INSTITUTE FOR MEDICAID INNOVATION

2022 Annual Medicaid MCO Survey

Please return your completed survey to Dr. Jennifer Moore at JMoore@MedicaidInnovation.org.
Due Date: March 14, 2022

The Institute for Medicaid Innovation's (IMI)'s annual Medicaid managed care survey was developed, piloted, refined, and finalized in partnership with health plans, researchers, and policymakers. IMI's primary goal was to equip stakeholders with the information they needed to accurately articulate the national narrative about Medicaid managed care. The previous reports can be accessed at the IMI website.

IMI takes a number of steps to safeguard your health plan's data. Health plan data will be de-identified and stored in a locked room on a password-protected computer that is never connected to the Internet. Only IMI research staff will have access to the survey data, and all IMI staff will have received extensive training in research, data protection, and privacy. As with all IMI surveys, we will aggregate the reported findings from the analysis as a composite, so that no health plan-level identifiable data will be released. Furthermore, for variables with a small sample size, information will not be reported so as to protect the identity of the health plans.

Section A. Contact Information

IMI staff will use the following information provided below only for the purposes of clarifying survey responses.

Name:

Email:

Phone:

Name of your health plan:

Do you work at the parent organization or in an individual market?

- ◯ Parent Organization
- ◯ Individual Market

Please proceed to the next page to begin Section B. General Information.

Section B. General Information

Definitions and Acronyms for Section B

- **Children with Special Healthcare Needs (CSHCN) –** Individuals (under the age of 18) who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally.
- **FQHC -** Federally Qualified Health Center.
- **I/DD –** Individuals with Intellectual and Developmental Disabilities.
- **MAT -** Medication-Assisted Treatment.
- **OUD -** Opioid Use Disorder.
- **SMI –** Individuals with Serious Mental Illness.
- **SUD –** Substance Use Disorder.

Please respond to the following items at the **parent level** for **only the Medicaid product line.**

1. Type of health plan of your parent organization
   - ○ Private, For-profit
   - ○ Private, Non-profit
   - ○ Government or Other, specify:

2. Is your parent organization provider-owned?
   - ○ Yes
   - ○ No

3. In what year did your health plan begin participating in Medicaid programs as a managed care organization (MCO)?

4. How many individuals were enrolled in your Medicaid MCO in all contracts and markets as of December 2021?

5. Considering your 2021 contracts, across all of your markets, indicate which populations your Medicaid MCO had experience serving? ***Check all that apply.***

- [ ] Children
- [ ] Adult Caregivers
- [ ] Aged, Blind, Disabled
- [ ] Medicare and Medicaid Enrollees (Duals)
- [ ] Children and Youths in Foster Care
- [ ] Children with Special Healthcare Needs
- [ ] Individuals with I/DD
- [ ] Individuals with SMI
- [ ] Childless Adults
- [ ] Individuals with SUD/OUD
- [ ] Pregnant Individuals
- [ ] Sexual and Gender Minorities

6. Across all of your markets in 2021, did your health plan offer targeted programs to address sexual and gender minority health?

- ○ Yes
- ○ No, but considering
- ○ No, and not considering

7. Considering your 2021 contracts, across all markets, indicate which benefits your Medicaid MCO actively managed (i.e., accepted financial risk and coordinated benefits). ***Check all that apply.***

- [ ] Physical Health
- [ ] Behavioral Health
- [ ] Institutional Care (e.g., Nursing facility and/or intermediate care facilities for developmentally disabled)
- [ ] Home and Community-Based Waiver Services
- [ ] Pharmacy (i.e., in-patient, out-patient and/or injectables)
- [ ] Dental
- [ ] Gender-affirming treatment, including hormone therapies and surgical procedures
- [ ] Vision

8. Does your organization currently have Medicaid contracts in...

- ○ Multiple states
- ○ Single state

9. Please indicate the following health care settings with which you had at least one contract in 2021 in any of your markets. ***Check all that apply.***

- [ ] Academic medical centers
- [ ] Public hospitals
- [ ] Urgent care clinics
- [ ] Retail clinics (e.g., CVS Minute Clinic)
- [ ] Community health centers (e.g., FQHCs)
- [ ] Maternal and child health clinics
- [ ] Family planning clinics (Title X)
- [ ] Planned Parenthood
- [ ] Behavioral health centers
- [ ] SUD agencies (e.g., methadone and other MAT clinics)
- [ ] HIV/AIDS services organizations (e.g., Ryan White providers)
- [ ] School-based clinics
- [ ] Indian Health Service providers or tribal health clinics
- [ ] Local/County health departments
- [ ] Rural health clinics
- [ ] Skilled nursing facilities
- [ ] Safety-net hospitals
- [ ] None of the above
- [ ] Other, specify:

10. Across all of your markets in 2021, identify the strategies your Medicaid MCO used to recruit and retain providers. Include strategies used for any type of provider or provider location. ***Check all that apply.***

- [ ] Prompt payment policies (e.g., guaranteed payment timeframe)
- [ ] Financial incentives (e.g., sign-on bonus or bonus payments tied to quality indicators)
- [ ] Debt repayment
- [ ] Pay rates comparable to Medicare or commercial rates
- [ ] Automatic assignment of members to primary care providers
- [ ] In-person outreach to providers
- [ ] Reduced administrative burdens (e.g., streamline reporting requirements)
- [ ] Streamlined credentialing and re-credentialing process
- [ ] Use of technology (e.g., electronic health records or provider portal)
- [ ] Streamlined referral and authorization practices
- [ ] Dedicated provider hotline for questions, problems, and needs
- [ ] Other, specify:
- [ ] None

Section C. High-Risk Care Coordination

Definitions and Acronyms for Section C

- **Care team –** Group of individuals (clinicians and non-clinicians) within and outside the health plan that support members' access, coverage, and coordination of care.
- **Community health worker –** Community health workers (CHWs) are lay members of the community who work in association with the local health care system. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve.
- **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.
- **General Medicaid contract –** Medicaid contracts with managed care that primarily focus on Medicaid benefits outlined in the state plan, typically consisting of eligibility categories for women, children, and childless adults.
- **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 MCO or a delegated entity and include programs such as Complex Member Management, Disease Management, High-Risk Maternity Management, etc.
- **MCOs –** Managed care organizations. For the purposes of this survey, we are exclusively interested in Medicaid managed care organizations.
- **MLTSS –** Managed long-term services and supports.
- **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.
- **Peer support worker -** Individuals with lived experience of a health condition who helps and provides social, emotional, or practical support to others experiencing the same condition.

Please respond to the following items for **only the Medicaid product line.**

This section will focus on the use of high-risk care coordination within general Medicaid contracts. Unique care delivery models designed for complex population contracts or MLTSS contracts are **not** the focus of this section.

1. Of the following, select the items that prevented the completion of individual health risk assessments of your members in 2021. ***Check all that apply.***

- ☐ Difficulty reaching member because of inaccurate information (e.g., lack of confirmed member record, dispute in resolving the identify of member, incorrect contact information)
- ☐ Difficulty reaching member with accurate information (e.g., member did not want to be reached, member's phone ran out of minutes)
- ☐ Member refused
- ☐ State deadline to complete assessments within timeframe
- ☐ Other, specify:
- ☐ None

2. Across all of your markets in 2021, what were the core functions performed under high-risk care coordination beyond those that were contractually obligated? ***Check all that apply.***

- ☐ Provided guided referrals or "hand-offs" to other needed social services (e.g., faith-based, non-profit, other government programs)
- ☐ Coordinated with social services (i.e., housing providers, nutrition programs) as part of care plan development and adherence
- ☐ Shared data with social service organizations
- ☐ Coordinated multiple care coordinators from health systems, provider practices, clinics, etc.
- ☐ Other, specify:
- ☐ None

3. In any market in 2021, identify which outcomes you used to track the effectiveness of high-risk care coordination. ***Check all that apply.***

- [ ] Emergency Department utilization (HEDIS measure)
- [ ] Emergency Department utilization (unrelated to HEDIS measure)
- [ ] Inpatient utilization (HEDIS measure)
- [ ] Inpatient utilization (unrelated to HEDIS measure)
- [ ] Impact on other HEDIS measures

  Please list measures:
- [ ] Preventive care
- [ ] Outpatient primary care utilization
- [ ] Total spending
- [ ] Patient experience survey results (e.g., Consumer Assessment of Healthcare Providers and Systems)
- [ ] Provider experience survey results
- [ ] Complaints and grievances
- [ ] Other, specify:
- [ ] Our health plan did not track the effectiveness

4. Of the following, identify the barriers that your health plan experienced in any market in 2021 in providing effective high-risk care coordination. ***Check all that apply.***

- [ ] Member access to primary care
- [ ] Member access to specialty care
- [ ] Ability to contact member
- [ ] Obtaining consent
- [ ] Member's willingness to engage
- [ ] Access to information from previous providers (e.g., mental health)
- [ ] Ability to share information with service providers
- [ ] Provider willingness to engage with health plan
- [ ] Availability of social supports
- [ ] Member's ability to navigate multiple care coordinators from health systems, provider practices, clinics, etc.
- [ ] Member's unmet social needs
- [ ] Ability to connect individuals to necessary non-clinical social supports
- [ ] Churn (member or eligibility-related)
- [ ] Member's knowledge of managed care
- [ ] Language barrier(s)
- [ ] Other, specify:
- [ ] None

5. Please list any additional information or categories of data that state Medicaid agencies could provide to help health plans better target high-risk care coordination (e.g., historical claims data, clinical encounters, school enrollment, interactions with the criminal justice system, and other demographics, etc.). ***Check all that apply.***

General background data, such as:

- [ ] Demographic data (e.g., age, gender)
- [ ] Race, Ethnicity and Language (REaL) data
- [ ] Contact data (e.g., phone numbers, email addresses)
- [ ] Household data (e.g., POA, Guardian, and Head of Household information)
- [ ] Other, specify:
- [ ] None

Medical system data, such as:

- [ ] Historical claims data and clinical encounters
- [ ] Case management or social work encounters
- [ ] Behavioral health diagnoses/treatment/providers
- [ ] Health status indicators
- [ ] Special health care needs indicators
- [ ] Smoking/tobacco use
- [ ] Other, specify:
- [ ] None

Social determinants of health data, such as:

- [ ] School enrollment
- [ ] Foster care status
- [ ] Engagement in other state programs (e.g., WIC)
- [ ] Housing situation/stability (e.g., unhoused)
- [ ] Other, specify:
- [ ] None

6. Across all of your markets in 2021, please identify your non-clinical high-risk care coordination workforce? ***Check all that apply.***

- [ ] Community Health Worker
- [ ] Perinatal Community Health Worker
- [ ] Peer Support Worker
- [ ] Doula
- [ ] Health Educator
- [ ] Other, specify:
- [ ] None

7. Across all of your markets in 2021, what types of engagement or communication channels did your health plan use to provide high-risk care coordination services? ***Check all that apply.***

- ☐ Home visits
- ☐ Video visits
- ☐ Telephonic
- ☐ Community center visits
- ☐ Community-based adult services center visits
- ☐ Other, specify:
- ☐ None

8. OPTIONAL: Does your health plan offer any innovative initiatives or best practices in high-risk care coordination? If yes, please briefly describe below.

Who can we contact for more information?

Name: Phone:

Email:

9. OPTIONAL: Did we miss anything? Please share any information that you feel would be helpful in understanding how Medicaid MCOs provide high-risk care coordination services and any issues that are encountered in delivering these services.

Section D. Value-Based Purchasing

Definitions and Acronyms for Section D

- **APM -** Alternative Payment Model.
- **CAHPS -** Consumer Assessment of Healthcare Providers and Systems (CAHPS).
- **COVID-19 Pandemic -** Global prevalence and spread of COVID-19.
- **CQMC -** Core Quality Measures Collaborative.
- **HEDIS -** Healthcare Effectiveness Data and Information Set.
- **VBP -** Value-Based Payment.

Please respond to the following items for **only the Medicaid product line.**

1. Across all of your markets in 2021, did your health plan use APM or VBP arrangements?

   - ○ Yes
   - ○ No

If no, proceed to Section E.

2. In 2021, were any of your contracts (markets) required by the state to implement VBP or APM contracting between health plans and providers?

   - ○ Yes
   - ○ No, but we anticipate it with the next contract renewal
   - ○ No, and not planned with the next contract renewal
   - ○ Other, specify:

3. Across any of your markets in 2021, to what extent did your health plan implement VBP within specific populations (anything not targeted toward your entire population)? ***Check all that apply.***

   - ☐ We did not develop population-specific VBP models; our VBP arrangements are focused on the Medicaid population broadly
   - ☐ We explored but did not implement population-specific VBP arrangements
   - ☐ We piloted population-specific VBP arrangements

     List populations:

   - ☐ We expanded our pilots with population-specific VBP arrangements

     List populations:

   - ☐ We had extensive VBP arrangements that are population-specific

     List populations:

4. To what extent did your health plan, in any market, have VBP arrangements within the following provider categories in 2021? ***Select one response per row.***

	Worked with a Majority of Providers	Worked with Select Providers	Did Not Work with This Provider
Behavioral Health Providers	○	○	○
Dentists	○	○	○
Home and Community-Based Service Providers	○	○	○
Long-Term Care Facilities	○	○	○
Midwives	○	○	○
OBGYNs	○	○	○
Orthopedics	○	○	○
Primary Care Providers (i.e., Physicians, Advanced Practice Nurses, Physician Assistants)	○	○	○
Hospitals	○	○	○
Ambulatory Surgery Centers	○	○	○
Federally Qualified Health Centers or Rural Health Centers	○	○	○
Other Specialists	○	○	○

5. Across all of your markets in 2021, were any of the above providers required to participate in VBP or APM arrangements?

- ○ Yes
- ○ No

6. In any market in 2021, identify any of the following payment strategies that your health plan used. ***Check all that apply.***

- ☐ Enhanced payment rates for providers in rural or frontier areas
- ☐ Enhanced payment rates for hard-to-recruit provider types
- ☐ Payment incentives for availability of same-day or after-hours appointments
- ☐ Payment incentives based on performance measures related to access to care
- ☐ Incentive payments for addressing health disparities
- ☐ Incentive payments for addressing health inequities
- ☐ Enhanced payment rates for providers financially impacted by the COVID-19 pandemic
- ☐ Other, specify:
- ☐ We did not use any payment strategies

7. In any of your markets in 2021, please indicate whether your Medicaid MCO used any of the following VBP arrangements or APMs for any providers. ***Check all that apply.***

- [ ] Non-payment or reduced payment for elective deliveries before 39 weeks
- [ ] Non-payment or reduced payment for patient safety issues (e.g., never events)
- [ ] Incentive/bonus payments tied to specific performance measures (e.g., pay-for-performance)
- [ ] Payment withholds tied to performance
- [ ] Bundled or episode-based payments
- [ ] Global or capitated payments to primary care providers or integrated provider entities
- [ ] Arrangements with upside risk
- [ ] Arrangements with downside risk
- [ ] Upfront payments to encourage faster movement to more advanced APMs
- [ ] Other, specify:
- [ ] None

8. In any of your markets in 2021, what were the operational barriers experienced for your MCO that were addressed for adoption and innovation in VBP and/or APMs? ***Check all that apply.***

- [ ] Data reporting to providers
- [ ] IT system preparedness
- [ ] Support to providers to make determinations on VBP and/or APM
- [ ] Pricing structures/actuarial soundness
- [ ] Tracking quality and reporting within new structure
- [ ] Contract requirements on VBP/APM approaches
- [ ] Human Resources
- [ ] None
- [ ] Other, specify:

9. In any of your markets in 2021, identify the external barriers that influenced the adoption and innovation in VBP and/or APMs. ***Check all that apply.***

- ☐ Provider readiness and willingness
- ☐ Health plan-provider data sharing capabilities
- ☐ State requirements limiting VBP and/or APM models
- ☐ Medicaid payment rates
- ☐ Impact of 42 CFR Part 2 on limiting access to behavioral health data
- ☐ Uncertain or shifting federal policy requirements/priorities
- ☐ Uncertain or shifting state policy requirements/priorities
- ☐ Variation in payment models across payers (e.g., Medicaid, commercial, Medicare)
- ☐ COVID-19 pandemic
- ☐ Lack of consistent evidence of efficacy of VBP and/or APM models
- ☐ None
- ☐ Other, specify:

10. Across all of your markets in 2021, what, if any, measure sets did you consider or use to evaluate performance in your VBP model? Please specify measures used within each set.

- ☐ HEDIS measures
  Please specify:
- ☐ CQMC measures
  Please specify:
- ☐ CAHPS
  Please specify:
- ☐ Medicaid Core Sets
  Please specify:
- ☐ Patient-reported outcome measures
  Please specify:

11. What specific changes to state requirements and guidance would remove barriers and assist in more effectively implementing VBP and/or APM? ***Check all that apply.***

- [ ] More flexibility in the design of VBP components (e.g., member attribution, benchmarking)
- [ ] Development of a multi-year proposed VBP strategy to allow for longer-term contracts with Medicaid
- [ ] Provision of additional policy and/or fiscal levers for MCOs to ensure provider engagement in VBP models
- [ ] Policies to facilitate data sharing between payers and providers
- [ ] Removal of data sharing restrictions
- [ ] Better education for providers on state and health plan expectations
- [ ] Better education for health plans on state expectations for VBP
- [ ] Reporting of consistent metrics
- [ ] Removal of requirements that limit VBP and APM model development
- [ ] Streamlined VBP design across payers, including aligned performance measures
- [ ] Multi-payer alignment in VBP strategies
- [ ] Other, specify:
- [ ] None

12. Across all of your markets in 2021, to what degree did your VBP and APM designs incorporate social determinants of health? ***Check all that apply.***

- [ ] Our model designs required screening for social determinants
- [ ] Our performance measures included social determinant-related outcomes, such as food insecurity or housing instability
- [ ] Health care providers were incentivized to intervene on certain social determinants of health
- [ ] We did not specifically address social determinants of health in our VBP or APM designs

13. Across all of your markets in 2021, what impact, if any, did the COVID-19 pandemic have on your VBP and/or APM strategies in 2021? ***Check all that apply.***

- [ ] Opportunities for implementation of new strategies
- [ ] Higher provider participation rates in VBP/APMs
- [ ] Lower provider participation rates in VBP/APMs
- [ ] Modification or suspension of VBP and/or APM payment methodologies (e.g., quality metrics or benchmarks)
- [ ] Reconsideration of long-term organizational strategy for VBP and/or APMs
- [ ] Other, specify:
- [ ] None

14. OPTIONAL: Does your health plan have any innovative initiatives or best practices in VBP and/or APM? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

15. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs are leveraging VBP and/or APM, along with any issues that are encountered in delivering these services.

Section E. Pharmacy

Definitions and Acronyms for Section E

- **EHR -** Electronic health record.
- **FFS -** Fee-for-service.
- **MTM -** Medication Therapy Management.
- **PA -** Prior Authorization.
- **PBM -** Pharmacy benefit manager.
- **PDL -** Prescription drug list.

Please respond to the following items for **only the Medicaid product line.**

1. During 2021, in any market, was your health plan at-risk for pharmacy benefits under any of your contracts?

   - ○ Yes
   - ○ Yes, but only a portion of the pharmacy spend
   - ○ No

If no, proceed to Section F.

2. If your health plan had an MTM program in 2021, what types of pharmacists were involved? ***Check all that apply***

   - ☐ Internal pharmacy staff
   - ☐ Community pharmacists
   - ☐ Pharmacists integrated in provider groups and/or hospitals
   - ☐ Pharmacists from an MTM vendor
   - ☐ We did not have an MTM program
   - ☐ MTM program did not include pharmacists

3. For 2021, across all of your markets, identify the major challenges that your health plan faced when managing the prescription drug benefit. ***Check all that apply.***

- ☐ Pharmacy benefits or subset of benefits carved out of managed care
- ☐ Difference between plan formularies and methodologies and state requirements
- ☐ Utilization and cost history unknown for new drugs entering a market; had an impact on capitation rates and pricing
- ☐ Members' comprehension of and engagement in programs
- ☐ Formulary notification requirements as part of Medicaid MCO Final Rule
- ☐ Pharmacy network requirements
- ☐ Single PDL/formulary requirements
- ☐ Increase in number of specialty pharmacy medications
- ☐ Increase in cost of specialty pharmacy medications
- ☐ Vendor performance management (e.g., PBM, specialty)
- ☐ Other, specify:
- ☐ None

4. In any market in 2021, what functionality of electronic prior authorization system did your health plan use? ***Check all that apply.***

- ☐ Integration of plan formulary into EHR
- ☐ Electronic PA submission
- ☐ Automated PA adjudication
- ☐ Other, specify:
- ☐ None, but is in development
- ☐ None

5. In 2021, what were the most effective strategies that the state(s) you had contracts with used to address the costs of new or high- cost drugs for Medicaid MCOs? ***Check all that apply.***

- ☐ Carved-out the drug costs completely; pay FFS for certain drug(s)
- ☐ Transition period where drug(s) are offered in FFS to get claims data then rolled into contracts
- ☐ Capitation rate adjustments made off the normal rate cycle
- ☐ Capitation rate adjustment as part of regular rate adjustments
- ☐ Stop-loss provision to cap the plan's cost for the drug
- ☐ Risk corridor for high-cost medications
- ☐ Risk sharing
- ☐ Kick payment for certain drug(s)
- ☐ Value-based contracts with manufacturers
- ☐ States have not addressed the cost
- ☐ Other, specify:

6. As of 2021, what pharmacy benefit/formulary activities or initiatives has your health plan implemented to address the opioid epidemic? ***Check all that apply.***

- ☐ Quantity and/or days' supply limits for new starts
- ☐ Review dose limit policies to ensure they do not encourage involuntary tapers and prompt clinical review of exception requests to ensure that harm does not exceed benefit for individual members
- ☐ Remove or restrict methadone for pain
- ☐ Policies to decrease new starts for concurrent opioid/benzodiazepine
- ☐ Remove or reduce restrictions for or add to formulary common non-opioid pain medications (e.g., topicals, antidepressants, neuroleptics with indications for pain)
- ☐ Remove or reduce restrictions for other pain services
- ☐ Pharmacy and/or prescriber lock program for members using multiple prescribers
- ☐ Case management to ensure appropriate care and referral to services
- ☐ Removing barriers to MAT (e.g., PA for testing or MAT)
- ☐ Other, specify:

7. OPTIONAL: Does your health plan have any innovative initiatives or best practices in pharmacy management (e.g., e-prescribing system, real time benefits check)? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

8. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs provide pharmacy services and any issues that are encountered in delivering these services.

Section F. Behavioral Health

Definitions and Acronyms for Section F

- **SUD -** Substance use disorder.

Please respond to the following items for **only the Medicaid product line.**

1. In 2021, across any of your markets, were you at-risk for behavioral health services?

   - ○ Yes
   - ○ No

If no, proceed to Section G.

2. Please indicate the barriers that your health plan experienced in 2021 across any of your markets when addressing **behavioral and physical health integration**.
   Check all that apply.

Operational Barriers

- ☐ Staffing in care management to align skills sets with integrated care needs
- ☐ Communication between care management and behavioral health
- ☐ Access to data between care management and behavioral health teams
- ☐ System differences with subcontractor
- ☐ Other, specify:

Network Barriers

- ☐ Provider's capacity to provide integrated physical and behavioral health at point of care
- ☐ Behavioral health provider's readiness for managed care
- ☐ Behavioral health provider's adoption of electronic health records
- ☐ Other, specify:

Policy Barriers

- ☐ 42 CFR Part 2 limitations on SUD treatment information being shared
- ☐ Institutions of Mental Disease (IMD) exclusion
- ☐ Fragmentation in program funding and contracting for physical and behavioral health services
- ☐ State-specific substance use confidentiality laws
- ☐ State-specific behavioral health confidentiality laws
- ☐ Other, specify:

3. Across any of your markets in 2021, did your health plan's contract(s) with the state include the following types of services and medications for most Medicaid members? ***Please select one response per row.***

	Yes, Managed by Our Medicaid MCO	Yes, Sub-contracted to a Vendor	Varied by Population	No	Not Applicable
Behavioral health assessment/screening	○	○	○	○	○
Outpatient mental health services	○	○	○	○	○
Inpatient/residential mental health services	○	○	○	○	○
Outpatient substance use disorder treatment services	○	○	○	○	○
Inpatient/residential substance use disorder treatment services	○	○	○	○	○
Detox services (outpatient or residential)	○	○	○	○	○
Partial hospitalization/ intensive outpatient treatment for substance use	○	○	○	○	○
Partial hospitalization/ intensive outpatient treatment for mental health	○	○	○	○	○
Substance use disorder recovery support services	○	○	○	○	○
Medication for opioid use disorder	○	○	○	○	○
Medication for alcohol use disorder	○	○	○	○	○

4. OPTIONAL: Does your health plan have any innovative initiatives or best practices specific to behavioral health? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

5. OPTIONAL: Did we miss anything? Please share anything that might be helpful in understanding how MCOs provide behavioral health services and any issues that are encountered in delivering these services.

Section G. Women's Health

At the Institute for Medicaid Innovation, we recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this survey uses both gendered terms such as "women" or "mothers" and gender-neutral terms such as "people," "pregnant people," and "birthing persons."

Definitions and Acronyms for Section G

- **LTSS -** Long-term services and supports.
- **Social Needs -** The needs that create social value and opportunities for people to have an active and effective role in society. For example, access to healthy food or living in a safe neighborhood without police violence.

Please respond to the following items for **only the Medicaid product line.**

1. In 2021, in any market, please identify the women's health priorities that had a specific targeted program(s) or engagement strategies. ***Check all that apply.***

- ☐ Prenatal care
- ☐ Intrapartum care
- ☐ Postpartum care, including lactation support
- ☐ Heart disease
- ☐ Cancer screening and treatment
- ☐ Diabetes
- ☐ Obesity
- ☐ Behavioral health
- ☐ Sexual and reproductive health care
- ☐ Health disparities
- ☐ Social needs
- ☐ Issues related to aging (e.g., osteoporosis management, urinary incontinence, cognitive health)
- ☐ LTSS
- ☐ Intimate partner violence
- ☐ Trauma-informed care
- ☐ Other, specify:
- ☐ None

2. In 2021, in any of your markets, which of the following provider types did your health plan contract with to serve as a primary care provider for women? ***Check all that apply.***

- ☐ Nurse practitioners
- ☐ Nurse-midwives
- ☐ Geriatricians
- ☐ Certified professional midwives
- ☐ Certified midwives
- ☐ Licensed midwives
- ☐ Other, specify:
- ☐ None

3. In 2021, for any market, please identify the provider settings that your health plan contracted with to provide your members with sexual and reproductive health care. ***Check all that apply.***

- ☐ Freestanding family planning providers
- ☐ Planned Parenthood Health Centers
- ☐ Rural health centers
- ☐ Federally qualified health centers/community health centers
- ☐ State or local health departments
- ☐ School-based clinics
- ☐ Hospital-based clinics
- ☐ Freestanding birth centers
- ☐ Telecontraception platforms
- ☐ Other, specify:
- ☐ None

4. In 2021, across all of your markets, is your health plan utilizing any contraceptive quality measures. ***Check all that apply.***

- ☐ Contraceptive care – most and moderately effective methods
- ☐ Contraceptive care – access to LARC
- ☐ Contraceptive care – postpartum
- ☐ Patient-centered contraceptive counseling
- ☐ Other/specify:
- ☐ None

6. In any of your markets in 2021, did your health plan have any initiatives to improve health outcomes and experiences related to the following including but not limited to efforts focused on health inequities, safety, respectful care, and shared decision making? ***Check all that apply.***

- ☐ Maternal health
- ☐ Teens and adolescents
- ☐ Post-menopausal women
- ☐ Other, specify:
- ☐ None

7. Across all of your markets in 2021, which, if any, of the following ancillary services were covered benefits for childbearing people?

- ☐ Nutritional counselling
- ☐ Support from a community health worker
- ☐ Childbirth education class
- ☐ Breastfeeding class
- ☐ Doula
- ☐ Centering Pregnancy
- ☐ Lactation counseling
- ☐ Parenting class
- ☐ Other, specify:
- ☐ None

8. In any market in 2021, did your health plan provide maternity-focused training to improve birth equity (e.g., explicit or implicit bias, trauma-informed care, structure, institutional, or interpersonal racism) to providers/partners?

- ○ Yes
- ○ No, but exploring.
- ○ No, and no plans to offer this type of equity training.

9. OPTIONAL: Does your health plan have any innovative initiatives or best practices specific to women's health? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

10. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs address women's health.

Section H. Child & Adolescent Health

Definitions and Acronyms for Section H

Children with Special Healthcare Needs (CSHCN) – 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.

Please respond to the following items for **only the Medicaid product line.**

1. In 2021, in any of your markets, did your health plan offer targeted programs to address children's health?

- ○ Yes
- ○ No

If no, proceed to Section I.

2. In 2021, in any market, please identify the health priorities that had a specific targeted program(s) or engagement strategies for children and adolescents, in addition to well- child visits and immunizations. ***Check all that apply.***

- ☐ Asthma
- ☐ Obesity
- ☐ Diabetes
- ☐ Autism spectrum disorder
- ☐ ADHD/ADD
- ☐ Depression/Anxiety
- ☐ Adverse Childhood Experiences
- ☐ Children with Special Healthcare Needs
- ☐ Behavioral health screening and treatment
- ☐ Substance use disorder
- ☐ Dental health
- ☐ Comprehensive sex education and health services
- ☐ Transitioning to adulthood and independence for children and youth in foster care
- ☐ Transitioning from pediatric to adult systems of care for CSHCN
- ☐ Tobacco use
- ☐ Teen pregnancy and parenting
- ☐ Readiness to start school
- ☐ Health disparities impacting individuals with diverse sexual orientations and gender identities
- ☐ Coordination with school-based health care
- ☐ Mother/child dyadic services
- ☐ Other, specify:
- ☐ None

3. Please indicate which of the following barriers your health plan encountered in 2021 in any market when serving children. ***Check all that apply.***

- ☐ Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)
- ☐ Engaging family members who are not enrolled in the plan
- ☐ Engaging family members to address social determinants of health
- ☐ Program fragmentation
- ☐ Language barriers
- ☐ Churn (member or eligibility-related)
- ☐ Inability to find needed health care providers or beds
- ☐ Coordinating with Department of Child Services/Department of Juvenile Justice for children engaged with child welfare or juvenile justice systems
- ☐ Barriers related to foster care system
- ☐ Immigration status of parents/caregivers
- ☐ Carved-out benefits
- ☐ Other, specify:
- ☐ None

4. In 2021, across any of your markets, did states contract with your health plan for CSHCN?

- ○ Yes
- ○ No

5. Across any of your markets in 2021, please indicate which of the following barriers your health plan encountered when serving CSHCN. ***Check all that apply.***

- ☐ Consistency in identification parameters
- ☐ Misinformation about managed care value to CSHCN
- ☐ Carved-out services created an increased risk for duplication and costs
- ☐ Carved-out services created inefficient services for families (e.g., too many coordinators)
- ☐ Inadequate communication and coordination among multiple providers
- ☐ Lack of consistent quality measures specific to unique needs of CSHCN
- ☐ Insufficient information regarding the goals and preferences of CSHCN and their families
- ☐ Churn (member or eligibility-related)
- ☐ Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)
- ☐ Carved-out services created information silos which hindered coordination
- ☐ Access to pediatric specialty providers
- ☐ Language barriers
- ☐ Coordinating with Department of Child Services/Department of Juvenile Justice for children engaged with child welfare and juvenile justice systems
- ☐ Other, specify:
- ☐ None

6. Across all of your markets in 2021, did your health plan track COVID-related disruption of screenings, immunizations, and other services that must be provided at regular intervals for children and adolescents?

- ○ Yes
- ○ No

If no, skip to question #9.

7. If yes, how did you track disruptions? Please briefly describe below.

8. If yes, what did you find? Please briefly describe below.

9. OPTIONAL: Does your health plan have any innovative initiatives or best practices in child and adolescent health? If yes, please briefly describe below.

Who could we contact for more information?

Name: Phone:

Email:

10. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how MCOs provide child and adolescent health services and any issues that are encountered in delivering these services.

Section I. Managed Long-Term Services and Supports

Definitions and Acronyms for Section I

- **AAA -** Area Agency on Aging.
- **ADL/IADL -** Activities of Daily Living/Independent Activities of Daily Living.
- **CIL -** Centers for Independent Living.
- **MLTSS -** Managed Long-Term Services and Supports.

Please respond to the following items for **only the Medicaid product line.**

1. In any of your markets in 2021, were you at-risk for managed long-term services and supports?

   - ○ Yes
   - ○ No

If no, please proceed to Section J.

2. If you used MLTSS care teams in 2021 in any of your markets, what was the standard team composition? ***Check all that apply.***

   - ☐ Individual member
   - ☐ Family member
   - ☐ Guardian
   - ☐ Representative from primary care clinician's office
   - ☐ Member's primary care provider
   - ☐ Member of the social services network (e.g., AAA, housing agency, transportation agency, meals provider)
   - ☐ Other health care professional not employed by the health plan
   - ☐ Natural/community supports other than guardian (e.g., family, friend, neighbor, clergy)
   - ☐ Representative from nursing home
   - ☐ Care coordinator within the health plan
   - ☐ Behavioral health specialist within the health plan
   - ☐ Pharmacist within the health plan
   - ☐ Community health worker within the health plan
   - ☐ Peer support specialist within the health plan
   - ☐ Any person the member wanted to invite
   - ☐ Other, specify:
   - ☐ Our health plan did not use care teams

3. Across all of your markets in 2021, identify the barriers that affected your health plan's ability to manage MLTSS in any of your markets. ***Check all that apply.***

- ☐ Fragmented Medicaid benefit design – behavioral health and/or physical health benefits – limits ability to serve the whole individual
- ☐ Medicare and Medicaid misalignment creates challenges and financial disincentives
- ☐ State requirements for health plans to contract with specific organizations or providers for care coordination
- ☐ Restrictions to in-person assessments and care delivery due to COVID-19
- ☐ Challenges related to the direct-care workforce (e.g., lack of staff, turnover, training, and qualification challenges)
- ☐ State program requirements that limit the effectiveness of managed care strategies (e.g., any-willing-provider provisions, continuity-of-care provisions)
- ☐ Waiver waitlists
- ☐ 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)
- ☐ Churn (member or eligibility-related)
- ☐ Other, specify:
- ☐ None

4. In 2021, in any market, indicate to what extent your health plan leveraged the following innovations. ***Select one response per row.***

Innovations	Always (i.e., A required part of our approach to MLTSS)	Sometimes (i.e., Based on members' needs)	Limited (i.e., Small pilot program or case-by-case)	Not Provided
Remote monitoring	○	○	○	○
Telehealth other than remote monitoring that is specific to the MLTSS population	○	○	○	○
Care coordination communication tools with caregivers, direct services workers, and other in-home providers or support organizations	○	○	○	○
Partnerships with community-based organizations (e.g., AAAs, CILs)	○	○	○	○
Electronic Visit Verification	○	○	○	○
Value-based payment arrangements with MLTSS providers	○	○	○	○
Caregiver supports and services (outside of administering benefits required by state plan)	○	○	○	○
Wellness initiatives	○	○	○	○
Healthy eating or nutrition programs outside of administering benefits required by state plan	○	○	○	○
Unique housing strategies outside of administering benefits required by state plan	○	○	○	○
Money Follows the Person or other community transition programs	○	○	○	○
Self-advocacy	○	○	○	○
Employment initiatives outside of administering benefits required by state plan	○	○	○	○
Tools for self-direction	○	○	○	○
Transportation innovations	○	○	○	○
In-home care to support targeted complex population(s)	○	○	○	○
Other, specify				

5. Across all of your markets in 2021, what barriers, if any, did your health plan encounter when supporting various transitions of care?

	Barriers								
	Data exchange	Housing/ Bed availability	Caregiver support	Availability of in-home supports	Coordi-nation of community services in advance of transition	Continuity of services	Availability of respite care	Availability of hospice	Identifying and offering dedicated resources and support to caregivers
Community to institution	☐	☐	☐	☐	☐	☐	☐	☐	☐
Institution to institution	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hospital to nursing facility	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hospital to home	☐	☐	☐	☐	☐	☐	☐	☐	☐
Home to hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nursing facility to home	☐	☐	☐	☐	☐	☐	☐	☐	☐
Home to nursing facility	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. OPTIONAL: Does your health plan have any innovative initiatives or best practices specific to managed long-term services and supports? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

7. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs provide coverage for MLTSS that we did not ask about.

Section J. Social Determinants of Health

Definitions and Acronyms for Section J

- **CBO -** Community-Based Organization.
- **CMS -** Centers for Medicare and Medicaid Services.
- **COC -** Continuum of Care.
- **CSHCN -** Children with special health care 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 that required by children generally.
- **EHR -** Electronic Health Record.
- **IEP -** Individualized Education Plan.
- **IMD** - Institution for Mental Diseases.
- **NEMT** - Non-Emergency Medical Transportation.
- **PHA -** Public Housing Agencies.
- **SDOH -** Social determinants of health, also referred to as social influencers of health are environmental conditions into 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. For example, housing, food, and public safety.
- **SNAP -** Supplemental Nutrition Assistance Program.
- **TANF -** Temporary Assistance for Needy Families.
- **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.

Please respond to the following items for **only the Medicaid product line.**

1. In any of your markets in 2021, to which populations did you offer targeted SDOH programs? ***Check all that apply.***

- [ ] People with criminal legal system involvement
- [ ] People living with HIV/AIDS
- [ ] Pregnant and postpartum individuals
- [ ] Foster care youth/Youth transitioning to adulthood
- [ ] CSHCN
- [ ] People experiencing homelessness/housing insecurity
- [ ] Adults with substance use disorder
- [ ] Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)
- [ ] Individuals in IMD
- [ ] Residential institution/Facility placed individuals
- [ ] Child welfare/Child protective services involving families
- [ ] Adults with disabilities (e.g., physical, intellectual, developmental)
- [ ] Aged, blind, and disabled
- [ ] Expansion members
- [ ] Adults with serious mental illness
- [ ] Individuals with diverse sexual orientations and gender identities
- [ ] Medicare and Medicaid Enrollees (Duals)
- [ ] People with limited English proficiency
- [ ] Other, specify:
- [ ] None of the above

2. In any of your markets in 2021, what SDOH screening tools did you utilize? ***Check all that apply.***

- ☐ American Community Survey
- ☐ The EveryOne project: Advancing health equity in every community, Toolkit by American Academy of Family Physicians
- ☐ Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE)
- ☐ Social Needs Screening Toolkit, HealthLeads USA
- ☐ Social Determinants Screening Tool, AccessHealth Spartanburg, Center for Health Care Strategies version
- ☐ Self-Sufficiency Outcomes Matrix, OneCare Vermont, Center for Health Care Strategies version
- ☐ Arizona Self-Sufficiency Matrix
- ☐ Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)
- ☐ CMS Accountable Health Communities Health-Related Social Needs Screening Tool
- ☐ Tool(s) embedded in provider EHR
- ☐ Adaptation of one or more of the tools listed above
- ☐ Internally developed tool that is not based on one of the tools listed above
- ☐ State-mandated tool, list states:
- ☐ Other, specify:
- ☐ None

3. Across all your markets in 2021, which SDOH issues did your members identify as needing support? ***Check all that apply.***

- ☐ Housing
- ☐ Nutrition/Food security
- ☐ Social Isolation/Sense of belonging
- ☐ Education
- ☐ Financial literacy (i.e., assistance with household budgets and finances)
- ☐ Non-emergency medical transportation (NEMT)
- ☐ Non-medical transportation
- ☐ Utilities
- ☐ Employment, job placement, and/or skills training
- ☐ Environmental health (e.g., lead abatement)
- ☐ Violence/Interpersonal violence
- ☐ Trauma
- ☐ Application assistance (e.g., TANF, SNAP, WIC)
- ☐ Language/Linguistic support
- ☐ Not assessed/No information collected
- ☐ Other, specify:

4. In any of your markets in 2021, did your health plan use any of the following strategies specific to SDOH? ***Check all that apply.***

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Provided application assistance (e.g., TANF, SNAP, WIC)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Engaged interdisciplinary community care team including CBOs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified and coordinated with CBOs to link members with needed social services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Provided guided referrals or "hand-offs" to other needed social services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Question #4, continued.

	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
Engaged in direct community investment and capacity building (e.g., provided funding, in-kind contributions)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worked with local and state health departments to address challenges or coordination of services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coordinated with schools to provide IEP services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coordinated with social services as part of care plan development and adherence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Established agreement for data sharing with social services and community partners	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other, specify:												

5. In any of your markets in 2021, in what ways did the state(s) support your health plan's SDOH initiatives for Medicaid members? ***Check all that apply.***

- ☐ Provided administrative assistance (e.g., staff resources)
- ☐ Improved analytic capacity
- ☐ Allowed or improved data sharing
- ☐ Provided financial support
- ☐ Provided screening tools
- ☐ Made policy/regulatory changes to support SDOH initiatives
- ☐ Submitted/received approval for a Medicaid waiver(s) that included support of SDOH initiatives
- ☐ Provided support for cultural and linguistic competency
- ☐ Other, specify:
- ☐ States did not support social need initiatives

6. In any of your markets in 2021, what types of support were provided by your health plan to providers to screen, refer, and/or follow-up on SDOH needs? ***Check all that apply.***

- ☐ Staff
- ☐ Pay-per-performance incentives
- ☐ Data or information sharing
- ☐ Member stratification
- ☐ Ability to bill for multiple codes, joint billing
- ☐ Access to repository of community agencies/and supports/referral tool
- ☐ Provided screening tool
- ☐ Other, specify:
- ☐ No incentives/supports were provided

7. In any of your markets in 2021, what metrics were used to assess and evaluate SDOH initiatives? ***Check all that apply.***

- ☐ Cost utilization
- ☐ Cost savings
- ☐ Performance measures
- ☐ Access to care
- ☐ Market capacity
- ☐ ROI
- ☐ Percentage of eligible population impacted by services offered
- ☐ Other, specify:
- ☐ No performance metrics were used

8. In any of your markets in 2021, please identify how state Medicaid agencies could further assist health plans in addressing SDOH needs of Medicaid members. ***Check all that apply.***

- ☐ Improve data sharing between state and MCOs
- ☐ Improve data sharing between government agencies (e.g., foster care system, criminal justice system) and MCOs
- ☐ Improve data sharing between MCOs and community-based organizations
- ☐ Improve data sharing between MCOs and provider groups
- ☐ Increase financial resources from state to MCOs
- ☐ Increase technical assistance resources
- ☐ Increase resources to support capitated payments models, pay-for-performance, and risk programs with providers
- ☐ Increase resources to support facilitation of partnerships
- ☐ Facilitate contracting with community-based organizations
- ☐ Standardize 834 enrollment file to include social needs information
- ☐ Purchase tools and resources that require a license and provide access to all health plans
- ☐ Other, Specify:

9. Across all your markets in 2021, what efforts did you use to incorporate the use of Z-codes by providers?

- ○ Provided financial incentives to providers to use Z-codes
- ○ Encouraged the use of Z-codes through provider education
- ○ Did not encourage the use of Z-codes
- ○ Other, specify:

10. In any of your markets in 2021, which performance measures were used to assess and evaluate SDOH initiatives? ***Check all that apply.***

- ☐ Utilization metrics (e.g., emergency department, inpatient utilization, unnecessary care)
- ☐ HEDIS scores (e.g., prenatal visit, well child visit)
- ☐ Number of members engaged/served
- ☐ Referrals completed, incomplete/pending referrals, CBO capacity (completed versus denied referrals), denied referrals
- ☐ Housing stability
- ☐ Number of members engaged/served by community health workers/peer or care coordination
- ☐ Member satisfaction (e.g., CAHPS)
- ☐ Provider satisfaction
- ☐ Other, specify:
- ☐ None

11. OPTIONAL: Does your health plan have any innovative initiatives or best practices in addressing SDOH? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

12. OPTIONAL: Did we miss anything? Please share anything that you think would be helpful in understanding how Medicaid MCOs assist in addressing SDOH needs for members and any issues that are encountered in delivering the benefits of these services.

Section K. COVID-19 Pandemic

Definitions and Acronyms for Section K

- **CBO -** Community-Based Organization.
- **Coronavirus disease 2019 (COVID-19) -** Respiratory illness caused by a virus identified in 2019.
- **COVID-19 Pandemic -** Global prevalence and spread of COVID-19.
- **ED -** Emergency Department.
- **HEDIS -** Healthcare Effectiveness Data and Information Set.
- **Public Health Emergency (PHE)** - 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 exist. A PHE declaration allows the secretary to take actions to respond to the PHE.
- **Telehealth -** The use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely.

Please respond to the following items for **only the Medicaid product line.**

1. Across all your markets in 2021, reflecting on your health plan's response to the COVID-19 pandemic, what changes, if any, were made that will be beneficial in preparing for the next public health emergency. ***Check all that apply.***

   - ☐ Efficient telehealth operations
   - ☐ Expanded and strengthened telehealth platforms and infrastructure
   - ☐ Supported members' social and health-related needs
   - ☐ Bolstered disaster planning and emergency response efforts
   - ☐ Enacted service and benefit flexibilities
   - ☐ Provided resources or support to clinicians
   - ☐ Provided resources or support to CBO's
   - ☐ Made changes to our operations and staffing accommodations
   - ☐ Public relations and messaging
   - ☐ Other, specify:
   - ☐ We did not make changes that will affect future public health emergencies.

2. Across all of your markets in 2021, how did your health plan provide support with housing or transitional care (e.g., skilled nursing facilities and acute rehab units) for enrollees who were housing insecure or homeless and recovering from COVID-19. ***Check all that apply.***

- ☐ Provided additional financial support and coverage
- ☐ Provided temporary housing support
- ☐ Designated care coordinators to provide member support
- ☐ Enacted health care provider and CBO partnerships to assist inpatient facilities with transitioning patients to post-acute levels and in-home care
- ☐ Other, specify:
- ☐ None

3. In any of your markets in 2021, **list the ways**, if any, that your health plan provided resources or support to community-based organizations during the pandemic. Please briefly describe below.

4. In 2021, across all of your markets, which of the following items were started/continued? ***Check all that apply.***

- ☐ Coverage of member benefits expanded
- ☐ Extended, removed, and altered authorizations
- ☐ Service provision and utilization management transitioned to telehealth delivery
- ☐ Care and case managers transitioned to proactive member outreach
- ☐ Increased support was offered to hospitals in managing patient flow and disposition
- ☐ Facilitated COVID-19 vaccination efforts
- ☐ Decline in in-person visits, telehealth visits increased
- ☐ Other, specify:
- ☐ We did not see any trends specific to the pandemic that continued to trend after the peak of the pandemic.

5. Across all of your markets in 2021, identify ways in which your health plan closed gaps in HEDIS measures with fewer in-person visits. ***Check all that apply.***

- ☐ In-home testing
- ☐ Vaccine drive-throughs
- ☐ Remote device monitoring
- ☐ Telephonic appointments
- ☐ Video appointments
- ☐ Other, specify:

6. OPTIONAL: Does your health plan have any innovative initiatives or best practices specific to your response to the COVID-19 pandemic? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

7. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs responded to the COVID-19 pandemic and any issues that were encountered in that response.

Section L. Health Equity & Structural Racism

At the Institute for Medicaid Innovation, we recognize and respect that individuals have a range of racial and ethnic identities, and do not always identify with or prefer the language of the categories used by state Medicaid programs. In recognition of the diversity of identities, this survey tool reflects terms used by both the state Medicaid programs including, White, American Indian or Alaska Native, Black or African American, Hispanic or Latino, Asian, Native Hawaiian or Other Pacific Islander, and Other, as well as other terms such as "people of color," "Indigenous" and "Black, Indigenous, and people of color (BIPOC)" to be responsive to the range of identities.

Definitions and Acronyms for Section L

- **Antiracism-** the work of actively opposing racism by advocating for changes in political, economic, and social life. Anti-racism tends to be an individualized approach and is set up in opposition to individual racist behaviors and impacts.
- **Distrust-** the feeling that someone or something cannot be relied upon. When someone doubts the honesty or reliability of; regard with suspicion.
- **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-** 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.
- **Mistrust-** to be suspicious of; have no confidence in. To lack trust or have suspicion.
- **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.
- **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.
- **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.

Please respond to the following items for **only the Medicaid product line.**

1. In any of your markets in 2021, did your health plan have a dedicated person or team focused on addressing any of the following? ***Check all that apply.***

   - ☐ Health disparities
   - ☐ Health equity
   - ☐ Racial equity
   - ☐ Structural racism
   - ☐ Antiracism
   - ☐ Other, specify:

2. In any of your markets in 2021, did your health plan have a health equity strategy or approach?

   - ○ Yes
   - ○ No

If no, please proceed to question 5.

3. In 2021, in any of your markets, for which of the following groups did you have a health equity strategy or approach? ***Check all that apply.***

   - ☐ Specific **member population**

     Please identify populations:

   - ☐ All **members**
   - ☐ **Provider groups**

     Please identify provider groups:

   - ☐ **Health plan internal staff**
   - ☐ Other, specify:

4. In any of your markets in 2021, in what ways, if any, did you encounter barriers to integrating public data sources into your disparities and equity strategy or approach?

   - ○ We were unable to access the data
   - ○ We did not have the analytic abilities to use the data
   - ○ We do not know what data are available
   - ○ Other, specify:
   - ○ None. We did not experience any barriers.

5. Across all of your markets in 2021, for which of the following categories did your health plan track the proportion of providers? ***Check all that apply.***

- ☐ Race/Ethnicity
- ☐ Sex (e.g., male, female)
- ☐ Gender (e.g., man, woman, non-binary)
- ☐ Language(s) spoken
- ☐ Other category, specify:
- ☐ None

6. In any of your markets in 2021, did your health plan have a strategy for working or contracting with Small Disadvantaged Businesses or Small and Diverse Businesses?

- ○ Yes, Small Disadvantaged Businesses
- ○ Yes, Small Diverse Businesses
- ○ Yes, both Small Disadvantaged Businesses **and** Small and Diverse Businesses
- ○ No, neither

7. In any of your markets in 2021, what did your health plan implement, if anything, to address structural racism or promote racial equity? ***Check all that apply.***

- ☐ Programs/policies for **health plan internal staff**
- ☐ Programs/policies for **members**
- ☐ Programs/policies for **provider groups**
- ☐ Programs/policies for **communities** experiencing inequities
- ☐ Made changes to health plan governance or operations
- ☐ Programs/policies for vendors and contracting
- ☐ Social investment with financial reserves
- ☐ Other, specify:
- ☐ None

8. At the parent level in 2021, did your plan have a chief equity officer or an equivalent role?

- ○ Yes
- ○ No, but considering creating such a position
- ○ No, and not considering creating such a position

9. In any of your markets in 2021, in what ways, if any, did your health plan stratify data by race and ethnicity? ***Check all that apply.***

- ☐ Cost
- ☐ Quality (e.g., HEDIS)
- ☐ Utilization
- ☐ Member experience/satisfaction
- ☐ Grievances
- ☐ Health outcomes (e.g., functional status)
- ☐ Members of health care team
- ☐ Other, specify:
- ☐ We did not stratify data by race and ethnicity

10. In 2021, in any of your markets, have you evaluated any clinical algorithms, policies (e.g., clinical, utilization management), or risk prediction models for bias?

- ○ Yes
- ○ No

If yes, has the health plan changed or abandoned those algorithms, policies, or models if bias was discovered?

- ○ Yes
- ○ No

11. Has your health plan pursued NCQA Health Equity Accreditation status?

- ○ Yes
- ○ No, but planning to pursue
- ○ No, and no plans to pursue

12. OPTIONAL: Does your health plan have any innovative initiatives or best practices for addressing health equity and structural racism? If yes, please briefly describe below.

Who can we contact for more information?

Name: Phone:

Email:

13. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs address health equity and structural racism and any issues that were encountered in that response.

Section M. Telehealth

Definitions and Acronyms for Section M

- **eConsult -** asynchronous, consultative, provider-to-provider communications within a shared electronic health record (EHR) or web-based platform.
- **ED -** Emergency Department.
- **I/DD -** Intellectual and Developmental Disabilities.
- **Remote patient monitoring (RPM) -** uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.
- **SMI -** Serious Mental Illness.
- **Telehealth** - The use of digital information and communication technologies, such as telephone, computers, and mobile devices, to access synchronous health care services remotely.

Please respond to the following items for **only the Medicaid product line.**

1. Across all of your markets in 2021, what telehealth (virtual/remote care) modalities did your health plan utilize? ***Check all that apply.***

- ☐ Audio only/telephone
- ☐ Live text chat
- ☐ Live video
- ☐ Provider to Provider/eConsult
- ☐ Remote Patient Monitoring (e.g., blood pressure monitoring, digital scales, blood glucose monitoring, heart rate, oxygen saturation, etc.)
- ☐ Use of a health portal (e.g., for on-line appointment scheduling, obtaining test results, and secure messaging with one's provider)
- ☐ Other, specify:
- ☐ None

2. In any market in 2021, what, if any, barriers did your health plan encounter related to telehealth? ***Check all that apply.***

Provider Barriers

- [ ] External factors/ IT systems
- [ ] Broadband access
- [ ] Computer/technology literacy
- [ ] Lack of technological resources
- [ ] Payment parity
- [ ] Payment incentives
- [ ] Integration into care models
- [ ] Provider disinterest
- [ ] Interpreter services
- [ ] Trust
- [ ] Privacy
- [ ] Quality concerns
- [ ] Other, specify:
- [ ] None

Member Barriers

- [ ] Broadband access
- [ ] Limited data plans/insufficient data or minutes covered by smartphone plans
- [ ] Technology/communication devices (i.e., laptop, smartphone)
- [ ] Health literacy
- [ ] Computer/technology literacy
- [ ] Trust
- [ ] Privacy
- [ ] Other, specify:
- [ ] None

3. In any of your markets in 2021, what specific populations did your health plan target telehealth initiatives? ***Check all that apply.***

- [ ] Children
- [ ] Adult caregivers
- [ ] Aged, Blind, Disabled
- [ ] Medicare and Medicaid Enrollees (Duals)
- [ ] Children and Youth in Foster Care
- [ ] Children with Special Health Care Needs
- [ ] Individuals with I/DD
- [ ] Individuals with SMI
- [ ] Expansion members
- [ ] Pregnant individuals
- [ ] Postpartum individuals
- [ ] Patients with Limited English proficiency
- [ ] Individuals with Substance Use Disorder/Opioid Use Disorder
- [ ] Individuals with diverse sexual orientations and gender identities
- [ ] Other, specify:
- [ ] None

4. In any market in 2021, did your health plan include performance metrics specific to provision of telehealth/digital care?

- ○ Yes, please specify:
- ○ No

5. In any market in 2021, what outcomes did your health plan attribute to telehealth? ***Check all that apply.***

- ☐ Decreased member no shows
- ☐ Decreased ED utilization
- ☐ Decreased urgent care utilization
- ☐ Increased patient access
- ☐ Increased primary care utilization
- ☐ Increased behavioral health care utilization
- ☐ Increased member satisfaction
- ☐ Increased provider satisfaction
- ☐ Sustained or increased primary care utilization during COVID
- ☐ Sustained or increased mental health utilization during COVID
- ☐ Improved continuity of care
- ☐ Improved patient compliance with care
- ☐ Duplication of services
- ☐ Cost savings
- ☐ Other, specify:
- ☐ None

6. Across all your markets in 2021, how did your health plan support audio-only telehealth. ***Check all that apply.***

- ☐ All audio-only telehealth visits were covered
- ☐ Audio-only telehealth visits were covered for specific services
- ☐ Telehealth services must include video component
- ☐ Audio-only visits are only covered for responses related to COVID-19
- ☐ We did not support audio-only telehealth.
- ☐ Other, please specify:

7. Across all your markets in 2021, what categories of services were prioritized for telehealth? ***Check all that apply.***

- ☐ Substance abuse
- ☐ Behavioral health
- ☐ Complex case management
- ☐ Prenatal and postpartum health care services
- ☐ Primary care
- ☐ We did not prioritize specific services for telehealth.
- ☐ Other, please specify:

8. Across all your markets in 2021, in what ways, if any, did your health plan tailor telehealth initiatives to advance health equity? Please briefly describe below.

9. OPTIONAL: Does your health plan have any innovative initiatives or best practices in telehealth? If yes, please briefly describe below.

Who can we contact for more information?

Name: Phone:

Email:

10. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs use telehealth and any issues that were encountered in that response.

Thank you for completing the survey.
Please return your completed survey to Dr. Jennifer Moore at JMoore@MedicaidInnovation.org by March 14, 2022.

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