2019 Annual Medicaid MCO Survey

Please return your completed survey to Dr. Jennifer Moore at JMoore@MedicaidInnovation.org.
Due Date: March 22, 2019

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 first report from the inaugural survey 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.

New for 2019: A new category of questions focused on the social determinants of health. In addition, all health plans that respond to the survey will receive an individualized, benchmarked report that compares their responses to the aggregate, de-identified responses of similar-size health plans.

Section A. Contact Information

IMI staff will only use the following information provided below 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

- **ACO -** Accountable Care Organization
- **ID/DD –** Individuals with Intellectual and Developmental Disabilities
- **MAT -** Medication-Assisted Therapy
- **PCMH -** Patient-Centered Medical Home
- **SMI –** Serious Mental Illness
- **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 that required by children generally.

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

   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?

4. How many individuals were enrolled in your Medicaid MCO in all contracts and markets as of December 2018?

5. Medicaid MCO members make up approximately what percentage of your health plan's total enrollment across all lines of business as of December 2018?

Under 25%

25% to 49%

50% to 74%

75% to 99%

100%

6. Considering your 2018 contracts, across all of your markets, indicate which populations your MCO had experience serving? ***Check all that apply.***

Children

Adult Caregivers

Aged, Blind, Disabled

Medicare and Medicaid Enrollees (Duals)

Children and Youth in Foster Care

Children with Special Healthcare Needs

Individuals with ID/DD

Individuals with SMI

Medicare Only

Childless Adults

7. Considering your 2018 contracts, across all markets, indicate which benefits your 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 develop mentally disabled.)

Home and Community Based Waiver Services

Pharmacy (i.e., in-patient, out-patient and/or injectables)

Dental

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

Multiple states

Single state

9. In which lines of business did your MCO participate in 2018? ***Check all that apply.***

Medicaid

Children's Health Insurance Program (CHIP)

Medicare Advantage

Medicare Special Needs Plan

Health Insurance Marketplace/Exchange (qualified health plans), including both the Federally facilitated Marketplace and state-based marketplaces such as Covered California and New York State of Health

Individual market

Employer market (small and/or large group)

Other, specify:

10. Please indicate the following provider types with which you had at least one contract in 2018 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

Maternal and child health clinics

Family planning clinics (Title X)

Planned Parenthood

Behavioral health centers

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

None of the above

Other, specify:

11. Across all of your markets in 2018, identify the strategies your MCO uses 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

12. In 2018, did your Medicaid MCO contract with an Accountable Care Organization (ACO) in any of your markets?

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

13. In 2018, did your Medicaid MCO contract with an integrated health system that is not an ACO in any of your markets?

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

14. Across all of your markets in 2018, approximately what percentage of your Medicaid members received services through a PCMH?

- Under 25%
- 26%- 50%
- 51%- 75%
- 76%- 100%

Section C. High Risk Care Coordination

Definitions and Acronyms for Section C

- **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.
- **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.
- **High-risk –** Identified by clinical data risk stratification or definitions of certain populations with focused needs that require specific or high utilization.
- **Complex population contracts –** Contracts that include Individuals with Intellectual and Developmental Disabilities (ID/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.
- **LTSS –** Long-Term Services and Supports
- **LTSS Medicaid contract –** Contracts inclusive of institutional, home, and community-based services that are targeted to individuals who qualify for long-term care based on functional need.
- **MCOs –** Managed Care Organizations. For the purposes of this survey, we are exclusively interested in the Medicaid managed care organizations.
- **PCP –** Primary Care Provider.

Please respond to the following items at the **parent level** 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 LTSS contracts are **not** the focus of this section.

1. Across your 2018 general Medicaid contracts, what percentage of health plan enrollees received high-risk care coordination services?

    5% and under

    6-9%

    10-15%

    Over 15%

2. Of the following, select the items that prevented the completion of individual health risk assessments of your members in 2018. ***Check all that apply.***

   - Lack of confirmed member record
   - Dispute in resolving the identity of members
   - Inaccurate member information (e.g., phone number, address)
   - Difficulty reaching members
   - Lack of member willingness to conduct a needs assessment
   - State deadline to complete assessments within timeframe
   - Overlapping assessments tied to eligibility
   - Other, specify:

3. With member approval, did your health plan share member health risk assessment information in 2018 with any of the following? ***Check all that apply.***

   - Health plan to network providers
   - Health plan to member
   - Health plan to member guardian or responsible party
   - Health plan to member preferred provider
   - Health plan to care coordinator
   - Health plan to community-based organization
   - Network provider to health plan
   - Did not share

4. Across all of your markets in 2018, what were the core functions performed under high-risk care coordination? ***Select one response per row.***

	Always (i.e., Required for care coordination.)	**Sometimes** (i.e., Based on member needs.)	**Limited** (i.e., Small pilot program or case-by-case.)	**Did Not Provide**	**Not Applicable** (i.e., Carved out program.)
Served as single point of contact for the member					
Engaged a care team of professionals to address the needs of the member					
Developed a plan of care					
Supported adherence to plans of care					
In addition to supplying the provider directory, supported the member in identifying and connecting with providers					
Coordinated in-home services					
Prepared the member for appointments					
Arranged transportation for appointments					
Provided information on other types of social services (e.g., faith based, non-profit, other government programs)					
Provided guided referrals or "hand-offs" to other needed social services (e.g., faith based, non-profit, other government programs)					

Section C. Question #4 continued.

	Always (i.e., Required for care coordination.)	**Sometimes** (i.e., Based on member needs.)	**Limited** (i.e., Small pilot program or case-by-case.)	**Did Not Provide**	**Not Applicable** (i.e., Carved out program.)
Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence					
Shared data with social services					
Coordinated with multiple care coordinators from health systems, provider practices, clinics, etc.					
Other, specify:					

5. In any market in 2018, did you use care teams?

Yes

No

If no, proceed to Question #7.

6. If you used care teams in 2018 in any market, how frequently did the following participate?

	Always	Sometimes	Never
Individual member			
Family member			
Guardian			
Representative from PCP office			
Member's PCP			
Other health care professional not employed by health plan			
Natural/community supports (other than guardian)			
Care coordinator within health plan			
Behavioral health specialist within health plan			
Pharmacist within health plan			
Community health worker within health plan			
Peer support specialist within health plan			
Non-health plan care coordinators (e.g., from health system, provider practices, clinics, etc.)			

7. In any market in 2018, did you measure the effectiveness of high-risk care coordination?

Yes

No

If no, proceed to Question #9.

8. If yes, identify how you are track effectiveness. ***Check all that apply.***

ER utilization

Preventative care

Impact on HEDIS measures

Inpatient utilization

Total spending

Patient experience survey results

Provider experience survey results

Other, specify:

9. Of the following, identify the barriers that your health plan experienced in any market in 2018 in providing effective high-risk case management. ***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

Coordination with 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

Other, specify:

None

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

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

Who can we contact for more information?

Name: Phone:

Email:

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

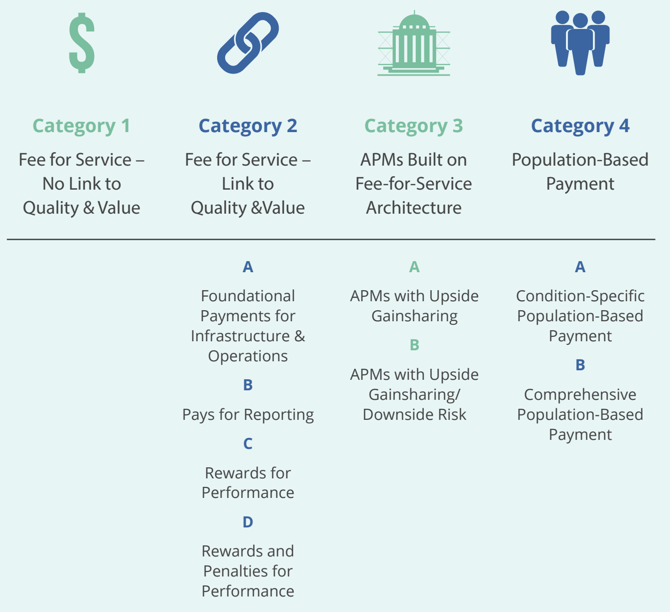
Section D. Value-Based Purchasing

Definitions and Acronyms for Section D

- **APM -** Alternative Payment Methodology
- **FFS -** Fee-for-service
- **VBP -** Value-Based Payment

This section is guided by the work of the Health Care Payment Learning Action Network (HCP-LAN) Alternative Payment Model (APM) Framework.
Refer to Table 1.
(https://hcp-lan.org/)

Table 1. HCP-LAN Alternative Payment Model Framework



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

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

1. Across all of your markets in 2018, did your health plan use APM or VBP structures?

   Yes

   No

If no, proceed to Section E.

2. Identify the HCP-LAN APM categories that your health plan was engaged in for 2018, in any market. ***Check all that apply.***

   Category 1: FFS, no link to quality or value

   Category 2: FFS, link to quality and value

   Category 3: APMs built on FFS architecture

   Category 4: Population-based payment

3. In 2018, did any of your contracts (markets) require your health plan 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:

4. Across any of your markets in 2018, to what extent did your health plan implement VBP within specific populations?

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:

5. To what extent did your health plan, in any market, implement VBP within the following provider categories in 2018? ***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			
Nurse-Midwives			
OBGYNs			
Orthopedics			
Primary Care Providers (i.e., Physicians, Advanced Practice Nurses, Physician Assistants)			
Other Specialists			

6. In any market in 2018, 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

Medicaid MCO did not implement any of these strategies within the past 12 months

Other, specify:

We did not use any payment strategies

7. In any of your markets in 2018, please indicate whether your Medicaid MCO used any of the following APMs for any providers. ***Check all that apply.***

Non-payment or reduced payment for 39-week elective delivery

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

Shared savings

Shared savings and risk

Other, specify:

None

8. In any of your markets in 2018, approximately what share of your Medicaid MCO's payments to primary care providers was made through APMs (e.g., incentive/bonus payment tied to performance, payment withholds, bundled or episode-based payments, global or capitated payments, shared savings and/or risk)?

1-15%

16-30%

More than 30%

None

9. In any of your markets in 2018, approximately what share of your Medicaid MCO's payments to hospitals was made through APMs (e.g., incentive/bonus payment tied to performance, payment withholds, bundled or episode-based payments, global or capitated payments, shared savings and/or risk)?

1-15%

16-30%

More than 30%

None

10. In any of your markets in 2018, what were the operational barriers that were addressed for adoption and innovation in VBP or APMs? ***Check all that apply.***

Data reporting to providers

IT system preparedness

Support to providers to make determinations on VBP/APM

Pricing VBP/APM

Tracking quality and reporting within new structure

Contract requirements on VBP/APM approaches

None

Other, specify:

11. In any of your markets in 2018, identify the external factors that influence the adoption and innovation in VBP or APMs. ***Check all that apply.***

Provider readiness and willingness

Provider IT capabilities

State requirements limiting VBP/APM models

Medicaid payment rates

Impact of 42CFR on limiting access to behavioral health data

Uncertain or shifting **federal** policy requirements/priorities

Uncertain or shifting **state** policy requirements/priorities

None

Other, specify:

12. OPTIONAL: Does you health plan have any innovative initiatives or best practices in VBP or APM? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

13. OPTIONAL: What specific changes to **state** requirements would remove barriers and assist in more effectively implementing VBP or APM?

14. OPTIONAL: What specific changes to **federal** requirements would remove barriers and assist in more effectively implementing VBP or APM?

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

Section E. Pharmacy

Definitions and Acronyms for Section E

- **DUR -** Drug Utilization Review
- **EMR -** Electronic Medical Record
- **FFS -** Fee-for-service
- **MTM -** Medication Therapy Management
- **PBM -** Pharmacy Benefit Manager

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

1. During 2018, 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. Did you use pharmacists for any aspects of MTM in any market in 2018?

   Yes

   No

If no, proceed to Question #4.

3. Across any of your markets in 2018, identify the ways pharmacists were used for MTM.
   Select one response per row.

	In-person	Over-the-Phone	Using Other Telecommunication Technology
Medication therapy reviews			
Medication-related action plans			
Intervention and/or referrals			
Documentation and follow-up			
Other:			

4. Across any market in 2018, select the ways your health plan used community-based provider contracts with pharmacists? ***Check all that apply.***

- Medication adherence rate
- Drug Utilization Rate (e.g. duplicative therapies)
- Identification of lower cost medication alternatives
- Hospital readmissions
- Emergency department visits
- Pharmacotherapy consults
- None
- Other, specify:

5. For 2018, across any market, identify the 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; impacting capitation rates and pricing
- Member comprehension and engagement of programs
- Formulary notification requirements as part of MMCO Final Rule
- Pharmacy network requirements
- None
- Other, specify:

6. In any of your markets in 2018, did you support an e-prescribing systems through your contracted PBM (e.g., sending eligibility, formulary status, med history, DUR to the prescribers)?

- Yes
- No

7. In any market in 2018, did your health plan have an electronic prior authorization system?

- Yes, it was available through a separate electronic prior authorization portal
- Yes, it was integrated into the provider's EMR
- No, but in development
- No

8. In 2018, how have the state(s) you have contracts with addressed the cost of new or high cost drugs for MCOs? ***Check all that apply.***

Carved-out the drug costs completely/Pay fee-for-service for certain drug(s)

Transition period where drug(s) are offered in FFS to get claims data then rolled into contracts

Stop loss provision to cap the plan's cost for the drug

Capitation rate adjustments made off the normal rate cycle

Capitation rate adjustment as part of regular rate adjustments

States have not addressed the cost

None

Other, specify:

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

10. OPTIONAL: Does your health plan have any innovative initiatives or best practices in pharmacy management? If yes, please briefly describe.

Who can we contact for more information?

Name: Phone:

Email:

Section F. Behavioral Health

Definitions and Acronyms for Section F

- **SUD -** Substance Use Disorders

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

1. In 2018, across any of your markets, were you at-risk for behavioral health services in at least one of your contracted markets?

   Yes

   No

If no, proceed to Section G.

2. In 2018, for any of your markets, did care coordinators and medical directors at your health plan have access to review medical records inclusive of physical and behavioral health information?

   Yes, all markets

   Yes, in some markets

   No

3. In 2018, for any of your markets, did you subcontract for behavioral health management?

   Yes, we subcontracted but our subcontractor operations were merged with our health plan

   Yes, we subcontracted. Behavioral health services are managed separately

   No, we coordinated and managed physical and behavioral health

   No, behavioral health benefits are not managed by our health plan

4. In 2018, across all of your markets, in what way(s) did you...

Work with **behavioral health providers** to address ***physical*** health needs? ***Check all that apply.***

- Making screening tools available
- Information/data sharing on behavioral health
- Education
- Value-based contracting across physical and behavioral health
- Embedding physical/behavioral specialists in medical practices
- Allowing payment for multiple services at the same location and date of service
- Specialized programs or offerings, describe:
- Other, specify:

Work with **physical health providers** to address ***behavioral*** health needs? ***Check all that apply.***

- Making screening tools available
- Information/data sharing on behavioral health
- Education
- Value-based contracting across physical and behavioral health
- Embedding physical/behavioral specialists in medical practices
- Allowing payment for multiple services at the same location and date of service
- Specialized programs or offerings, describe:
- Other, specify:

5. Please indicate the barriers that your health plan experienced in 2018 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 capacity to provide integrated physical and behavioral health at point of care
- Behavioral health provider readiness for managed care
- Behavioral health provider adoption of electronic health records
- Other, specify:

Policy Barriers

- CFR 42 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
- Other, specify:

6. Across any of your markets in 2018, did your health plan contract(s) with the state include the following types of services for most Medicaid members? ***Please select one response per row.***

	Yes, Managed by our Medicaid MCO	Yes, Sub-contracted to a Vendor	Varies by Population	No
Behavioral health assessment/screening				
Outpatient mental health services				
Inpatient mental health services				
Outpatient substance use treatment services				
Inpatient/residential substance use treatment services				
Detox services (outpatient or residential)				
Outpatient substance use treatment services				

7. 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:

8. OPTIONAL: Provide additional information about the barriers and challenges regarding behavioral and physical health integration.

9. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how MCOs provide behavioral health services that we did not ask?

Section G. Women's Health

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

1. Across any of your markets in 2018, did your health plan offer targeted programs to address women's health?

    Yes

    No

If no, proceed to Section H.

2. In 2018, across any of your markets, please indicate your health plan's women's health priorities. ***Check all that apply.***

    Prenatal and postpartum care

    Family planning

    Heart disease

    Cancer screening and treatment

    Diabetes

    Obesity

    Substance use disorder

    Depression/Anxiety

    Eating disorders

    Behavioral health, generally

    Sexual health

    Other, specify:

3. In 2018, in any market, please identify the health priorities that had a specific targeted program(s) or engagement strategies. ***Check all that apply.***

    Prenatal and postpartum care

    Family planning

    Heart disease

    Cancer screening and treatment

    Diabetes

    Obesity

    Substance use disorder

    Depression/Anxiety

    Eating disorders

    Behavioral health, generally

    Sexual health

    Other, specify:

    None

4. Across any of your markets in 2018, what was the average duration of enrollment among Medicaid members? ***Select one response per row.***

	Enrolled for less than 6 months	Enrolled for 6-12 months	Enrolled for more than 1 but less than 2 years	Enrolled for 2 or more years	Not applicable. We do not enroll this population.
Pregnant women					
Parents					
Childless adults					
Aged, blind, and disabled					
Medicare and Medicaid eligible					

5. Across any of your markets in 2018, identify the challenges that your health plan encountered associated with churn for women. ***Check all that apply.***

Maintaining access to providers and care

Clinical care disruption and care management continuity

Repeated member on-boarding

Quality measure disruption

Completeness of patient/member history

Other, specify:

None

6. In 2018, in any of your markets, which of the following provider types served as a medical home or primary care provider for women? ***Check all that apply.***

Family physicians

Nurse practitioners

Nurse-midwives

Obstetricians/Gynecologists

Pediatricians

Geriatricians

School-based health centers

Internists

Other, specify:

None

7. Approximately what percentage of women enrolled in your health plan, across all of your markets, had an established medical home in 2018?

    0-25%

    26-50%

    51-75%

    76-100%

8. In 2018, for any market, please identify the provider types who could provide members with contraception. ***Check all that apply.***

    Freestanding family planning clinics

    Planned Parenthood clinics

    Community health/Rural health centers

    Federally qualified health centers

    State or local health departments

    School-based clinics

    Hospital-based clinics

    Other, specify:

    None

9. In 2018, across all of your markets, when did your health plan most frequently provide information to Medicaid enrollees about post-partum contraception or sterilization?

    Never

    If the member asks

    Immediate post-partum (i.e., during inpatient stay for delivery)

    Within 6 weeks post-partum

    Prior to birth

    Annually to all women of reproductive age

10. 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:

11. OPTIONAL: What are the top challenges your plan encounters in addressing women's health, including reproductive health and family planning services and supplies?

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

Section H. Child & Adolescent Health

Definitions and Acronyms for Section H

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 that required by children generally.

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

1. In 2018, 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 2018, across all of your markets, indicate your health plan's health priorities for children and adolescents. ***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

   Success in school

   Sex education

   Transitioning to adulthood and independence

   Tobacco use

   Teen pregnancy

   Readiness to start school

   Other, specify:

   None

3. In 2018, in any market, please identify the health priorities that had a specific targeted program(s) or engagement strategies. ***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
- Success in school
- Sex education
- Transitioning to adulthood and independence
- Tobacco use
- Teen pregnancy
- Readiness to start school
- Other, specify:
- None

4. Please indicate which of the following barriers your health plan experienced in 2018 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 same plan to address social determinants of health
- Policies or program structures that create barriers if the parent(s) have more than one child (e.g. transportation policies)
- Program fragmentation
- Language barriers within families
- Other, specify:
- None

5. In 2018, across any of your markets, did states contract with your health plan for CSHCN?

- Yes
- No

If no, proceed to Question #7.

6. Across any of your markets in 2018, what benefits did you manage for CSHCNs? ***Check all that apply.***

Conducted risk assessments

Served as a single point of contact for the member

Engaged a care team of professionals to address the needs of the member

Developed a comprehensive plan of care with the family/caregivers

Supported and encouraged adherence to care plan

Supported the member in identifying and connecting with providers (in addition to supplying the provider directory)

Coordinated in-home services

Helped in making appointments with providers

Supported the member preparedness for appointments

Arranged transportation for appointments

Provided information and coordinated with other needed social service organizations (e.g., faith based, housing, nutrition, non-profit, etc.) as part of care plan development and adherence

Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential)

Transition planning (e.g., acute care to residential care, residential care to the community)

Caregiver support

Coordinated behavioral health services

Shared data with social services

Screened for social isolation

Medication management

Lab testing

Vaccines

Equipment and supplies

Family transportation and lodging for out-of-town/state specialist visits

Care coordination

Nutrition education

Transportation to and from medical appointments

Parent education

School-based healthcare services

Other, specify:

7. Across any of your markets in 2018, please indicate which of the following barriers your health plan experienced when serving children with special healthcare needs. ***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)
- Poor communication among multiple providers to families
- Lack of consistent quality measures specific to unique needs of CSHCN
- Insufficient information regarding the goals and preferences of children with special health care needs and their families
- Other, specify:
- None

8. 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:

9. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how MCOs provide services to children.

Section I. 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
- **DPOA -** Durable Power of Attorney
- **HCBS -** Home and Community Based Services
- **LTSS -** Long-Term Services and Supports
- **MOLST -** Medical Orders for Life-Sustaining Treatment
- **MLTSS -** Managed Long-Term Services and Supports
- **POA -** Power of Attorney

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

1. Any of your markets in 2018, were you at-risk for long-term services and supports in at least one of your contracted markets?

Yes

No

If no, please proceed to Section J.

2. In 2018, across any of your markets, did your health plan employ a different clinical model of care for individuals enrolled in MLTSS programs compared to your general Medicaid managed care contracts?

Yes

No

3. In 2018, across all of your markets, on average what percentage of your LTSS members had an assigned care coordinator?

5% and under

6-25%

26-50%

51-75%

Over 75%

4. In 2018, for all of your markets, what was the average (most common) timeframe from enrollment to **completion of the assessment** for members' LTSS needs?

0 to 30 days

31 to 90 days

91 to 120 days

More than 120 days

5. In 2018, for all of your markets, what was the average (most common) timeframe from enrollment to the **completion of a plan of care?**

    0 to 30 days

    31 to 90 days

    91 to 120 days

    More than 120 days

6. Please identify the core functions performed in 2018 under your health plan's LTSS care coordination models across any of your markets. ***Check all that apply.***

    Conducted risk assessments

    Served as a single point of contact for the member

    Engaged a care team of professionals to address the needs of the member

    Developed a plan of care

    Supported and encouraged adherence to care plan

    In addition to supplying the provider directory, supported the member in identifying and connecting with providers

    Coordinated in-home services

    Coordinated home and community-based services (e.g., day care, employment, rehab, durable medical equipment, home modifications, personal emergency response systems, residential)

    Helped in making appointments with providers

    Supported the member preparedness for appointments

    Arranged transportation for appointments

    Provided information on other needed social services (e.g., faith based, non-profit, other government programs)

    Provided guided referrals or "hand-offs" to other needed social services (e.g., faith-based, non-profit, or other government programs)

    Coordinated with social services (i.e. housing providers, nutrition programs) as part of care plan development and adherence

    Transition planning (e.g., acute care to residential care; residential care to the community)

    Caregiver support

    Coordinated behavioral health services

    Shared data with social services

    Screened for social isolation

    Other, specify:

    None

7. Did your health plan use care teams in 2018 for LTSS in any of your markets?

    Yes

    No

If no, please proceed to Question #9.

8. If you used LTSS care teams in 2018 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 office

    Member's primary care provider

    Other health care professional not employed by the health plan

    Natural/community supports other than guardian

    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

    Other, specify:

9. In 2018 across all of your markets, did care coordinators and medical directors at your health plan have access to review medical records including medical, facility-based care, and community based care information?

    Yes

    No

10. In 2018 across all of your markets, did care coordinators and medical directors at your health plan have access to review medical records inclusive of medical, behavioral health, and LTSS information?

- Yes
- No

11. Across all of your markets in 2018, please indicate which of the following topics were included in the plan of care. ***Check all that apply.***

Care Plan Components

- Demographic and social needs screening information (e.g., housing, financial, insurance, employment history)
- Caregiver information and status
- Goals – personal and care goals
- End-of-life plan including MOLST and DPOA/POA/guardianship
- Primary care provider
- Emergency (crisis) plan
- Other, specify:
- None

Medical Components

- Recent hospitalizations or emergency department visits
- Current health/medical status
- Behavioral health status/condition (i.e., depression, anxiety, stress, drug, alcohol screening)
- Community transition plan
- Durable medical equipment use, hearing aids and vision impairments
- Activities of daily living (i.e., feeding, dressing, toileting, ambulating, sleep)
- Medication list
- Safety screening (i.e., feeling safe and secure)
- Other, specify:
- None

12. Across all of your markets in 2018, identify the program design considerations that impacted your health plan's ability to manage LTSS in any of your markets.

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

State program requirements that limit 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)

Appropriate benefit and program design to allow for community transitions and long-term sustainability

Other, specify:

None

13. In 2018, in any market, indicate to what extent your health plan leveraged the following innovations. ***Select one response per row.***

	Always (A required part of our approach to LTSS.)	**Sometimes** (Based on member needs.)	**Limited** (Small pilot program or case-by-case.)	**Not Provided**
Remote monitoring				
Telehealth other than remote monitoring that is specific to the LTSS 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 LTSS 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 community transition programs				
Self-advocacy				
Employment initiatives outside of administering benefits required by state plan				
Tools for self-direction				
Transportation innovations				

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

Who can we contact for more information?

Name: Phone:

Email:

14. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how MCOs manage LTSS that we did not ask.

Section J. Social Determinants of Health

Definitions and Acronyms for Section J

- **CBO -** Community-Based Organization
- **COC -** Continuum of Care
- **CSHCN -** Children with special health care needs- 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. that required by children generally.
- **IEP -** Individualized Education Plan
- **IMD** - Institution for Mental Diseases
- **MLTSS -** Managed Long-Term Services and Supports
- **NEMT** - Non-Emergency Medical Transportation
- **PHA -** Public Housing Agencies
- **SDOH -** Social determinants of health, also referred to as social influencers of health are 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. For example, housing, food, and public safety.
- **TANF -** Temporary Assistance for Needy Families
- **SNAP -** Supplemental Nutrition Assistance Program.
- **WIC -** Special supplemental nutrition program for women, infants, and children.

1. In any of your markets in 2018, did you have targeted SDOH programs for specific populations?

    Yes

    No

If yes, please continue to the next page to complete Section J. Social Determinants of Health.

If no, you have completed the survey. Thank you. Please email your completed survey to Dr. Jennifer Moore at JMoore@MedicaidInnovation.org by ***March 22, 2019.***

2. In any of your markets in 2018, for what populations did you offer targeted SDOH programs?
   Check all that apply.

   - Criminal justice involved
   - HIV/ AIDS
   - Pregnant women
   - Foster care youth/ Youth transitioning to adulthood
   - CSHCN
   - Homeless/ housing insecure
   - 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 involved families
   - Adults with disabilities (e.g., physical, intellectual, developmental)
   - Expansion members
   - Adults with serious mental illness
   - Other, specify:
   - None of the above

3. Across all of your markets in 2018, what SDOH issues were identified for your members?
   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, Special Supplemental Nutrition Program for WIC)
   - Not assessed/No information collected
   - Other, specify:

4. In any of your markets in 2018, 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												
Assessed/ screened for member needs												
Provided application assistance (e.g., TANF, SNAP, WIC)												
Provided caregiver support												
Utilized peers												
Used community health workers												
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 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. Across any of your markets in 2018, select the types of programs and initiatives that your health plan led or participated in to assist members experiencing homelessness or housing instability. ***Check all that apply.***

   - Outreach to members or potential members who were homeless or housing insecure to help them access health care coverage and services
   - Case management or care coordination for homeless or housing insecure individuals
   - Respite, palliative, or recuperative care for homeless or housing insecure individuals
   - Had a strategy for developing agreements and/or protocols with public housing agencies (PHAs) and/or continuum of care (COCs) programs to submit applications for housing assistance
   - Payment for Medicaid-covered housing-related services
   - Participation in a state-level Medicaid-housing initiative
   - Partnership with state or local housing agencies or organizations
   - Other, specify:
   - None

6. In any of your markets in 2018, 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 AAFP
   - Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE)
   - Social Needs Screening Toolkit, HealthLeads USA
   - Social Determinants Screening Tool, AccessHealth Spartanburg, CHCS version
   - Self Sufficiency Outcomes Matrix, OneCare Vermont, CHCS version
   - Arizona Self Sufficiency Matrix
   - Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)
   - CMS Accountable Health Communities Health-Related Social Needs Screening Tool
   - Other, specify:
   - None

7. In any of your markets in 2018, in what ways did the state support your health plan's SDOH initiatives for Medicaid members? ***Check all that apply.***

    - Provided administrative assistance
    - 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

8. In any of your markets in 2018, 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
    - Other, specify:
    - No incentives/supports were provided

9. In any of your markets in 2018, what metrics were used to assess and evaluate SDOH initiatives? ***Check all that apply.***

    - Cost utilization
    - Cost savings
    - Performance measures (please identify specific measures):
    - Access to care
    - Other, specify:
    - No performance metrics were used

10. Please identify barriers that state Medicaid agencies could remove to assist health plans in addressing SDOH needs of Medicaid members.

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 feel would be helpful in understanding how MCOs assist in addressing SDOH needs for members and any issues that are encountered in delivering the benefits of these services.

Thank you for completing the survey.
Please return your completed survey to Dr. Jennifer Moore
at JMoore@MedicaidInnovation.org by March 22, 2019.

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