INSTITUTE FOR MEDICAID INNOVATION

2023 Annual Medicaid MCO Survey

Please return your completed survey to the Survey Project Team at MCOSurvey@MedicaidInnovation.org.

Due Date: March 15, 2023

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

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

If you would prefer to complete the survey online, please click here.

Section A. Contact Information

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

Name:

Email:

Phone:

Name of your health plan:

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

Parent Organization

Individual Market

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

Section B. General Information

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

3. How many individuals are currently enrolled in your Medicaid MCO in all contracts and markets?

4. Does your organization currently have Medicaid contracts in:

    Multiple states

    SIngle states

5. Please select the state(s) and territories where you currently have Medicaid contracts.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
DC
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Section C. High-Risk Care Coordination

Definitions and Acronyms for Section C

- **Care team –** Group of individuals (clinicians and non-clinicians) within and outside the health plan that supports members' access, coverage, and coordination of care.
- **Community health worker –** Community health workers (CHWs) are lay members of the community who work in association with the local health care system. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve.
- **Complex population contracts –** Contracts that include individuals with intellectual and developmental disabilities (I/DD), children with special healthcare needs (CSHCN), individuals with serious mental illness (SMI), and foster care.
- **General Medicaid contract –** Medicaid contracts with managed care that primarily focus on Medicaid benefits outlined in the state plan, typically consisting of eligibility categories for women, children, and childless adults.
- **HEDIS -** Healthcare Effectiveness Data and Information Set. HEDIS includes more than 90 measures of quality and effectiveness of care used in quality improvement.
- **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 focuses on individuals at increased risk by providing support to navigate and coordinate needed care. These services are provided directly by the MCO or a delegated entity and include programs such as complex member management, disease management, high-risk maternity management, etc.
- **MCOs –** Managed care organizations. For the purposes of this survey, we are exclusively interested in Medicaid managed care organizations.
- **MLTSS –** Managed long-term services and supports.
- **MLTSS Medicaid contract –** Contracts inclusive of institutional, home, and community-based services that are targeted to individuals who qualify for long-term care based on functional need.
- **Peer support worker -** Individuals with lived experience of a health condition that help and provide social, emotional, or practical support to others experiencing the same condition.
- **SDOH -** Social determinants of health, also referred to as social influencers of health, are environmental conditions into which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functional, and quality-of-life outcomes and risks. For example, housing, food, and public safety.
- **SUD -** Substance use disorder.
- **WIC -** Special Supplemental Nutrition Program for Women, Infants, and Children.

Please respond to the following items **at the parent organizational 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 populations or contracts for managed long-term services and supports (MLTSS) are **not** the focus of this section.

1. In any of your Medicaid markets, identify which outcomes you currently use to track the effectiveness of high-risk care coordination. ***Check all that apply.***

Emergency department utilization (HEDIS measure)

Emergency department utilization (unrelated to HEDIS measure)

Inpatient utilization (HEDIS measure)

Inpatient utilization (unrelated to HEDIS measure)

Impact on other HEDIS measures.
Please list measures: ___________________

Preventive care utilization

Outpatient primary care utilization

Total spending

Patient experience survey results (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey)

Provider experience survey results

Complaints and grievances

Other, specify: _________________

Our health plan does not track the effectiveness

2. Identify the barriers that your health plan currently experiences in any Medicaid market 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

Member's willingness to engage with high-risk care coordination

Access to information from previous providers (e.g., mental health)

Ability to share information with service providers

Provider willingness to engage with high-risk care coordination

Availability of social supports

Member's ability to navigate multiple care coordinators from health systems, provider practices, clinics, etc.

Member's unmet social determinants of health

Ability to connect individuals to necessary non-clinical social supports

Churn (member or eligibility-related)

Member's knowledge of managed care

Language barrier(s)

Other, specify: __________

None

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

General background data, such as:

Demographic data (e.g., age, gender, education level)

Sexual orientation

Gender identity

Pronouns

Race

Ethnicity

Language

Contact data (e.g., phone numbers, email addresses)

Household data (e.g., power of attorney, guardian, head of household information, or household composition)

Other, specify: _______________

None

Medical system data, such as:

Historical claims data and clinical encounters

Case management or social work encounters

Behavioral health diagnoses/treatment/providers (including mental health and SUD)

Health status indicators

Special health care needs indicators

Smoking/vaping / nicotine/tobacco use

Other, specify: ______________

None

Social determinants of health data, such as:

School enrollment

Foster care status

Engagement in other state programs (e.g., WIC)

Housing situation/stability (e.g., unhoused)

Criminal justice involvement

Other, specify: ____________

None

4. Across all of your Medicaid markets, please identify the staff titles of your health plan's non-clinical high-risk care coordination team. ***Check all that apply.***

   Community health worker

   Perinatal community health worker

   Peer support worker

   Doula

   Health educator

   Other, specify: _________

   None

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

   Who can we contact for more information?

   Name:

   Phone:

   Email:

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

Section D. Alternative Payment Models

Definitions and Acronyms for Section D

- **APM -** Alternative Payment Model.
- **CAHPS** - Consumer Assessment of Healthcare Providers and Systems (CAHPS).
- **CFR -** Code of Federal Regulations.
- **CQMC** - Core Quality Measures Collaborative.
- **HEDIS -** Healthcare Effectiveness Data and Information Set.
- **PMPM -** Per Member Per Month.
- **VBP -** Value-Based Payment.

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

1. Across all of your Medicaid markets, does your health plan have any APM or VBP arrangements?

   Yes

   No

If no, proceed to Section E.

2. In any of your Medicaid markets, identify which of the following payment strategies your health plan uses. ***Check all that apply.***

   Enhanced payment rates for providers in rural or frontier areas

   Enhanced payment rates for hard-to-recruit provider types

   Payment incentives for availability of same-day or after-hours appointments

   Payment incentives based on performance measures related to access to care

   Incentive payments for addressing health disparities

   Incentive payments for addressing health inequities

   Enhanced payment rates for providers financially impacted by the COVID-19 pandemic

   Payment incentives to integrate behavioral health care into primary care

   Payment incentives to integrate primary care into behavioral health care

   Enhanced payments to providers for reimbursement parity with other MCOs

   Other, specify: _______

   None

3. In any of your Medicaid markets, please indicate which of the following VBP arrangements or APMs your health plan uses for any providers. ***Check all that apply.***

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

4. In any of your Medicaid markets, what operational barriers does your health plan experience that can be addressed with adoption and innovation in VBP and/or APM? ***Check all that apply.***

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

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

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

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

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

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

    Opportunities for implementation of new strategies

    Higher provider participation rates in VBP/APMs

    Lower provider participation rates in VBP/APMs

    Modification or suspension of VBP and/or APM payment methodologies (e.g., quality metrics or benchmarks)

    Reconsideration of long-term organizational strategy for VBP and/or APMs

    Other, specify: ________

    None

8. 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:

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

Section E. Pharmacy

Definitions and Acronyms for Section E

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

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

1. For any of your Medicaid contracts, is your health plan at-risk for pharmacy benefits?

   Yes

   Yes, but only a portion of the pharmacy spend

   No

If no, proceed to Section F.

2. Across all of your Medicaid markets, identify the major challenges that your health plan currently faces 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

   Members' comprehension of and engagement in programs

   Formulary notification requirements as part of Medicaid MCO Final Rule

   Pharmacy network requirements

   Single PDL/formulary requirements

   Increase in number of specialty pharmacy medications

   Increase in cost of specialty pharmacy medications

   Vendor performance management (e.g., PBM, specialty)

   Other, specify: __________

   None

3. What are the most effective strategies that the state(s) you have contracts with use to address the costs of new or high-cost drugs for Medicaid MCOs? ***Check all that apply.***

Carved-out the drug costs completely; pay FFS for certain drug(s)

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

Capitation rate adjustments made off the normal rate cycle

Capitation rate adjustment as part of regular rate adjustments

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

Risk corridor for high-cost medications

Risk sharing

Kick payment for certain drug(s)

Value-based contracts with manufacturers

Other, specify: ___________

States have not addressed the cost

4. What pharmacy benefit/formulary activities or initiatives does your health plan currently use to address the opioid epidemic? ***Check all that apply.***

Quantity and/or days' supply limits for new starts

Review dose limit policies to ensure they do not encourage involuntary tapers and prompt clinical review of exception requests

Remove or restrict methadone for pain

Policies to decrease new starts for concurrent opioid/benzodiazepine

Remove or reduce restrictions for or add to formulary common non-opioid pain medications (e.g., topicals, antidepressants, neuroleptics with indications for pain)

Remove or reduce restrictions for other pain services

Pharmacy and/or prescriber lock program for members using multiple prescribers

Case management to ensure appropriate care and referral to services

Removing barriers to MAT (e.g., PA for testing or MAT)

Other, specify: _________

None

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

   Who can we contact for more information?

   Name:

   Phone:

   Email:

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

Section F. Behavioral Health

Definitions and Acronyms for Section F

- **CFR -** Code of Federal Regulations.
- **SUD -** Substance use disorder.

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

1. Across any of your Medicaid markets, are you at-risk for behavioral health services?

Yes

No

If no, proceed to Section G.

2. Please indicate the barriers that your health plan experiences across any of your Medicaid 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 teams
- Access to data between care management and behavioral health teams
- Technological system differences with subcontractors
- Other, specify: ________
- We do not experience any operational barriers.

Network Barriers

- Provider's capacity to provide integrated physical and behavioral health at point of care
- Behavioral health provider's readiness for managed care
- Behavioral health provider's adoption of electronic health records
- Access to data from other network entities such as departments of health or substance use programs
- Other, specify: ________
- We do not experience any network barriers.

Policy Barriers

- 42 CFR Part 2 limitations on SUD treatment information being shared
- Institutions of mental disease (IMD) exclusion
- Fragmentation in program funding for physical and behavioral health services
- Fragmentation in program contracting for physical and behavioral health services
- State-specific substance use confidentiality laws
- State-specific behavioral health confidentiality laws
- Other, specify: __________
- We do not experience any policy barriers.

3. In any Medicaid market does your health plan provide **child/adolescent behavioral health services?**

- Yes
- No

If yes, proceed to question 4. If no, skip to question 6.

4. Please indicate the barriers your health plan encounters in any Medicaid market when providing **child/adolescent behavioral health services.** ***Check all that apply.***

Availability of in-person behavioral health providers

Availability of virtual behavioral health providers

Providers' inability to adopt the Collaborative Care Model

MCO's inability to embed a behavioral health provider in a primary care setting

Members' access to technology to engage in virtual behavioral health services

Members' ability to access in-person behavioral health

Providers' infrastructure to support virtual behavioral health

Pediatricians' capacity to assess behavioral health needs

Pediatricians' capacity to provide appropriate level of care for behavioral health needs

Excessive wait times for specialty care

Members' parents/caregivers' willingness to engage with behavioral health services

Cultural and familial stigma around mental illness

Availability of treatment options for substance use disorders specifically for children/adolescents

Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)

Language barriers

Churn (member or eligibility-related)

Coordinating with department of child services/departments of juvenile justice for children engaged with child welfare or juvenile justice systems

Immigration status of parents/caregivers

Carved-out benefits

Other, specify: ___________

None

5. Please indicate how your health plan addresses access barriers in any Medicaid market for providing **child/adolescent behavioral health services.** ***Check all that apply.***

- Contract with more virtual behavioral health providers
- Administer behavioral health services in schools
- Provide behavioral health services in medical emergency rooms
- Provide coaches and peer support to expand available resources
- Provide training to pediatricians on integrating behavioral health into their practice
- Connect members to infrastructure to access virtual care
- Incentivize members' parents/caregivers to engage with behavioral health services
- Educate members to help destigmatize mental illness
- Provide services in multiple languages
- Other, specify: _________
- None

6. 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:

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

Section G. Women's Health

At the Institute for Medicaid Innovation, we recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this survey uses both gendered terms such as "women" or "mothers" as presented in regulatory statue for the Medicaid program and gender inclusive terms such as "people," "pregnant people," and "birthing persons" when not specific to regulatory statute.

Definitions and Acronyms for Section G

- **EHR -** Electronic health record.
- **HIE -** Health information exchange.
- **LARC -** Long-Acting Reversible Contraception.
- **SDOH -** Social determinants of health, also referred to as social influencers of health, are environmental conditions into which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functional, and quality-of-life outcomes and risks. For example, housing, food, and public safety.
- **Sexual and reproductive health -** A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to . . . to read the full definition please visit the Guttmacher–Lancet Commission report on sexual and reproductive health.
- **SOGI -** Sexual orientation and gender identity.

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

1. In any of your Medicaid markets, which of the following provider types does your health plan contract with to serve as a primary care provider for sexual and reproductive health including pregnancy, childbirth, and the postpartum period? ***Check all that apply.***

    Nurse practitioners
    Nurse-midwives
    Geriatricians
    Certified professional midwives
    Certified midwives
    Licensed midwives
    Obstetricians/gynecologists
    Other, specify: ______
    None

2. In any of your Medicaid markets, please identify the provider settings that your health plan contracts with to provide your members with sexual and reproductive health care including pregnancy, childbirth, and the postpartum period. ***Check all that apply.***

- Freestanding family planning providers
- Planned Parenthood health centers
- Freestanding birth centers
- Telecontraception platforms
- None of the above

3. Across all of your Medicaid markets, what contraceptive quality measures is your health plan utilizing? ***Check all that apply.***

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

4. Across all of your Medicaid markets, which of the following ancillary services are covered benefits for childbearing people? ***Check all that apply.***

- Nutritional counselling
- Support from a community health worker
- Childbirth education class
- Breastfeeding class
- Support from a doula
- Group prenatal care (e.g., CenteringPregnancy)
- Lactation counseling
- Parenting class
- Other, specify: _______
- None

5. In any Medicaid market, does your health plan have a way to identify pregnant members during the first trimester?

Yes

No

If yes, proceed to question 5a. If no, skip to question 6.

5a. If yes, how do you identify who is pregnant? ***Check all that apply.***

EHR/HIE

Member self identifies

Enrollment data

Provider information (e.g., ONAF – Obstetric Needs Assessment Form)

Claims data

Lab results

Other, specify:

6. In any of your markets, please identify the provider types where increased Medicaid reimbursement rates would further assist health plans in addressing the **sexual and reproductive health needs including pregnancy, childbirth, and the postpartum period** of Medicaid members. ***Check all that apply.***

Midwives (e.g., certified professional midwives, certified midwives, and licensed midwives)

Nurse midwives

Doulas

Freestanding birth centers

Perinatal community health workers

Community health workers

Perinatal nutritionist

Other, specify: ______

None of the above

7. Across all of your Medicaid markets, does your health plan offer any specific programs to address health disparities impacting individuals with **diverse sexual orientations and gender identities?**

Yes

No, but considering

No, and not considering

8. In any of your Medicaid markets, do you offer specific SDOH programs to individuals with **diverse sexual orientations and gender identities?**

Yes

No, but considering

No, and not considering

9. In any Medicaid market, which gender affirming services does your health plan cover for **transgender youth and/or adults?** ***Check all that apply.***

Adult medical care (e.g., hormone therapy)

Adult surgery

Youth medical care (e.g., hormone therapy)

Youth surgery

Other, specify: _______

None

10. For all your Medicaid markets, what is your health plan's data source(s) for members' gender identity data? ***Check all that apply.***

State Medicaid enrollment files

Imputed from other data sources

Member self-report collected by the health plan

Data feed from provider organizations or state health information exchange

Other, specify: _______

We do not receive this data from any source.

Our health plan's data system does not currently record gender identity separate from sex.

11. For all your Medicaid markets, what is your health plan's data source(s) for members' sexual orientation data? ***Check all that apply.***

State Medicaid enrollment files

Imputed from other data sources

Member self-report collected by the health plan

Data feed from provider organizations or state health information exchange

Other, specify: _______

We do not receive this data from any source.

Our health plan's data system does not currently record sexual orientation.

12. Please indicate the barriers that your health plan experiences across any of your Medicaid markets related to sexual orientation & gender identity data. ***Check all that apply.***

Software the health plan uses does not maintain or display SOGI data

Response options on forms are not comprehensive/inclusive of all identities

Members express concern with sharing SOGI data

Health plan receives incomplete SOGI data

Other, specify: _______

We do not experience any barriers.

13. Please indicate the barriers that your health plan experiences across any of your Medicaid markets when addressing sexual and reproductive health needs of members. ***Check all that apply.***

Low or no availability of providers in certain geographical areas

Providers lack experience serving individuals with diverse sexual orientations and gender identities

State-specific confidentiality laws

State-specific restrictions for contraceptive care

State-specific restrictions for family planning services

State-specific restrictions for transgender care

Other, specify: _______

We do not experience any barriers.

14. In any of your markets, please identify how state Medicaid agencies could further assist health plans in addressing the sexual and reproductive health needs of Medicaid members. ***Check all that apply.***

Improve data sharing between state and MCOs

Improve quality of data shared 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 technical assistance resources

Increase resources to support facilitation of partnerships

Facilitate contracting with community-based organizations

Establish equitable and sustainable payment levels for doulas

Establish equitable and sustainable payment levels for midwives

Establish equitable and sustainable payment levels for non-hospital births (i.e., freestanding birth centers and home births)

Remove regulatory burdens and obstacles for midwives to practice at the top of their license

Remove regulatory burdens and obstacles for freestanding birth centers and home births

Remove funding restrictions for reproductive health care

Other, specify: __________

States cannot provide further assistance.

15. OPTIONAL: Does your health plan have any innovative initiatives or best practices specific to sexual and reproductive health? If yes, please briefly describe.

Who can we contact for more information?

Name:

Phone:

Email:

16. OPTIONAL: Did we miss anything? Please share anything that you feel would be helpful in understanding how Medicaid MCOs address sexual and reproductive health.

Section H. Child & Adolescent Health

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

1. Across any of your Medicaid markets, does your health plan offer specific programs to address children's health?

   Yes

   No

If no, proceed to Section I.

2. Please indicate which of the following barriers your health plan encounters in any Medicaid market when serving children. ***Check all that apply.***

   Identifying and coordinating with schools (e.g., unable to get documentation of care provided at schools)

   Engaging family members who are not enrolled in the plan

   Engaging family members to address social determinants of health

   State policies

   Federal policies

   Program fragmentation

   Language barriers

   Churn (member or eligibility-related)

   Inability to find needed health care providers or beds

   Coordinating with departments of child services/departments of juvenile justice for children engaged with child welfare or juvenile justice systems

   Barriers related to foster care system

   Immigration status of parents/caregivers

   Families express lack of transportation to treatment programs

   Other unmet social needs expressed by families

   Carved-out benefits

   Other, specify:

   None

3. In any Medicaid market, does your health plan cover child and adolescent comprehensive obesity treatment inclusive of intensive behavioral interventions, pharmacology, metabolic and bariatric surgery?

    Yes

    No

    No, but considering

4. In any Medicaid market, please indicate which of the following barriers your health plan encounters when providing obesity treatment for children and adolescents. ***Check all that apply.***

    Lack of payment structure to allow for coordination of treatment among different providers

    Lack of policies/structure that support coverage of pediatric dieticians

    Lack of coverage for obesity medication-based treatment options

    Lack of ancillary services such as nutritionists

    Lack of specialty care providers

    State policies

    Federal policies

    Program fragmentation

    Carved-out benefits

    Lack of screening and support for families with food and nutrition insecurity

    Lack of coverage for school physical activities

    Families express barriers accessing treatment (e.g., transportation, childcare, work schedules)

    Other, specify: ______

    We do not experience any barriers.

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

Who can we contact for more information?

Name:

Phone:

Email:

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

Section I. Managed Long-Term Services and Supports (MLTSS)

Definitions and Acronyms for Section I

- **ADL/IADL -** Activities of Daily Living/Independent Activities of Daily Living.
- **MLTSS -** Managed Long-Term Services and Supports.

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

1. For any of your Medicaid contracts, are you currently at-risk for managed long-term services and supports?

Yes

No

If no, proceed to Section I.

2. Across all of your Medicaid markets, identify the barriers that affect your health plan's ability to manage MLTSS. ***Check all that apply.***

Fragmented Medicaid benefit design – behavioral health and/or physical health benefits – limits ability to serve the whole individual

Medicare and Medicaid misalignment creates challenges and financial disincentives

State requirements for health plans to contract with specific organizations or providers for care coordination

Restrictions to in-person assessments and care delivery due to COVID-19

Challenges related to the direct-care workforce (e.g., lack of staff, turnover, training, and qualification challenges)

State program requirements that limit the effectiveness of managed care strategies (e.g., any-willing-provider provisions, continuity-of-care provisions)

Waiver waitlists

Institutional level-of-care requirements that do not align with state goals (e.g., ADL/IADL requirements that are too low or too high to support appropriate utilization)

Churn (member or eligibility-related)

Operationalizing electronic visit verification requirements

Other, specify: ______

None

3. Across all of your markets, what barriers, if any, does your health plan currently encounter when supporting various transitions of care. ***Check all that apply.***

Barriers									
	Data exchange	Housing/ Bed availability	Caregiver support	Availability of in-home support	Coordination of community services in advance of transition	Continuity of services	Availability of respite care	Availability of hospice	Awareness and availability of resources and support to caregivers
Nursing facility to hospital									
Hospital to nursing facility									
Hospital to home									
Home to hospital									
Nursing facility to home									
Home to nursing facility									

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

Who can we contact for more information?

Name:

Phone:

Email:

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

Section J. Social Determinants of Health

Definitions and Acronyms for Section J

- **CBO -** Community-Based Organization.
- **CMS -** Centers for Medicare and Medicaid Services.
- **EHR -** Electronic Health Record.
- **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.

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

1. In any of your Medicaid markets, for which populations listed do you offer specific SDOH programs? ***Check all that apply.***

People with justice system involvement

People living with HIV/AIDS

Pregnant and postpartum individuals

Foster care youth/youth transitioning to adulthood

People experiencing homelessness/housing insecurity

Adults with a substance use disorder

Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)

Child welfare/child protective services involved families

Adults with disabilities (e.g., physical, intellectual, developmental)

Aged, blind, and disabled

Expansion members

Adults with serious mental illness

Medicare and Medicaid enrollees (Dual enrollees)

People with limited English proficiency

Children/adolescents with behavioral health diagnoses (mental health or substance use)

Children with disabilities

Long-term services and supports (LTSS) population

Other, specify: __________

We do not have SDOH programs for specific populations.

2. In any of your Medicaid markets, what SDOH screening tools does your health plan currently use? ***Check all that apply.***

- American Community Survey data
- The EveryOne Project: Advancing Health Equity in Every CommunityToolkit by American Academy of Family Physicians
- Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE)
- Social Needs Screening Toolkit, HealthLeads USA
- Social Determinants Screening Tool, AccessHealth Spartanburg, Center for Health Care Strategies version
- Self-Sufficiency Outcomes Matrix, OneCare Vermont, Center for Health Care Strategies version
- Arizona Self-Sufficiency Matrix
- Vulnerability Index – Service Prioritization Decision Assistance Tool (VISPDAT)
- CMS Accountable Health Communities Health-Related Social Needs Screening Tool
- Tool(s) embedded in provider electronic health record (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: ________
- We do not use SDOH screening tools.

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

- Provide administrative assistance (e.g., staff resources)
- Provide tools and support for data analysis
- Allow or improve data sharing
- Provide financial support
- Provide screening tools
- Make policy/regulatory changes to support SDOH initiatives
- Submit/receive approval for a Medicaid waiver(s) that included support of SDOH initiatives
- Provide support for cultural and linguistic competency
- Other, specify: __________
- States do not support social need initiatives.

4. In any of your Medicaid markets, which metrics are currently used to assess and evaluate SDOH initiatives? ***Check all that apply.***

Cost utilization

Cost savings

Performance measures

Access to care

Market capacity

Return on investment (ROI)

Percentage of eligible population impacted by services offered

Other, specify: _________

No performance metrics are used

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

Improve data sharing between state and MCOs

Improve data sharing between government agencies (e.g., foster care system, criminal justice system) and MCOs

Improve data sharing between MCOs and community-based organizations

Improve data sharing between MCOs and provider groups

Increase financial resources from state to MCOs

Increase technical assistance resources

Increase resources to support capitated payments models, pay-for-performance, and risk programs with providers

Increase resources to support facilitation of partnerships

Facilitate contracting with community-based organizations

Standardize 834 enrollment file to include social needs information

Purchase tools and resources that require a license and provide access to all health plans

Other, specify: _______

States cannot provide any further assistance.

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

   Who can we contact for more information?

   Name:

   Phone:

   Email:

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

Section K. COVID-19 Pandemic

Definitions and Acronyms for Section K

- **CBO -** Community-based organization.
- **ED -** Emergency department.
- **HEDIS -** Healthcare Effectiveness Data and Information Set.
- **Public Health Emergency (PHE)** - Declaration from the secretary of the Department of Health and Human Services that 1) a disease or disorder presents a PHE or 2) a PHE, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exist. A PHE declaration allows the secretary to take actions to respond to the PHE.
- **Telehealth -** The use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely.

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

1. When reflecting on your health plan's response to the COVID-19 pandemic, what changes has your Medicaid health plan made that will be beneficial in preparing for the next public health emergency? ***Check all that apply.***

   Expanded and/or enhanced telehealth platforms and infrastructure (e.g., purchasing new technology systems)

   Supported members' social and health-related needs

   Bolstered disaster planning and emergency response efforts

   Enacted service and benefit flexibilities

   Provided resources or support to clinicians

   Provided resources or support to CBOs

   Made changes to operations and staffing accommodations

   Enhanced public relations and messaging

   Other, specify: ________

   We did not make changes that will affect future public health emergencies.

2. When reflecting on your Medicaid health plan's response to the COVID-19 pandemic, which of the following strategies did your Medicaid health plan deploy? ***Check all that apply.***

   Coverage of member benefits expanded

   Extended, removed, and altered authorizations

   Service provision and utilization management transitioned to telehealth delivery

   Care and case managers transitioned to proactive member outreach

   Increased support was offered to hospitals in managing patient flow and disposition

   Facilitated COVID-19 vaccination efforts

   Other, specify: _______

   We did not deploy any specific strategies.

3. Across all of your Medicaid markets, reflecting on your health plan's response to the COVID-19 pandemic, identify ways in which your health plan pivoted to close gaps in HEDIS measures with fewer in-person visits. ***Check all that apply.***

   In-home testing

   Vaccine drive-throughs

   Remote device monitoring

   Telephonic appointments

   Video appointments

   Other, specify: _______

   None

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

Who can we contact for more information?

Name:

Phone:

Email:

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

Section L. Health Equity & Structural Racism

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

Definitions and Acronyms for Section L

- **Antiracism-** The work of actively opposing all forms of racism, including structural racism, by advocating for changes in political, economic, and social life.
- **CAHPS-** Consumer Assessment of Healthcare Providers and Systems.
- **CG-CAHPS-** The CAHPS® Clinician & Group Survey asks patients to report their experiences with providers and staff in primary care and specialty care settings.
- **Health disparities-** A higher burden of illness, injury, disability, or mortality experienced by one group relative to another. Although the term disparities is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Disparities can also refer to differences between groups in health insurance coverage, access to and use of care, and quality of care when care is received.
- **Health equity-** Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
- **Health equity accountability measures-** Provider-level performance measures linked to provider accountability for advancing health equity and reducing disparities.
- **Health equity plan-** An action-oriented, results-driven approach for advancing health equity by removing barriers and improving access to and the quality of care provided to minoritized and other underserved demographic groups.
- **Health inequities-** Differences in health status or in the distribution of health resources among various population groups, arising from the social conditions in which people are born, grow, live, work, and age. Health inequities are unfair and can be reduced by institutional and government policies and public/private collaborations.
- **HEDIS-** Healthcare Effectiveness Data and Information Set. HEDIS includes more than 90 measures of quality and effectiveness of care used in quality improvement.
- **LGBTQ+**- A common acronym used to describe people who have non-heterosexual and/or non-cisgender identities. Stands for lesbian, gay, bisexual, transgender, and queer and/or questioning. The "+" is intended to include people with additional identities, such as asexual, intersex, nonbinary, and more.
- **NCQA**- National Committee for Quality Assurance.
- **Racial equity-** Just and fair inclusion into a society in which all people, regardless of their race or ethnicity, can participate, prosper, and reach their full potential.
- **Racism-** Prejudice plus power that leads to different consequences for different groups.
- **Structural racism-** A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It includes dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it is a result of the social, economic, and political systems in which we all exist.

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

1. Across all of your Medicaid markets, for which of the following groups do you currently have a documented health equity plan? ***Check all that apply.***

Specific member populations

Pregnant and postpartum individuals

Individuals with chronic illness

Individuals living with a disability

Black and/or African American individuals

Indigenous individuals

Hispanic and/or Latinx individuals

Refugees

Immigrants

LQBTQ+ individuals

Other, specify: _______

None

Provider groups

Reproductive health providers

Behavioral health providers

Substance use disorder providers

Federally qualified health centers

Other, specify: ______

None

Other groups

Health plan internal staff

Other, specify: _____

None

2. Across all of your Medicaid markets, what is your health plan currently leading, if anything, to address the impacts of structural racism? ***Check all that apply.***

- Programs/policies for health plan internal staff
- Programs/policies for members
- Programs/policies for provider groups
- Programs/policies for communities experiencing inequities
- Programs/policies in collaboration with community-based organizations
- Made changes to health plan governance or operations
- Programs/policies for vendors or contractors
- Social investment with financial resources
- Other, specify: _______
- None

3. Across all of your Medicaid markets, are you integrating publicly available data sources into your operations to address disparities (e.g., American Community Survey, social vulnerability index, etc.)?

- Yes
- No

If yes, proceed to 3a. If no, skip to question 4.

3a. If yes, for what purpose(s) are you using the data? ***Check all that apply.***

- Proxy for members' risk
- Modeling population risk
- Identifying communities experiencing inequities
- Incorporation into risk algorithms
- Other, specify: _______

4. Across all of your Medicaid markets, what challenges are you encountering when integrating publicly available data sources (e.g., American Community Survey, social vulnerability index, etc.) into your operations to address disparities? ***Check all that apply.***

   Data received was incomplete and/or inconsistent

   The data available does not meet our needs

   We were unable to access the data

   We did not have the analytic capabilities to use the data

   We do not know what data are available

   Level of granularity needed not available in public data sources

   Other, specify: _______

   We do not experience any challenges.

5. Across any of your Medicaid markets, in what ways, if any, is your health plan stratifying data by race and ethnicity? ***Check all that apply.***

   Cost

   Quality (e.g., HEDIS)

   Utilization

   Member experience/satisfaction

   Grievances

   Health outcomes (e.g., functional status)

   Members of health care team

   Provider/network

   Other, specify: _____

   None, please explain why:

6. In the last 12 months, for any of your Medicaid markets, have you evaluated any clinical algorithms, policies (e.g., clinical, utilization management), or risk prediction models for bias?

   Yes

   No

If yes, proceed to 6a. If no, skip to question 7.

6a. If yes, has the health plan changed or abandoned those algorithms, policies, or models if bias was discovered?

   Yes, we have changed algorithms, policies, or models

   Yes, we have abandoned algorithms, policies, or models

   Other, specify: _________

   We continue using the same algorithms, policies, or models. Please explain why:

7. Does your health plan have NCQA Health Equity Accreditation status?

Yes

No, but planning to pursue

No, and no plans to pursue

If yes, proceed to 8. If no, skip to question 9.

8. For multi-state health plans, what proportion of your individual Medicaid markets have NCQA Health Equity Accreditation status?

Less than 50%

50% or more

This data is not tracked at the parent organization level

Not applicable. We are not a multi-state health plan

9. Does your health plan have NCQA Health Equity Accreditation **Plus** status?

Yes

No, but planning to pursue

No, and no plans to pursue

If yes, proceed to 10. If no, skip to question 11.

10. For multi-state health plans, what proportion of your local health plans have NCQA Health Equity Accreditation **Plus** status?

Less than 50%

50% or more

This data is not tracked at the parent level

Not applicable. We are not a multi-state health plan

11. Across all of your Medicaid markets, in what ways, if any, does your health plan assess for member perception of discrimination experienced with interactions with the health plan and/or provider groups and clinicians? ***Check all that apply.***

	Interactions with health plan	Interactions with providers
We don't assess for it		
Questions in the CG-CAHPS		
Questions on post-encounter surveys		
Other, specify:		

12. Across all of your Medicaid markets, with which type of providers does your health plan currently have health equity accountability measures in contracts? ***Check all that apply.***

- Primary care providers
- Hospitals
- Specialty care providers
- Reproductive health providers
- Other, specify: ______
- None

13. Across all your Medicaid markets, what is your health plan's data source(s) for member race and ethnicity data? ***Check all that apply.***

	Race Data	Ethnicity Data
State Medicaid enrollment files		
Imputed from other data sources		
Member self-reported as collected by the health plan		
Data from provider organizations or state health information exchange		
We do not receive this data from any source		
Our health plan's data system does not currently record this data		
Other, specify:		

14. Across all your Medicaid markets, which provider characteristics are tracked by the health plan and shared with members? ***Check all that apply.***

Category	Track	Share with members
Race		
Ethnicity		
Sex (e.g., male, female)		
Gender (e.g., man, woman, non-binary)		
Language(s) spoken		
LQBTQ+ / Sexual orientation		
Other, specify:		
None		

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

Who can we contact for more information?

Name:

Phone:

Email:

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

Section M. Telehealth

Definitions and Acronyms for Section M

- **CBO -** Community-based organization.
- **eConsult -** Asynchronous, consultative, provider-to-provider communications within a shared electronic health record (EHR) or web-based platform.
- **ED -** Emergency department.
- **Remote care modalities -** The inclusive use of synchronous and asynchronous communication, including eConsult, RPM, and telehealth.
- **Remote patient monitoring (RPM) -** The use of digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.
- **Telehealth** - The use of digital information and communication technologies, such as telephone, computers, and mobile devices, to access synchronous health care services remotely.

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

1. Across all of your Medicaid markets, what telehealth and remote care modalities does your health plan currently cover as a billable visit or service provided through a vendor? ***Check all that apply.***

    Audio only/telephone

    Live text chat

    Live video visits

    Provider to provider eConsult

    Remote patient monitoring (e.g., blood pressure monitoring, digital scales, blood glucose monitoring, heart rate, oxygen saturation, etc.)

    Use of a health portal (e.g., for on-line appointment scheduling, obtaining test results, and secure messaging with one's provider)

    Other, specify: ______

    None

2. Across all of your Medicaid markets, what, if any, barriers does your health plan encounter related to telehealth? ***Check all that apply.***

Provider Barriers

- State telehealth coverage policies influencing provider adoption
- IT systems
- Broadband access
- Computer/technology literacy
- Lack of technological resources
- Payment parity
- Payment incentives
- Integration into care models
- Provider disinterest
- Lack of interpreter services
- Quality concerns from the provider
- Other, specify: ______
- None

Member Barriers

- Access to broadband or an internet subscription
- Limited data plans/insufficient data or minutes covered by smartphone plans
- Technology/communication devices (i.e., laptop, smartphone)
- Health literacy
- Computer/technology literacy
- Lack of interpreter services
- Lack of awareness of or interest in telehealth as an option for accessing providers
- Other, specify: _______
- None

3. Across all of your Medicaid markets, what outcomes does your health plan attribute to telehealth? ***Check all that apply.***

Decreased member no-shows

Decreased ED utilization

Decreased urgent care utilization

Increased patient access to services

Increased primary care utilization

Increased behavioral health care utilization

Increased member satisfaction

Increased provider satisfaction

Improved continuity of care

Improved patient compliance with care

Increased cost savings

Increased prescribing

Increased fraud/abuse

Increased duplication of services

Other, specify: ______

None

4. Across all of your Medicaid markets, is your health plan currently implementing any of the following to create more equitable access to telehealth? ***Check all that apply.***

Digital literacy / technology literacy education for members

Digital literacy / technology literacy education for providers

Digital navigators for members

Supplemental payments to members for in-home internet subscriptions

Supplemental payments to members for mobile devices or data packages

Supporting community hot spots for internet access

Leveraging / promoting the Federal Communications Commission (FCC)'s Affordable Connectivity Program

Leveraging / promoting the FCC's Lifeline Program

Partnering with telecom companies to offer low-cost internet to members

Connecting members to CBOs who support access to technology / devices

Connecting members to CBOs who support access to internet services

Other, specify: _______

None

5. Across all of your markets, what specific changes to state Medicaid policies or requirements could assist health plans to create more equitable telehealth access for Medicaid members? ***Check all that apply.***

Reimburse for evidence-based remote patient monitoring

Incentivize for evidence-based remote patient monitoring

Reimburse for provider-to-provider consultations, including eConsults that leverage telehealth modalities (such as store-and-forward), when a professional medical opinion is sought

Reimburse for services that can be delivered appropriately via audio-only, including outpatient evaluation and management services and professional outpatient mental health care

Reimburse for translation and interpreting services

Allow federally qualified health centers (FQHCs), rural health clinics (RHCs), Indian Health Service clinics (IHS), and community mental health centers (CMHCs) to serve as both origination and distant site providers

Support school-based health services delivered via telehealth, particularly behavioral health services

Enable MCOs to create innovative reimbursement models

Other, specify:

None

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

Who can we contact for more information?

Name: Phone:

Email:

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

Thank you for completing the survey. Please return your completed survey to the Survey Project Team at MCOSurvey@MedicaidInnovation.org by **March 15, 2023**.

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