2020 Annual Medicaid MCO Survey

Please return your completed survey to Dr. Jennifer Moore at JMoore@MedicaidInnovation.org.

Due Date: March 13, 2020

The Institute for Medicaid Innovation (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 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.
- **I/DD –** Individuals with Intellectual and Developmental Disabilities.
- **IHS –** Integrated Health System.
- **MAT -** Medication-Assistance Therapy.
- **PCMH -** Patient-Centered Medical Home.
- **SMI –** Individuals with Serious Mental Illness.
- **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. 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 2019?

5. Medicaid MCO members make up approximately what percentage of your health plan's total enrollment across all lines of business as of December 2019?

Under 25%

25% to 49%

50% to 74%

75% to 99%

100%

6. Considering your 2019 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 Youth in Foster Care

Children with Special Healthcare Needs

Individuals with I/DD

Individuals with SMI

Childless Adults

7. Across all of your markets in 2019, did your health plan offer targeted programs to address sexual and gender minority health?

Yes

No, but considering

No, and not considering

8. Considering your 2019 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

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

- Multiple states
- Single state

10. In which lines of business did your MCO participate in 2019? ***Check all that apply.***

- Medicaid
- Children's Health Insurance Program (CHIP)
- Medicare Advantage
- Medicare Advantage Dual 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:

11. Please indicate the following provider types with which you had at least one contract in 2019 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:

12. Across all of your markets in 2019, identify the strategies your Medicaid 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

13. In 2019, did your Medicaid MCO contract with an Accountable Care Organization (ACO) or integrated health system (IHS) in any of your markets?

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

14. In 2019, did your Medicaid MCO contract with an integrated health system (IHS), as implemented in California, that is not an ACO in any of your markets?

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

15. Across all of your markets in 2019, 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.
- **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.
- **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 MLTSS contracts are **not** the focus of this section.

1. Across your 2019 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 2019. ***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 participate in 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 2019 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
- Did not share
- Other

4. Across all of your markets in 2019, 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 2019, did you use care teams?

Yes

No

If no, proceed to Question #7.

6. If you used care teams in 2019 in any market, how frequently did the following participate?

	Always	Sometimes	Never
Individual member			
Family member			
Guardian			
Member's PCP			
Representative from PCP office			
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 2019, did you measure the effectiveness of high-risk care coordination?

   Yes

   No

If no, proceed to Question #9.

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

   Emergency Department 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 2019 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

   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

   Churn (member or eligibility-related)

   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 high-risk 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 coordination? 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 Medicaid MCOs provide high-risk care coordination services and any issues that are encountered in delivering these services.

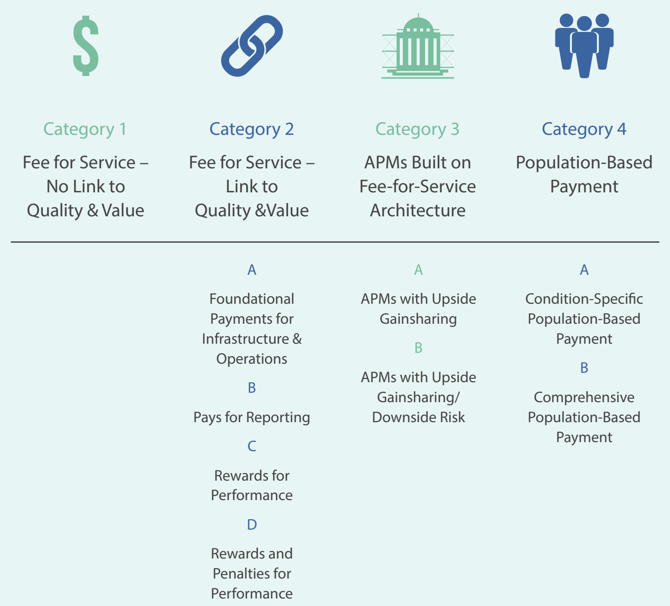
Section D. Value-Based Purchasing

Definitions and Acronyms for Section D

- **APM -** Alternative Payment Model.
- **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 Fee for Service – No Link to Quality & Value	Category 2 Fee for Service – Link to Quality &Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 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 2019, did your health plan use APM or VBP arrangements?

Yes

No

If no, proceed to Section E.

2. Identify the HCP-LAN APM categories that your health plan was engaged in for 2019, in any market. ***Check all that apply.***

Category 1: FFS, No Link to Quality or Value

Category 2: FFS, Link to Quality and Value

If yes to Category 2, in any market, check all of the sub-categories that apply.

Sub-Category A: Foundational Payments for Infrastructure & Operations

Sub-Category B: Pays for Reporting

Sub-Category C: Rewards for Performance

Sub-Category D: Rewards and Penalties for Performance

Category 3: APMs Build on FFS Architecture

If yes to Category 3, in any market, check all of the sub-categories that apply.

Sub-Category A: APMs with Upside Gainsharing

Sub-Category B: APMs with Upside Gainsharing/Downside Risk

Category 4: Population-Based Payment

If yes to Category 4, in any market, check all of the sub-categories that apply.

Sub-Category A: Condition-specific Population-Based Payment

Sub-Category B: Comprehensive Population-Based Payment

3. In 2019, 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:

4. Across any of your markets in 2019, to what extent did your health plan implement VBP within specific populations?

We did not develop population-specific VBP models; our VBP ar rangements 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:

All of the Above

List populations:

5. To what extent did your health plan, in any market, implement VBP within the following provider categories (excluding hospitals) in 2019? ***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 2019, 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

Other, specify:

We did not use any payment strategies

7. In any of your markets in 2019, 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 2019, 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 2019, 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 2019, what were the operational barriers 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 VBP and/or APM
- Tracking quality and reporting within new structure
- Contract requirements on VBP/APM approaches
- None
- Other, specify:

11. In any of your markets in 2019, identify the external factors that influence the adoption and innovation in VBP and/or APMs. ***Check all that apply.***

- Provider readiness and willingness
- Provider IT 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
- None
- Other, specify:

12. 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:

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

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

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

- **DUR -** Drug utilization review.
- **EHR -** Electronic health record.
- **FFS -** Fee-for-service.
- **MTM -** Medication Therapy Management.
- **PBM -** Pharmacy benefit Manager.
- **PDL -** Prescription drug list.

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

1. During 2019, 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 2019?

    Yes

    No

If no, proceed to Question #4.

3. Across any of your markets in 2019, identify the ways pharmacists were used for MTM. ***Check all that apply.***

	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 2019, 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 2019, 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 Medicaid MCO Final Rule

Pharmacy network requirements

Single PDL/formulary requirements

Increase in number of specialty pharmacy medications

None

Other, specify:

6. In any of your markets in 2019, did you support an e-prescribing system through your contracted PBM (e.g., sending eligibility, formulary status, med history, DUR to the prescribers)?

Yes

No

7. In any market in 2019, 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 EHR

No, but in development

No

8. In 2019, how have the state(s) you have contracts with addressed the cost 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
- 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: Does your health plan have any innovative initiatives or best practices in pharmacy management? If yes, please briefly describe.

10. 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.

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 2019, across any of your markets, were you at-risk for behavioral health services?

   Yes

   No

If no, proceed to Section G.

2. In 2019, for any of your markets, did care coordinators and/or 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 2019, 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 2019, 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
- Helped providers to get paid for case management of behavioral health
- 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
- Helped providers to get paid for case management of behavioral health
- Other, specify:

5. Please indicate the barriers that your health plan experienced in 2019 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

- 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:

6. Across any of your markets in 2019, 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 Medicaid 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 2019, did your health plan offer targeted programs to address women's health?

   Yes

   No

If no, proceed to Section H.

2. In 2019, 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 2019, 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 2019, what was the average duration of enrollment among female 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					
Female parents					
Female adults (Ex-pansion population)					
Female aged, blind, and disabled					
Female Medicare and Medicaid eligible					

5. Across any of your markets in 2019, 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 2019, in any of your markets, which of the following provider types served as a 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 primary care provider in 2019?

    0-25%

    26-50%

    51-75%

    76-100%

8. In 2019, 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 2019, 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 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 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 2019, 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 2019, 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

   Health disparities impacting sexual and gender minorities

   Other, specify:

   None

3. In 2019, in any market, please identify the health priorities that had a specific targeted program(s) or engagement strategies 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

Health disparities impacting sexual and gender minorities

Other, specify:

None

4. Please indicate which of the following barriers your health plan experienced in 2019 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

Churn (member or eligibility-related)

Other, specify:

None

5. In 2019, 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 2019, what benefits did you manage for CSHCN? ***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
- Pre-Exposure Prophylaxis (PrEP)
- Gender-affirming care for transgender/gender-nonconforming children and adolescents
- Other, specify:

7. Across any of your markets in 2019, please indicate which of the following barriers your health plan experienced 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)
   - 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 CSHCN and their families
   - Churn (member or eligibility-related)
   - 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 Medicaid MCOs provide services to children.

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

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

1. In any of your markets in 2019, were you at-risk for managed long-term services and supports?

    Yes

    No

If no, please proceed to Section J.

2. In 2019, 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 2019, across all of your markets, on average what percentage of your MLTSS members had an assigned care coordinator?

    5% and under

    6-25%

    26-50%

    51-75%

    Over 75%

4. In 2019, for all of your markets, what was the average (most common) timeframe from enrollment to **completion of the assessment** for members' MLTSS needs?

    0 to 30 days

    31 to 90 days

    91 to 120 days

    More than 120 days

5. In 2019, 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 2019 under your health plan's MLTSS 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 2019 for MLTSS in any of your markets?

    Yes

    No

If no, please proceed to Question #9.

8. If you used MLTSS care teams in 2019 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. Across all of your markets in 2019, 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 Medical Orders for Life-Sustaining Treatment (MOLST) and Durable Power of Attorney (DPOA)/Power of Attorney (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

10. Across all of your markets in 2019, identify the program design considerations that impacted 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
- 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
- Member churn
- Other, specify:
- None

11. In 2019, 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 MLTSS.)	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 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				

12. 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:

13. 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.

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.
- **SNAP -** Supplemental Nutrition Assistance Program.
- **TANF -** Temporary Assistance for Needy Families.
- **WIC -** Special Supplemental Nutrition Program for Women, Infants, and Children.

1. In any of your markets in 2019, 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 13, 2020.***

2. In any of your markets in 2019, 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
- Sexual and gender minorities
- Medicare and Medicaid Enrollees (Duals)
- Geographic location
- Other, specify:
- None of the above

3. Across all of your markets in 2019, 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, WIC)
- Not assessed/No information collected
- Other, specify:

4. In any of your markets in 2019, 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 2019, 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
   - 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 2019, 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
   - 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

7. In any of your markets in 2019, 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 2019, 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 2019, 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

8. In any of your markets in 2019, please identify the barriers that state Medicaid agencies could remove to 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

Other, Specify:

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 Medicaid 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 13, 2020.

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The views expressed here do not necessarily reflect the views of the Foundation.