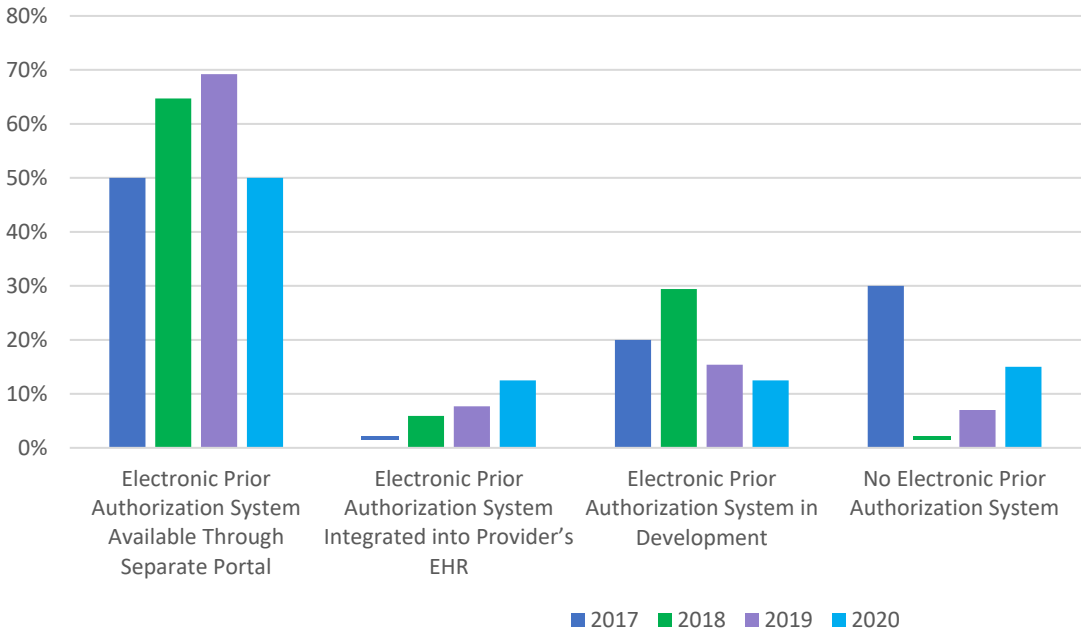
Figure 4. Utilization of Electronic Prior Authorization Systems, 2020



Note: Numbers might not add up to 100 due to rounding.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey"

Figure 5. Trends in Utilization of Electronic Prior Authorization Systems, 2017-2020



Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 20. Trends in Most Common Approaches by States to Address New or High-Cost Drugs, 2017-2020

State Approaches	2017	2018	2019	2020
Capitation rate adjustment as part of regular rate adjustments	67%	59%	62%	63%
Carved-out the drug costs completely/pay fee-for-service for certain drug(s)	67%	53%	46%	56%
Other	N/A	N/A	46%	31%
Transition period where drug(s) are offered in fee-for-service to get claims data then rolled into contracts	11%	36%	23%	25%
Capitation rate adjustments made off the normal rate cycle	56%	24%	23%	25%
States have not addressed the cost	N/A	24%	39%	19%
Stop-loss provision to cap the plan's cost for the drug	33%	24%	31%	19%
Risk corridor for high-cost medications	N/A	N/A	N/A	19%
Risk sharing	N/A	N/A	N/A	6%
None	0%	0%	8%	6%

Notes: We are unable to present trend data for some data points that were not answer options for all four years of the survey. "Other" included a state having a single preferred drug list (PDL), a state's PDL promoting use of high-cost brands to collect rebates, value-based all-inclusive arrangements, and supplemental payments.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 21. Percentage of Medicaid Health Plans At-Risk for Behavioral Health Benefits, by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	50%	71%	100%	77%
2018	72%	80%	100%	84%
2019	80%	67%	75%	73%
2020	90%	33%	100%	85%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 22. Most Common Barriers Medicaid Health Plans Experienced when Integrating Behavioral and Physical Health, 2020

Operational Barriers	Percentage of Medicaid Health Plans
Access to data between care management and behavioral health teams	61%
System differences with subcontractor	50%
Communication between care management and behavioral health	44%
Staffing in care management to align skills sets with integrated care needs	28%
Other	22%

Note: "Other" included behavioral health service carve-outs and limited functional outcome measures.

Network Barriers	Percentage of Medicaid Health Plans
Provider capacity to provide integrated physical and behavioral health at point of care	89%
Behavioral health provider readiness for managed care	61%
Behavioral health provider adoption of electronic health records	44%
Other	28%

Note: "Other" included a workforce shortage or limited network of behavioral health providers, lack of evidence-informed treatment, and behavioral health carve-outs impacting coordination and continuity of care.

Policy Barriers	Percentage of Medicaid Health Plans
42 CFR Part 2 limitations on SUD treatment information being shared	89%
Fragmentation in program funding and contracting for physical and behavioral health services	67%
Institutions for Mental Disease (IMD) exclusion	44%
State-specific substance use confidentiality laws	39%
State-specific behavioral health confidentiality laws	33%
Other	22%

Note: "Other" included underfunding of behavioral health services, behavioral health carve-outs impacting coordination and continuity of care, and Mental Health Parity and Addiction Equity (MHPAE) compliance complications.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 23. Behavioral Health Services Included in Contracts with States, 2020

	Yes, managed by Medicaid health plan	Yes, subcontracted to a vendor	Varied by population	No
Behavioral health assessment/screening	61%	17%	17%	6%
Outpatient mental health services	56%	28%	6%	11%
Inpatient mental health services	50%	11%	6%	33%
Outpatient substance use treatment services	44%	17%	11%	28%
Inpatient/residential substance use treatment services	44%	11%	11%	33%
Detox services (outpatient or residential)	44%	11%	17%	28%

Note: Numbers may not add up to 100 due to rounding.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 24. Percentage of Medicaid Health Plans with Targeted Women's Health Programs, by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	100%	86%	100%	92%
2018	86%	80%	100%	89%
2019	100%	83%	100%	93%
2020	90%	100%	100%	95%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 25. Women's Health Priorities Identified by Medicaid Health Plans Compared to Targeted Health Plan Programs & Engagement Strategies Across the Lifespan, 2020

Priorities	Percentage of Medicaid Health Plans Indicating a Priority	Percentage of Medicaid Health Plans with Targeted Program & Engagement Strategy
Prenatal and postpartum care	90%	90%
Depression/Anxiety	84%	74%
Health disparities	84%	84%
Social needs	79%	79%
Behavioral health, generally	68%	84%
Cancer screening and treatment	68%	63%
Family planning	68%	58%
Diabetes	68%	74%
Substance use disorder	53%	58%
Heart disease	42%	32%
Sexual health	42%	47%
Obesity	42%	37%
Aging/LTSS	32%	26%
Intimate partner violence	26%	21%
Other	16%	11%
Eating disorders	11%	11%

Note: "Other" included HIV/AIDS, oral health, and SDOH.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 26. Types of Providers for Primary Care, 2020

Provider Type	Percentage of Medicaid Health Plans
Family physicians	95%
Obstetricians/Gynecologists	95%
Nurse Practitioners	90%
Internists	79%
Pediatricians	63%
Physicians assistants	55%
Nurse-Midwives	53%
Geriatricians	42%
Other (e.g., HIV/AIDS specialists, FQHCs, and maternal health homes for pregnant individuals with SUD)	21%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

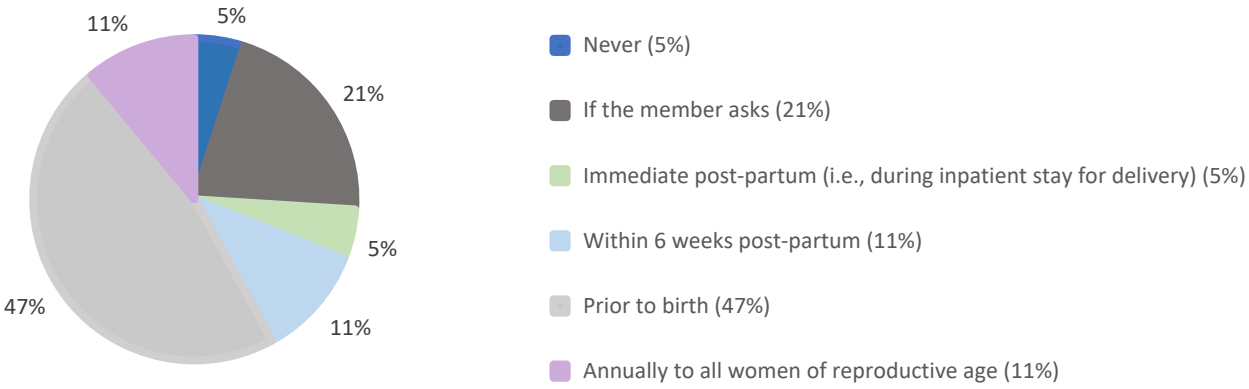
Table 27. Type of Settings Offering Contraception Counseling and Services, 2020

Provider Setting	Percentage of Medicaid Health Plans
Planned Parenthood clinics	90%
Federally qualified health centers	84%
Community health/Rural health centers	84%
Freestanding family planning clinics	79%
State or local health departments	79%
Hospital-based clinics	74%
School-based clinics	16%
Other	16%

Note: "Other" included FQHCs, primary care clinics, safety-net clinics.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Figure 6. Timing of Postpartum Contraception or Sterilization Information Provided by Medicaid Health Plans, 2020



Source: Institute for Medicaid Innovation. 2020 Annual Medicaid Health Plan Survey.

Table 28. Percentage of Medicaid Health Plans Addressing Maternal Health Outcomes and Social Needs, 2020

Efforts to Address Maternal Health Outcomes and Social Needs	Percentage of Medicaid Health Plans
Medicaid health plan had initiative to improve maternal health outcomes and experiences	79%
Medicaid health plan initiated new policy and/or program to address the social needs of pregnant individuals	63%
Vendor that Medicaid health plan contracted with provided additional or dedicated resources for the purpose of meeting the social needs of pregnant individuals	58%

Source: Institute for Medicaid Innovation, "2021 Annual Medicaid Health Plan Survey."

Table 29. Reported Degree of Commitment to Addressing the Social Needs of Pregnant Individuals, 2020

	Strong	Moderate	Limited
Vendors the health plan contracted with	42%	37%	21%
Leaders at the health plan	74%	21%	5%
Providers & facilities the health plan contracted with	53%	37%	11%

Note: None of the survey respondents selected "no interest" as an answer for any of these items.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 30. Percentage of Medicaid Health Plans Offering Targeted Child Health Programs, by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	100%	86%	100%	92%
2018	86%	100%	100%	95%
2019	100%	100%	100%	100%
2020	90%	100%	100%	95%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 31. Child & Adolescent Health Priorities Identified by Medicaid Health Plans Compared to Targeted Health Plan Programs & Engagement Strategies, 2020

Priorities	Priority	Targeted Program & Engagement Strategy
Asthma	90%	84%
Children with Special Health Care Needs	79%	74%
ADHD/ADD	79%	68%
Behavioral health screening and treatment	79%	68%
Depression/Anxiety	79%	63%
Adverse Childhood Experiences	68%	63%
Transitioning to adulthood and independence	68%	53%
Autism spectrum disorder	63%	58%
Dental health	63%	47%
Obesity	58%	42%
Diabetes	53%	47%
Substance use disorder	47%	58%
Teen pregnancy	47%	42%
Tobacco use	47%	37%
Health disparities impacting sexual and gender minorities	47%	13%
Other	37%	42%
Success in school	26%	16%
Sex education	21%	21%
Readiness to start school	21%	21%

Note: "Other" included lead screenings, metabolic monitoring for children and adolescents related to anti-psychotics, the social determinants of health (SDOH), children in foster care, and developmental screenings.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 32. Trends in Most Common Barriers for Medicaid Health Plans for Serving Child and Adolescent Members, 2017-2020

Barrier	2017	2018	2019	2020
Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)	75%	83%	67%	74%
Churn (member or eligibility-related)	N/A	N/A	67%	58%
Policies or program structures that create barriers if the parent(s) have more than one child (e.g. transportation policies)	67%	59%	60%	63%
Engaging family members who are not enrolled in the same plan to address social determinants of health	67%	59%	47%	53%
Language barriers within families	67%	48%	47%	58%
Program fragmentation	58%	53%	23%	47%
None	17%	6%	20%	5%
Other	N/A	24%	13%	16%

Note: We are unable to present a data trend for "Churn" as it was not an answer option for all four years of the survey. "Other" included COVID-19 disruptions to well visits and immunizations, behavioral health service carve-outs, private duty nurse workforce shortages, coordination with the Department of Child Services, and care coordination for infants with Neonatal Abstinence Syndrome.

Source: Institute for Medicaid Innovation. 2021 Annual Medicaid MCO Survey.

Table 33. Percentage of Medicaid Health Plans Contracting with State Medicaid Agencies for Children with Special Healthcare Needs (CSHCN), by Health Plan Size, 2020

Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
56%	67%	86%	68%

Source: Institute for Medicaid Innovation. 2021 Annual Medicaid Health Plans Survey.

Table 34. Trends in the Most Common Barriers Experienced by Medicaid Health Plans when Serving CSHCN, 2017-2020

Barrier	2017	2018	2019	2020
Poor communication among multiple providers to families	83%	77%	60%	72%
Carved-out services created inefficient services for families (e.g., too many coordinators)	75%	71%	73%	56%
Lack of consistent quality measures specific to unique needs of CSHCN	67%	41%	27%	50%
Carved-out services created an increased risk for duplication and costs	58%	53%	53%	44%
Consistency in identification parameters	58%	35%	27%	28%
Misinformation about managed care value to CSHCN	50%	47%	33%	22%
Insufficient information regarding the goals and preferences of CSHCN and their families	N/A	35%	27%	17%
Other	0%	6%	13%	11%
None	N/A	12%	7%	6%

Notes: We are unable to present trend data for some data points that were not answer options for all four years of the survey. "Other" included lack of coordination across state agencies and whole person care.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 35. Percentage of Medicaid Health Plans At-Risk for Managed Long-Term Services and Supports (MLTSS), by Health Plan Size, 2017-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2017	50%	86%	100%	85%
2018	43%	60%	100%	67%
2019	40%	33%	100%	53%
2020	50%	33%	86%	60%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 36. Percentage of Medicaid Health Plans Utilizing a Different Clinical Model of Care for Managed Long-Term Services and Supports (MLTSS) Members, by Health Plan Size, 2020

Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
20%	100%	83%	58%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 37. Most Common Individuals in Care Team Composition for Managed Long-Term Services and Supports (MLTSS), 2020

Individuals	Percentage of Medicaid Health Plans
Family member	83%
Individual member	83%
Any person the member wanted to invite	83%
Care coordinator within the health plan	75%
Guardian	75%
Pharmacist within the health plan	75%
Member's primary care provider	67%
Behavioral health specialist within the health plan	67%
Natural/community supports other than guardian	67%
Other health care professional not employed by the health plan	58%
Community health worker within the health plan	50%
Representative from primary care clinician's office	42%
Peer-support specialist within the health plan	25%
Other	17%
Our health plan did not use care teams	8%

Note: "Other" included MLTSS providers, member advocates, medical directors, state agency representatives.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 38. Most Common Challenges to Managing Long-Term Services and Supports (MLTSS), 2020

Challenges	Percentage of Medicaid Health Plans
Medicare and Medicaid misalignment creates challenges and financial disincentives	75%
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%
Fragmented Medicaid benefit design – behavioral health and/or physical health benefits – limits ability to serve the whole individual	50%
State program requirements that limit effectiveness of managed care strategies (e.g., any willing provider provisions, continuity of care provisions)	42%
Appropriate benefit and program design to allow for community transitions and long-term sustainability	42%
Other	42%
Waiver waitlists	33%
State requirements for health plans to contract with specific organizations or providers for care coordination	25%
Churn (member- or eligibility-related)	25%

Note: "Other" included provider availability, change in members' health plan, adequacy of HCBS network, disparities between financial eligibility for Medicaid and waiver programs, and member concerns about COVID-19 exposure.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 39. Frequency of Innovations Leveraged by Medicaid Health Plans for Managed Long-Term Services and Supports (MLTSS), 2020

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
Self-advocacy	58%	42%	0%	0%
Wellness initiatives	50%	50%	0%	0%
Partnerships with community-based organizations (e.g., AAAs, CILs)	42%	42%	8%	8%
Caregiver supports and services (outside of administering benefits required by state plan)	33%	25%	17%	25%
Healthy eating or nutrition programs outside of administering benefits required by state plan	33%	33%	8%	25%
Money follows the person or community transition programs	33%	42%	17%	8%
Tools for self-direction	33%	50%	8%	8%
Electronic visit verification	25%	42%	25%	8%
Unique housing strategies outside of administering benefits required by state plan	17%	58%	17%	8%
Employment initiatives outside of administering benefits required by state plan	17%	33%	33%	17%
Remote monitoring	8%	42%	25%	25%
Telehealth other than remote monitoring that is specific to the MLTSS population	8%	33%	17%	42%
Care coordination communication tools with caregivers, direct services workers, and other in-home providers or support organizations	8%	75%	8%	8%
Transportation innovations	8%	33%	50%	8%
Value-based payment arrangements with MLTSS providers	0%	17%	25%	58%

Note: Numbers may not add up to 100% due to rounding.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 40. Percentage of Medicaid Health Plans with Targeted Social Determinants of Health Programs, by Health Plan Size, 2018-2020

Year	Medicaid health plans with < 250,000 covered lives	Medicaid health plans with 250,001 to 1,000,000 covered lives	Medicaid health plans with over 1,000,000 covered lives	All Medicaid health plan respondents
2018	57%	80%	100%	78%
2019	100%	100%	100%	100%
2020	90%	100%	100%	95%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 41. Most Common Social Needs Programs Led by Medicaid Health Plans for Their Members, 2020

Social Need	Percentage of Medicaid Health Plans
Housing	100%
Nutrition/Food security	100%
Social isolation/Sense of belonging	95%
Non-emergency medical transportation (NEMT)	95%
Employment, job placement, and/or skills training	90%
Application assistance	90%
Non-medical transportation	84%
Utilities	84%
Education	79%
Environmental health (e.g., lead abatement)	79%
Violence/Interpersonal violence	79%
Financial literacy	74%
Trauma	58%
Other	11%

Notes: No respondents selected "Not assessed/No information collected." "Other" included SSI assistance, substance use, health care.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 42. Trends in Targeted Social Determinants of Health Programs, Provided by Medicaid Health Plans, by Population, 2018-2020

Population	2018	2019	2020
People experiencing homelessness/housing insecurity	79%	87%	79%
Pregnant individuals	86%	73%	68%
Adults with serious mental illness	65%	67%	63%
Adults with substance use disorder	72%	53%	58%
Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)	50%	53%	58%
Adults with disabilities (e.g., physical, intellectual, developmental)	58%	40%	58%
Foster care youth/Youth transitioning to adulthood	36%	27%	42%
Children with Special Healthcare Needs (CSHCN)	43%	40%	42%
Child welfare/Child protective services involved families	43%	27%	42%
Medicare and Medicaid enrollees (Duals)	N/A	40%	42%
Expansion members	50%	47%	37%
People with criminal legal system involvement	58%	33%	32%
Residential Institution/Facility-placed individuals	15%	13%	26%
People living with HIV/AIDS	29%	20%	21%
Individuals with diverse sexual orientations and gender identities	N/A	7%	16%
Individuals in Institutions of Mental Diseases (IMD)	8%	7%	5%

Note: We are unable to present trend data for some data points that were not included an answer options for all four years of the survey.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 43. Trends in Most Common Social Needs Programs Led by Medicaid Health Plans for Their Members, 2018-2020

2018		2019		2020	
Nutrition/Food security	100%	Nutrition/Food security	100%	Nutrition/Food security	100%
Housing	100%	Housing	93%	Housing	100%
Employment, job placement, and/or skills training	100%	Employment, job placement, and/or skills training	93%	Social isolation/Sense of belonging	95%
Utilities	93%	Non-emergency medical transportation (NEMT)	93%	Non-emergency medical transportation (NEMT)	95%
Non-medical transportation	93%	Non-medical transportation	87%	Employment, job placement, and/or skills training	90%
Application assistance	93%	Application assistance	87%	Application assistance	90%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Key for Table 44

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 44. Percentage of Medicaid Health Plans Providing Targeted Strategies to Address Social Needs, 2020

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	95%	95%	79%	79%	84%	84%	95%	84%	90%	74%	90%	79%
Assessed/Screened for member needs	100%	95%	84%	68%	47%	90%	90%	84%	68%	68%	84%	63%
Provided application assistance	74%	74%	26%	42%	47%	47%	32%	58%	42%	42%	26%	21%
Provided caregiver support	53%	47%	37%	37%	26%	42%	47%	32%	37%	37%	37%	21%
Utilized peers	42%	37%	47%	32%	21%	26%	26%	21%	26%	21%	26%	26%
Used community health workers	79%	74%	68%	63%	63%	74%	68%	58%	68%	58%	47%	47%
Engaged interdisciplinary community care team including CBOs	95%	68%	42%	47%	32%	53%	53%	42%	47%	37%	53%	53%
Identified and coordinated with CBOs to link members with needed social services	95%	95%	79%	79%	68%	79%	84%	84%	90%	84%	84%	68%
Provided guided referrals or "hand-offs" to other needed social services	90%	95%	74%	63%	53%	84%	90%	79%	74%	74%	84%	74%
Engaged in direct community investment and capacity building	79%	63%	42%	32%	21%	32%	32%	32%	32%	11%	21%	42%
Worked with local health departments to address challenges or coordination of services	42%	37%	5%	16%	11%	11%	11%	5%	11%	42%	16%	21%
Coordinated with schools to provide IEP services	5%	11%	5%	32%	5%	5%	5%	5%	11%	11%	5%	16%
Coordinated with social services as part of care plan development and adherence	74%	58%	47%	26%	32%	37%	32%	26%	37%	32%	42%	42%
Established agreement for data sharing with social services and community partners	63%	47%	21%	11%	5%	26%	26%	11%	16%	16%	16%	16%

Notes: IEP is individualized education plan. CBOs is community-based organizations.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 45. Most Common Programs Led by Medicaid Health Plans to Assist with Homelessness or Housing Instability, 2020

Program	Percentage of Medicaid Health Plans
Outreach to members or potential members who were homeless or housing insecure to help them access health care coverage and services	90%
Case management or care coordination for homeless or housing-insecure individuals	84%
Partnership with state or local housing agencies or organizations	79%
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	58%
Respite, palliative, or recuperative care for homeless or housing-insecure individuals	53%
Payment for Medicaid-covered, housing-related services	53%
Healthcare for the Homeless outreach/coordination	47%
Participation in a state-level, Medicaid-housing initiative	37%
Other	26%

Note: "Other" included investment in permanent housing and supports for families and provision of funds for member housing needs.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 46. Most Common Social Determinant of Health Screening Tools Used by Medicaid Health Plans, 2020

Screening Tool	Percentage of Medicaid Health Plans
Internally developed tool that is not based on an existing tool	53%
Adaptation of one or more of existing tools	47%
Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)	37%
Tool(s) embedded in provider electronic health records (EHR)	26%
Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)	21%
State-mandated tool	16%
CMS Accountable Health Communities Health-Related Social Needs Screening Tool	16%
Other	16%
American Community Survey	11%
Social Determinants Screening Tool, AccessHealth Spartanburg, Center for Health Care Strategies (CHCS) version	0%
Social Needs Screening Toolkit, HealthLeads USA	0%
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%

Note: "Other" included CMS/NCQA Model of Care Health Risk Assessment for C-SNP, EPIC EHR SDOH survey)

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 47. Most Common Approaches Used by States to Support the Efforts of Medicaid Health Plans to Address Social Needs, 2020

State Approaches to Support Medicaid Health Plans	Percentage of Medicaid Health Plans
Made policy/regulatory changes to support SDOH initiatives	58%
Submitted/received approval for a Medicaid waiver(s) that included support of SDOH initiatives	37%
Provided screening tools	26%
Allowed or improved data sharing	21%
Provided financial support	21%
States did not support social needs initiatives	21%
Other	21%
Provided administrative assistance	16%
Provided support for cultural and linguistic competency	11%
Improved analytic capacity	0%

Notes: SDOH is social determinants of health. "Other" included planned SDOH initiatives with financial support to start in 2021, provided training on trauma-informed care and adverse childhood experiences, led an SDOH collaborative, and conducted a needs assessment.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

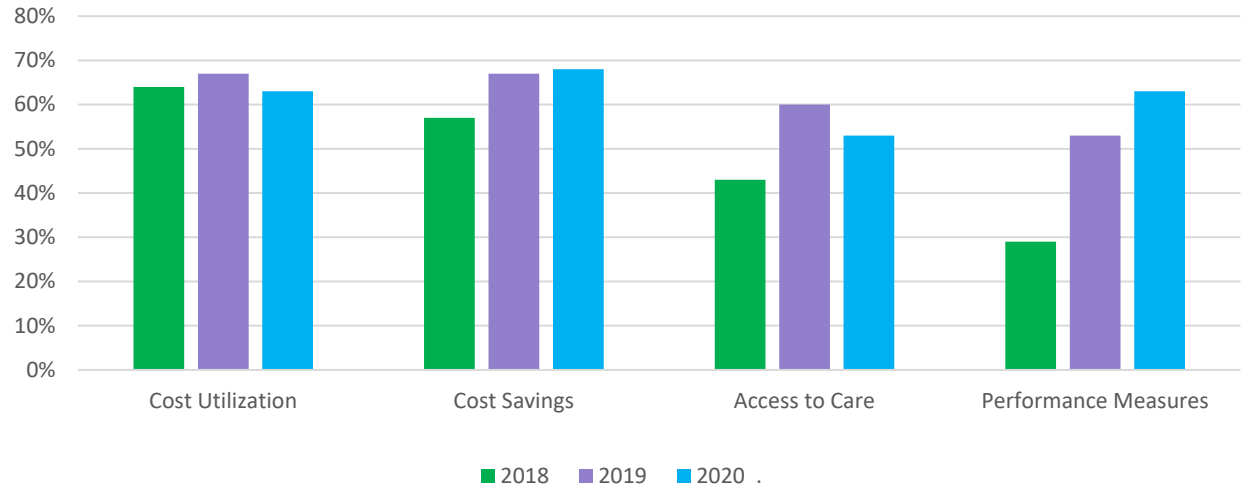
Table 48. Most Common Approaches Used by Medicaid Health Plans to Support Provider Efforts to Address Social Needs, 2020

Medicaid Health Plan Approaches to Support Providers	Percentage of Medicaid Health Plans
Data or information sharing	63%
Member stratification	58%
Staff	47%
Pay-per-performance incentives	42%
Other	42%
Ability to bill for multiple codes, joint billing	32%
No incentives/supports were provided	5%

Note: "Other" included provided screening incentives, trainings, capacity building webinars, and dedicated housing and intake staff, implemented Aunt Bertha, tracked receipt of referrals from providers for the social determinants of health (SDOH), and developed an SDOH referral process to be used by clinics.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Figure 7. Most Common Metrics Used by Medicaid Health Plans to Assess and Evaluate Social Determinants of Health Initiatives, 2020



Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 49. Most Common Barriers State Medicaid Agencies Could Remove to Assist Medicaid Health Plans in Addressing Social Needs of Medicaid Members, 2020

Barriers	Percentage of Medicaid Health Plans
Improve data sharing between state and MCOs	95%
Increase financial resources from state to MCOs	95%
Improve data sharing between government agencies (e.g., foster care system, criminal justice system) and MCOs	90%
Improve data sharing between MCOs and community-based organizations	90%
Standardize 834 enrollment file to include social needs information	90%
Increase resources to support capitated payments models, pay-for performance, and risk programs with providers	84%
Facilitate contracting with community-based organizations	84%
Increase resources to support facilitation of partnerships	74%
Improve data sharing between MCOs and provider groups	53%
Increase technical assistance resources	53%
Other	16%

Notes: SDOH is social determinants of health. MCOs is managed care organizations. "Other" included build infrastructure to include detoxification/rehabilitation facilities, adopt a common platform for SDOH referrals and CBO engagement, and improve reporting of race/ethnicity.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 50. Most Common Z Codes Used by Providers, 2020

Z Codes	Percentage of Medicaid Health Plans
Z59 – Problems related to housing and economic circumstances	63%
Z55 – Problems related to education and literacy	47%
Z60 – Problems related to social environment	47%
Z62 – Problems related to upbringing	47%
Z62.819 - Personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry	47%
Z63 – Other problems related to primary support group, including family circumstances	47%
Z64 – Problems related to certain psychosocial circumstances	47%
Z65 – Problems related to other psychosocial circumstances	47%
Z56 – Problems related to employment and unemployment	42%
Z57 – Occupational exposure to risk factors	42%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 51. Changes Made by Medicaid Health Plans That Will Support Preparation for the Next Public Health Emergency, 2020

Health Plan Changes to Meet the Needs of Members during the COVID-19 Pandemic
Conducted an efficient transition into and maintenance of telework operations
Expanded and strengthened telehealth platforms and infrastructure
Supported members' social and health-related needs--health plans adapted their operations to ensure continuity of care and patient support
Bolstered disaster planning and emergency response efforts
Enacted service and benefit flexibilities

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 52. Transitional Care Support Provided by Medicaid Health Plans for Enrollees Who Were Housing Insecure and Recovering from COVID-19, 2020

Transitional Care Support
Provided additional financial support, coverage, and requirement waivers
Designated service coordinators to provide member support
Enacted health care provider and community-based organization (CBO) partnerships to assist inpatient facilities with transitioning patients to post-acute levels and in-home care

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 53. Resources and Support Provided by Medicaid Health Plans to Community-Based Organizations during the Pandemic, 2020

Resources and Support
Engaged in frequent and direct communication with CBOs
Provided financial support, sponsorship funds, equity and resilience grants, or technical and billing assistance
Hosted virtual event series
Established partnerships with CBOs to provide services
Provided members, health care providers, and CBOs with COVID19-related and general care identification and coordination resources
Maintained and offered updates on all flexibilities and service delivery waivers impacting members

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Challenges and Barriers Experienced with Telehealth during the Pandemic, 2020

Reported challenges and barriers faced by members pertaining to the transition to telehealth platforms and billing strategies included:

Challenges and Barriers Faced by Members

- Limited or no access to technology, broadband, and/or connectivity.
- Limited and varying technology and telehealth literacy.
- Lack of:
    - Private locations for telehealth visits
    - Trust in health care providers
    - Requisite equipment necessary for in-home care
- Telehealth's inability to connect clinicians adequately to members to provide specific diagnoses
- Telehealth's lack of suitability for specific populations (e.g., young children)
- Member preference for in-person care
- Member challenges with telehealth technology causing missed appointments and difficulties with virtual appointment scheduling
- Language barriers and interpreter service challenges

Challenges and Barriers Faced by Medicaid Health Plans

- Limitations in provider familiarity, capability, and capacity to deliver telehealth services, consequently delaying or preventing access to care
- Outdated telehealth policies that are inconsistent across sectors and states
- Narrow and overly restrictive telehealth definitions that limit the scope of care, effectively dampening innovation and adoption

Table 54. Changes Enacted by Medicaid Health Plans Related to Telehealth, 2020

Changes	Percentage of Medicaid Health Plans
Committed to rendering care via telehealth	95%
Expanded coverage to new services	85%
Achieved payment parity between telehealth and equivalent in-person service	70%
Other	30%
Incentivized telehealth services over in-person visits	15%
Implemented telehealth triage prior to ED visits	10%

Note: "Other" included collaborated with state on commitment to regulatory changes, implemented a platform for after-hour care and support, increased education related to telehealth for members and providers, and invested in capacity building with providers.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 55. Medicaid Health Plan Utilization Management Changes over the Past Year, 2020

Utilization Management Changes
Coverage of member benefits was expanded, shifting the financial burden of care to health plans
Authorizations were extended, removed, and altered
Service provision and utilization management transitioned to telehealth delivery, bolstering telehealth infrastructure in the process.
Care and case managers transitioned to proactive member outreach, follow-up, resource coordination, and triage and referral
Increased support was offered to hospitals

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

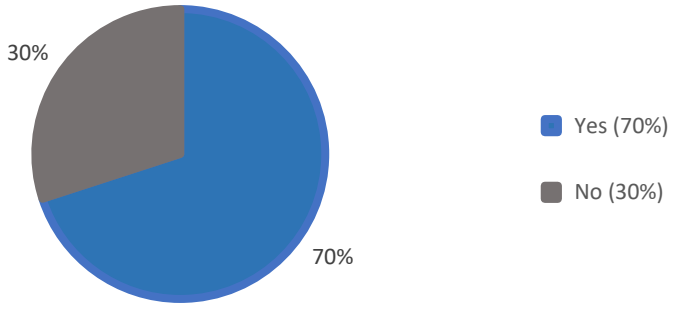
Table 56. How Medicaid Health Plans Closed Gaps in HEDIS Measures with Fewer In-Person Visits, 2020

Methods to Close Gaps in HEDIS Measures
Transitioned from in-person care to telehealth
Expanded on-site service provision to prevent members from having to visit additional providers for requisite care
Provided at-home testing and medical supplies
Enacted cross-sector partnerships to ensure care delivery
Implemented care management initiatives focused on drivers for hospital and facility admission, reducing readmission, and increasing follow-up and treatment retention
Conducted data analyses of members missing routine care and ways to locate and remain in contact with members
Engaged in practitioner and provider group outreach to provide guidance and alternatives to in-person care and chronic care management
Waived cost-sharing requirements for telehealth visits with in-network providers and for preventative services
Implemented educational campaigns targeting both communities and health care providers

Note: HEDIS is Healthcare Effectiveness Data and Information Set.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Figure 8. Percentage of Medicaid Health Plans with a Health Equity Plan, 2020



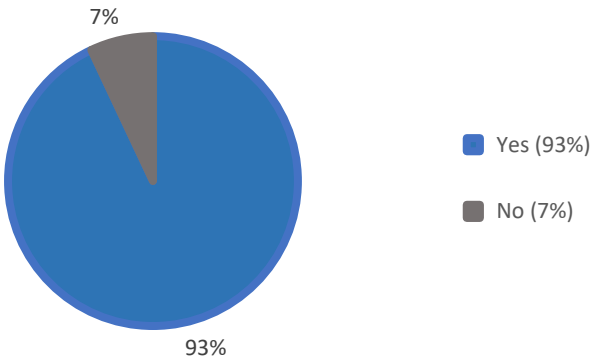
Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 57. Medicaid Health Plans with Dedicated Person or Team, 2020

Role/Team	Percentage of Medicaid Health Plans
Dedicated role/team for health disparities	100%
Dedicated role/team for health equity	87%
Dedicated role/team for racial equity	67%
Dedicated role/team for structural racism	60%
None	7%

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Figure 9. Percentage of Medicaid Health Plans with a Health Equity or Disparities Strategy or Approach, 2020



Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 58. Populations for Which Medicaid Health Plans Had a Health Equity or Disparities Strategy or Approach, 2020

Population	Percentage of Medicaid Health Plans
Health plan internal staff	79%
Provider groups	64%
Specific member population	57%
All members	50%
Other	7%

Notes: The most common specific member populations that were identified included pregnant individuals, LGBTQ+ members, children and adolescents, and people of color. "Other" included vendors.

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 59. Actions Taken by Medicaid Health Plans to Incorporate Public Health Data in Health Equity or Disparities Strategy or Approach, 2020

Use of Public Health Data
Developed a framework of data analytics through the lens of intersectionality
Implemented market scans and member planning
Conducted research and data analyses surrounding health disparities
Utilized an area deprivation index to collect data on member experiences with social determinants of health
Applied data analyses and findings to member outreach, support, and education efforts
Monitored catchment areas for pertinent outcomes using public health data

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Table 60. Approaches Utilized to Address Mis/Distrust and Past Trauma Interacting with Health Care System, 2020

Approaches
Incorporated education and awareness of health disparities, social injustice, and systemic oppression and how they impact members in all programs, operations, and levels of care
Established consistent and regular trainings, individual and group supervision, and steering committees and councils dedicated to furthering diversity, equity, and inclusion in health care
Facilitated internal and external trainings and webinars
Established long-term commitments to health equity
Enacted partnerships with community and civic organizations
Engaged members to learn about their lived experiences and relationships with the health care system and infrastructure
Committed to learning and unpacking the role of the health system on an individual and larger scale in upholding systemic oppression

Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan 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 health plan survey was developed through the contribution of national experts who volunteered countless hours over three years reviewing, editing, and finalizing the original survey instrument.

The IMI's Annual Medicaid Health Plan Survey was developed to address the paucity of national data on Medicaid managed care. The findings from the longitudinal survey that are contained in this report are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care.

Overall, the 2021 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. The response rate for the survey is calculated by Health Management Associates (HMA) utilizing their proprietary data set. The denominator excludes covered lives who are in non-managed care health plans, state pilot health plans (e.g., Colorado), carved-out health plans (e.g., Medicaid behavioral health), and health plans with limited Medicaid coverage (e.g., only dually eligible members). In addition, the survey was able to capture unique qualitative data on the barriers and challenges Medicaid health plans experience when providing access and coverage to enrollees, 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 2021 survey was distributed to all Medicaid health plans 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, health plans having no affiliation with either trade association, were individually contacted and encouraged to participate. All plans initially received the survey on March 12, 2021, with a completion deadline of April 9, 2020. 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 2020; 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 December 2020 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 health plan 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 the state could mitigate for Medicaid health plans to better address SDOH.

In the 2021 survey, in acknowledgment of the impact of the COVID-19 pandemic on Medicaid health plans and enrollees, we added a new category of questions focused on the response health plans led throughout the pandemic to support the needs of members. In addition, we added a second category of questions focused on health equity and structural racism to capture the growing efforts of health plans to center equity in their programs and operations and to consider their role in addressing structural racism. Both categories were developed with input from experts and Medicaid stakeholders. Lastly, we included a new series of questions in the women's health category to understand how Medicaid health plans are addressing the social needs of childbearing people.

Key Details

- The survey is intended to collect information longitudinally to capture trends that can inform and guide policy regarding Medicaid managed care.
- The survey collects information designed to provide an accurate and timely narrative about Medicaid health plans, highlighting what works and opportunities for improvement.
- The development of the inaugural survey included representatives from Medicaid health plans who were engaged in all steps of the three-year survey development, testing, and implementation phases.
- The survey is divided into several key categories that were identified by the Medicaid health plan representatives and Medicaid experts. They include High-Risk Care Coordination, Value-Based Purchasing, Pharmacy, Behavioral Health, Women's Health, Child and Adolescent Health, Managed Long-Term Services and Supports, Social Determinants of Health, COVID-19 Pandemic, and Health Equity and Structural Racism.
- 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, which suggests that the data presented are representative. The data provide a strong representation of the range of Medicaid health plans.

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's 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, 2020, and 2021 surveys, and no items were dropped from the report.

2015 – 2018 Medicaid Health Plan Representation for Inaugural Survey Development*

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

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

Appendix B: Survey Acronyms and Definitions

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

AAA: Area Agency on Aging.

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

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

APM: Alternative Payment Model.

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.

CMS: Centers for Medicare and Medicaid Services.

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.

Coronavirus Disease 2019 (COVID-19): Respiratory illness caused by a virus identified in 2019.

COVID-19 Pandemic: Global prevalence and spread of COVID-19.

Distrust: the feeling that someone or something cannot be relied upon. When someone doubts the honesty or reliability of; regard with suspicion.

DUR: Drug Utilization Review.

ED: Emergency Department.

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.

HBCUs: Historically Black Colleges and Universities.

Health disparities refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. Although the term "disparities" is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location are some of the factors that influence the social position and power afforded to any particular individual. How society, organizations, and individuals perceive and respond to these factors influence an individual's ability to receive high-quality health care and achieve good health. Disparities can also refer to differences between groups in health insurance coverage, access to and use of care, and quality of care.

Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically.

Health equity plan is an action-oriented, results-driven approach for advancing health equity by improving the quality of care provided to minority and other underserved members.

Health inequities are differences in health status or in the distribution of health resources among various population groups, arising from the social conditions in which people are born, grow, live, work, and age. Health inequities are unfair and could be reduced by the right mix of government policies.

HEDIS: Healthcare Effectiveness Data and Information Set.

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 managed care organization (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.

MAT: Medication-Assisted Treatment.

Mistrust: to be suspicious of; have no confidence in. To lack trust or have suspicion.

MLTSS: Managed Long-Term Supports and Services.

MLTSS 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.

MTM: Medication Therapy Management.

NEMT: Non-Emergency Medical Transportation.

OUD: Opioid Use Disorder.

PBM: Pharmacy Benefit Manager.

PDL: Prescription Drug List.

PHA: Public Housing Agencies.

PPE: Personal Protective Equipment.

Public Health Emergency (PHE): a declaration from the secretary of the Department of Health and Human Services that 1) a disease or disorder presents a PHE or 2) a PHE, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists. A PHE declaration allows the secretary to take actions to respond to the PHE.

Racial equity: defined as just and fair inclusion into a society in which all people, regardless of their race or ethnicity, can participate, prosper, and reach their full potential.

Racism: prejudice plus power that lead to different consequences for different groups.

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.

Small and Diverse Business: refers to a business that is owned by a person of color; a female; someone who is service-disabled; someone who identifies as lesbian, gay, bisexual, or transgender (LGBT); and/or someone with a disability.

Small Disadvantaged Business: refers to a business that is at least 51 percent owned and controlled by a socially and economically disadvantaged individual or individuals.

SMI: Serious mental illness.

SNAP: Supplemental Nutrition Assistance Program.

Social Need: The needs that create social value and opportunities for people to have active and effective roles in society.

Structural Racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic, and political systems in which we all exist.

SUD: Substance use disorders.

TANF: Temporary Assistance for Needy Families.

Telehealth: The use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely.

VBP: Value-based payment.

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

Z Codes: Codes for the reporting of factors influencing health status and contact with health services.