



Annual Medicaid MCO Survey Managed Long-Term Services & Supports (MLTSS)

54% of responding Medicaid health plans are at risk for MLTSS

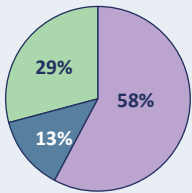
Note: Health plans that are not at risk for MLTSS did not respond to questions in the MLTSS section of the 2023 Annual Medicaid Health Plan survey.

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Methods and Overview

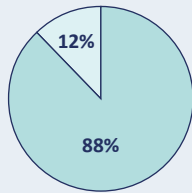
In its sixth year, the 2023 survey findings represent health plan data from almost every state with Medicaid managed care. The annual surveys collected information at the parent company/corporate levels and are intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care.

Health Plan Tax Status



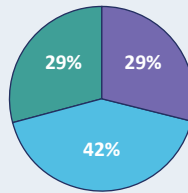
- Private Nonprofit
- Private For-Profit
- Government or Other

Health Plan Markets



- Single State
- Multistate

Health Plan Size



- Small Health Plans (<250K Covered)
- Medium Health Plans (250K-1 Million Covered)
- Large Health Plans (>1 Million Covered)

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Percent of Medicaid Health Plans Experiencing Housing/Bed Availability Barriers during Health Care Transitions for MLTSS

	Nursing facility to home transitions	92%
	Hospital to home transitions	85%
	Hospital to nursing facility transitions	77%
	Home to nursing facility transitions	62%
	Nursing facility to hospital transitions	31%
	Home to hospital transitions	23%

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Barriers Experienced by Medicaid Health Plans When Managing MLTSS

- Challenges related to the direct-care workforce (e.g., lack of staff, turnover, training, and qualification challenges) **85%**
- Restrictions to in-person assessments and care delivery due to COVID-19 **54%**
- Medicare and Medicaid misalignment creates challenges and financial disincentives **46%**
- Waiver waitlists **46%**
- Fragmented Medicaid benefit design—behavioral health and/or physical health benefits—limits ability to serve the whole individual **39%**
- Churn (member or eligibility-related) **39%**
- 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 are not enrolled in the plan) **31%**
- State requirements for health plans to contract with specific organizations or providers for care coordination **23%**
- State program requirements that limit the effectiveness of managed care strategies (e.g., any-willing-provider provisions, continuity-of-care provisions) **23%**
- Operationalizing electronic visit verification requirements **23%**
- Other* **23%**

Note: Other* includes lack of data sharing between health plans and other state programs and inadequate resources to keep individuals in their communities (e.g., in-home support services, caregiver respite services, and dementia care).

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."



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