INSTITUTE FOR MEDICAID INNOVATION

2024 Annual Medicaid MCO Survey

Your completed survey can be submitted via our secure web-based platform or you can email your pdf to MCOSurvey@MedicaidInnovation.org.

Due date: March 15, 2024

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 the data collected from health plans. Only IMI research staff have access to the survey data, and all IMI staff have received extensive training in research ethics, data protection, confidentiality, and privacy. As with all IMI surveys, we aggregate the reported findings from the analysis as a composite to ensure the protection of health plan–level identifiable data. For variables with a small sample size, findings will not be reported. Finally, no findings are released without the review and approval of the IMI survey subcommittee and the data and research committee, composed of Medicaid health plan representatives.

Section A. Contact Information

IMI staff will use the following information for the purpose of clarifying survey responses.

Name:

Title:

Email:

Phone:

Name of your health plan:

Please select the option that best represents your health plan.

- ○ Parent organization
- ○ Individual market

Proceed to the next page to begin section B.

Section B. General Information

Institute for Medicaid Innovation staff will use the following information for the purpose of categorizing survey responses.

Definitions and Acronyms

- **MCO**—Managed care organization.

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

1. What type of health plan is your parent organization?

   ◯ Private, for profit
   ◯ Private, nonprofit
   ◯ Government
   ◯ Other, specify: _____

2. In what year did your health plan begin participating in Medicaid programs as an MCO?

   _____

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

   _____

4. Does your Medicaid health plan prioritize employing people with lived experience (e.g., individuals with current or past enrollment in Medicaid or caregivers with experience?)

   ◯ Yes
   ◯ No
   ◯ Unsure
   ◯ Other, specify: _____

5. Does your organization currently have Medicaid contracts in one of the following?

   ◯ Multiple states
   ◯ Single state

6. Please select the state or states 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

- **Care team**—Group of individuals (clinicians and nonclinical) within and outside the health plan that supports members' access, coverage, and coordination of care.
- **CHW**—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 health care 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.
- **MCO**—Managed care organization.
- **MLTSS**—Managed long-term services and supports.
- **MLTSS Medicaid contract**—Contracts inclusive of institutional, home, and community-based services that are targeted to individuals who qualify for long-term care based on functional need.
- **Peer support worker**—Individuals with lived experience of a health condition who help 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 (e.g., 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 population contracts for managed long-term services and supports 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
- ☐ Members' experience survey results (e.g., Consumer Assessment of Healthcare Providers and Systems survey)
- ☐ Provider experience survey results
- ☐ Complaints and grievances
- ☐ Our health plan does not track the effectiveness
- ☐ Other, specify:

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.***

- [ ] Members' access to primary care
- [ ] Members' access to specialty care
- [ ] Members' access to behavioral and mental health care
- [ ] Ability to contact member
- [ ] Members' 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
- [ ] Members' ability to navigate multiple care coordinators from health systems, provider practices, clinics, etc.
- [ ] Members' unmet social determinants of health
- [ ] Ability to connect individuals to necessary nonclinical social supports
- [ ] Churn (member or eligibility related)
- [ ] Members' knowledge of managed care
- [ ] Language barriers
- [ ] None
- [ ] Other, specify: _____

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. ***Check all that apply.***

General background data, such as:

- [ ] Demographic data (e.g., age, sex, 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)
- [ ] None
- [ ] Other, specify:

Medical system data, such as:

- [ ] Historical claims data and clinical encounters
- [ ] Case management or social work encounters
- [ ] Behavioral health diagnoses, treatment, or providers (including mental health and substance use disorder)
- [ ] Health status indicators
- [ ] Special health care needs indicators
- [ ] Smoking, vaping, or nicotine or tobacco use
- [ ] Chronic medical conditions or diagnoses (e.g., sickle cell disease, HIV/AIDS)
- [ ] None
- [ ] Other, specify:

Social determinants of health data, such as:

- [ ] School enrollment
- [ ] Child welfare involvement
- [ ] Juvenile justice system involvement
- [ ] Participation in other state programs (e.g., WIC)
- [ ] Housing situation or stability (e.g., unhoused)
- [ ] Criminal justice system involvement
- [ ] None
- [ ] Other, specify:

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

- ☐ Community health worker
- ☐ Perinatal community health worker
- ☐ Peer support worker
- ☐ Doula
- ☐ Health educator
- ☐ Case management assistant
- ☐ Care coordinators
- ☐ Community health navigator
- ☐ None
- ☐ Other, specify: _____

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

Whom can we contact for more information?

Name: _____ Title: _____

Email: _____ Phone: _____

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

Section D. Alternative and Value-Based Payment Models

Definitions and Acronyms

- **APM**—Alternative Payment Model.
- **CAHPS**—Consumer Assessment of Healthcare Providers and Systems.
- **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 yes, proceed to question 2. If no, skip 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
   ☐ 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 health plans
   ☐ Optional benefits for select populations as authorized by statute (e.g., sickle cell disease)
   ☐ None
   ☐ Other, specify: _____

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

- [ ] Nonpayment or reduced payment for elective deliveries before 39 weeks
- [ ] Nonpayment or reduced payment for patient safety issues (e.g., never events)
- [ ] Incentive or 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 APM arrangements
- [ ] Shared savings arrangements
- [ ] PMPM for care management services
- [ ] None
- [ ] Other, specify: _____

4. In any of your Medicaid markets, identify the barriers to the adoption and innovation in APM and/or VBP. ***Check all that apply.***

Health plan operational barriers

- [ ] Data sharing readiness
- [ ] Information technology system preparedness
- [ ] Staff capacity
- [ ] Staff expertise and skills
- [ ] Willingness to participate in APM and/or VBP models
- [ ] Pricing structures or actuarial soundness
- [ ] Contract requirements on APM and/or VBP approaches
- [ ] None
- [ ] Other, specify:

Provider operational barriers

- [ ] Data sharing readiness
- [ ] Information technology system preparedness
- [ ] Staff capacity
- [ ] Staff expertise and skills
- [ ] Willingness to participate in APM and/or VBP models
- [ ] Pricing structures or actuarial soundness
- [ ] Contract requirements on APM and/or VBP approaches
- [ ] Lack of consistent evidence of efficacy of APM and/or VBP models
- [ ] None
- [ ] Other, specify:

Policy barriers

- [ ] State requirements limiting APM and/or VBP models
- [ ] Medicaid payment rates
- [ ] Impact of 42 C.F.R. Part 2 on limiting access to behavioral health data
- [ ] Uncertain or shifting federal policy requirements or priorities
- [ ] Uncertain or shifting state policy requirements or priorities
- [ ] Variation in payment models across payers (e.g., Medicaid, commercial, Medicare)
- [ ] None
- [ ] Other, specify:

Other external barriers

- [ ] Lack of consistent evidence of efficacy of APM and/or VBP models
- [ ] None
- [ ] Other, specify:

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

- [ ] More flexibility in the design of VBP components (e.g., member attribution, benchmarking)
- [ ] Development of a multiyear VBP strategy to allow for longer-term contracts with Medicaid
- [ ] Provision of additional policy and/or fiscal levers for health plans 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 VBPs
- [ ] Reporting of consistent metrics
- [ ] Removal of requirements that limit APM and/or VBP model development
- [ ] Streamlined VBP design across payers, including aligned performance measures
- [ ] Multipayer alignment in VBP strategies
- [ ] None
- [ ] Other, specify:

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

Whom can we contact for more information?

Name: Title:

Email: Phone:

7. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs are leveraging APM and/or VBP arrangements and any issues that are encountered.

Section E. Pharmacy

Definitions and Acronyms

- **HER**—Electronic health record.
- **FFS**—Fee-for-service.
- **MAT**—Medication-Assisted Treatment.
- **MTM**—Medication Therapy Management.
- **OTC**—Over-the-counter.
- **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 yes, proceed to question 2. If no, skip 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 Rules in 2016, 2017, and 2020
- ☐ 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)
- ☐ None
- ☐ Other, specify: _____

3. In any of your markets, please identify how state Medicaid agencies could further assist health plans in addressing the cost of new or high-cost drugs. ***Check all that apply.***

- [ ] Completely carve in the drug costs to managed care
- [ ] Temporarily cover specific drugs through the state fee-for-service program to get utilization data with intent to carve in to managed care 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 drugs
- [ ] Value-based contracts with manufacturers
- [ ] Provide health plans with supplemental payments to cover the cost of specialty drugs
- [ ] Support creating alternative reimbursement models
- [ ] State or states cannot provide assistance
- [ ] Other, specify:

4. What pharmacy benefit or 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 or benzodiazepine
- [ ] Remove or reduce restrictions for or add to formulary common nonopioid 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)
- [ ] None
- [ ] Other, specify:

5. For all of your Medicaid markets, does your health plan currently or plan to cover or reimburse members for the first OTC hormonal birth control pill, Opill®? ***Check all that apply.***

- ☐ Yes
- ☐ No, but considering
- ☐ No, and not considering
- ☐ No, it is not permitted by the state agency
- ☐ Unable to answer

6. For all of your Medicaid markets, does your health plan cover or reimburse members for emergency contraceptive pills (ECPs). ***Check all that apply.***

	Yes	No, but considering	No, and not considering	No, it is not permitted by state agencies
OTC emergency contraceptive pills	☐	☐	☐	☐
Prescription emergency contraceptive pills	☐	☐	☐	☐

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

Whom can we contact for more information?

Name: _____ Title: _____

Email: _____ Phone: _____

8. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs provide pharmacy services and any issues that are encountered.

Section F. Behavioral Health

Definitions and Acronyms

- **CFR**—Code of Federal Regulations.
- **OUD**—Opioid use disorder.
- **MCO**—Managed care organizations.
- **SUD**—Substance use disorder.

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 behavioral health services?

- ◯ Yes
- ◯ Yes, but only specific services including:

  _____

- ◯ No

If yes, proceed to question 2. If no, skip 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
- ☐ We do not experience any operational barriers
- ☐ Other, specify: _____

Network barriers

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

Policy barriers

- ☐ 42 C.F.R. 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
- ☐ We do not experience any policy barriers
- ☐ Other, specify: _____

3. In any Medicaid market does your health plan manage child or 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 managing child or 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
- [ ] Providers' 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' or 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 or 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 or departments of juvenile justice for children engaged with child welfare or juvenile justice systems
- [ ] Immigration status of parents or caregivers
- [ ] Carved-out benefits
- [ ] None
- [ ] Other, specify: _____

5. Please indicate how your health plan addresses access barriers in any Medicaid market for managing child or 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 emergency departments
- [ ] Provide coaches and peer support to expand available resources
- [ ] Provide training to pediatricians on integrating behavioral health into their practices
- [ ] Connect members to infrastructure to access virtual care
- [ ] Incentivize members' parents or caregivers to engage with behavioral health services
- [ ] Educate members to help destigmatize mental illness
- [ ] Provide services in multiple languages
- [ ] None
- [ ] Other, specify:

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

- [ ] Support behavioral health home and community-based service providers
- [ ] Expand payment around audio-only delivery of mental health and SUD services
- [ ] Expand payment around audiovisual delivery of mental health and SUD services
- [ ] Champion policies to facilitate data sharing across physical health and behavioral health MCOs
- [ ] Remove data sharing restrictions
- [ ] Facilitate increase in behavioral health provider workforce
- [ ] Facilitate increase of behavioral health provider participation in Medicaid
- [ ] Increase Medicaid payment rates for behavioral health
- [ ] Cover codes for mental health screening, peer support, and collaborative care
- [ ] Authorize telehealth regulations that permit virtual-only providers for behavioral health providers, including OUD treatment or buprenorphine prescribing
- [ ] Carve-in behavioral health (where not carved in)
- [ ] Authorize mobile crisis services
- [ ] States cannot provide further assistance
- [ ] Other, specify:

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

Whom can we contact for more information?

Name:		Title:	
Email:		Phone:	

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

Section G. Maternal and Perinatal Health

The Institute for Medicaid Innovation recognizes that transgender and nonbinary people become pregnant or seek perinatal health care services. In response, IMI is committed to creating resources that are gender inclusive and affirming, limiting gendered language and only using such terms when specified in Medicaid requirements, statutes, policies, research publications, and database variable names. As such, IMI's resources use both gender inclusive and affirming terms but also gender-specific terms like "women/woman" and "maternal.".

Definitions and Acronyms

- **Advanced Practice Registered Nurses (APRNs)**—also called Advanced Practice Nurses (APNs). Individuals who have been issued a license for an expanded scope of practice in nursing by a licensing board in the state where they practice. APRNs are licensed nurses with post-graduate education and training in nursing. There are four types of APRNs. These include nurse practitioners, certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists.
- **Certified Midwife (CM)**—CMs are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME). CMs pass a national certification exam administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CM.
- **Certified Nurse Midwife (CNM)**—CNMs are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME). CNMs pass a national certification exam administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM (if they have an active registered nurse [RN] credential at the time of the certification exam).
- **Certified Professional Midwife (CPM)**—CPMs meet the standards for certification set by the North American Registry of Midwives (NARM). There are multiple pathways to certification, including graduation from an education program accredited by the Midwifery Education Accreditation Council (MEAC) or the Accreditation Commission for Midwifery Education (ACME), completion of the Portfolio Evaluation Process, or holding current legal recognition to practice.
- **Licensed Midwife**—Individual who has been issued a license to practice midwifery by a licensing board in the state where they practice.
- **Midwife**—a person who has successfully completed a midwifery education program based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife,' and who demonstrates competency in the practice of midwifery.
- **Maternal & perinatal health**—Refers to an individual's health and well-being before, during, and after pregnancy and encompasses aspects of physical, mental, emotional, and social health. This term can also be applied collectively to the health of the population of people that experience pregnancy as well as infants, during the perinatal period.
- **Perinatal period—**The period beginning with pregnancy up to one year following birth.
- **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 read the full definition please visit the Guttmacher–Lancet Commission report on sexual and reproductive health.*

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 maternal/perinatal health services?

   ◯ Yes
   ◯ Yes, but only specific services including:

   ◯ No

If yes, proceed to question 2. If no, skip to section H.

2. In any of your Medicaid markets, does your health plan contract with any of the following types of providers for maternal/perinatal heath care? ***Check all that apply.***

   ☐ Nurse practitioners
   ☐ Certified nurse midwives
   ☐ Certified professional midwives
   ☐ Certified midwives
   ☐ Licensed midwives
   ☐ None of the above. Please explain why:
   ☐ Other, specify:

3. In any of your Medicaid markets, please identify the provider settings that your health plan contracts with to provide your members with maternal and perinatal health care. ***Check all that apply.***

   ☐ Freestanding family planning providers
   ☐ Planned Parenthood health centers
   ☐ Freestanding birth centers
   ☐ Telehealth platforms
   ☐ Federally Qualified Health Centers
   ☐ None
   ☐ Other, specify:

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

- ☐ Nutritional counseling
- ☐ Support from a community health worker
- ☐ Support from a social worker and/or nurse case manager
- ☐ Physical therapy
- ☐ Acupuncture
- ☐ Childbirth education
- ☐ Breastfeeding or chestfeeding education
- ☐ Support from a doula
- ☐ Group prenatal care (e.g., CenteringPregnancy)
- ☐ Lactation counseling (e.g., postpartum services provided by a lactation consultant)
- ☐ Parenting education
- ☐ Comprehensive dental care
- ☐ Services through telehealth. Please briefly describe: _____
- ☐ None
- ☐ Other, specify: _____

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.***

- ☐ Health information exchange
- ☐ Members self-identify through case managers or member services
- ☐ Enrollment data received from state
- ☐ Electronic health record, claims data, laboratory results, encounter data, or provider information (e.g., Obstetric Needs Assessment Form)
- ☐ Other, specify: _____

6. In any of your markets, please identify the provider types where increased Medicaid reimbursement rates would further address the maternal and perinatal health needs of members. ***Check all that apply.***

- [ ] Certified professional midwives
- [ ] Certified midwives
- [ ] Licensed midwives
- [ ] Certified nurse midwives
- [ ] Doulas
- [ ] Freestanding birth centers
- [ ] Perinatal community health workers
- [ ] Community health workers
- [ ] Perinatal nutritionist
- [ ] Behavioral health providers
- [ ] None
- [ ] Other, specify:

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

- [ ] Improve data sharing between state and MCOs
- [ ] Improve quality of data sharing between state and MCOs
- [ ] Improve data sharing between government agencies (e.g., child welfare system, justice system) and MCOs
- [ ] Improve data sharing between MCOs and CBOs
- [ ] Improve data sharing between MCOs and provider groups
- [ ] Increase resources to support facilitation of partnerships
- [ ] Facilitate contracting with CBOs
- [ ] Establish equitable and sustainable payment levels for doulas
- [ ] Establish equitable and sustainable payment levels for midwives
- [ ] Establish sustainable payment levels for perinatal physicians
- [ ] Establish sustainable payment levels for behavioral health providers
- [ ] Establish equitable and sustainable payment levels for births in freestanding birth centers
- [ ] Remove regulatory burdens and obstacles for midwives to practice at the top of their license
- [ ] Remove regulatory burdens and obstacles for freestanding birth centers
- [ ] Remove regulatory burdens and obstacles for home births
- [ ] Remove coverage restrictions for reproductive health care
- [ ] States cannot provide further assistance
- [ ] Other, specify:

8. For all of your Medicaid markets, please describe the barriers your health plan experiences specific to providing doulas as a covered benefit for members.

9. For all of your Medicaid markets, please describe the barriers your health plan experiences specific to providing midwives as a covered benefit for members.

10. For all of your Medicaid markets, please describe the barriers your health plan experiences specific to providing freestanding birth centers as a covered benefit for members.

11. For all of your Medicaid markets, please describe the barriers your health plan experiences specific providing maternal/perinatal mental health services as a covered benefit for members.

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

Whom can we contact for more information?

Name: Title:

Email: Phone:

13. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs provide maternal and perinatal health services and any issues that are encountered.

Section H. Sexual and Reproductive Health

The Institute for Medicaid Innovation recognizes that transgender and nonbinary people become pregnant or seek sexual and reproductive health care services. In response, IMI is committed to creating resources that are gender inclusive and affirming, limiting gendered language and only using such terms when specified in Medicaid requirements, statutes, policies, research publications, and database variable names. As such, IMI's resources use both gender inclusive and affirming terms but also gender-specific terms like "women/woman" and "maternal."

Definitions and Acronyms

- **CBO**—Community-based organization.
- **Gender affirming care**—"Health care that is specific to the needs of people who identify as transgender or nonbinary. Trans and nonbinary people have health care needs related to their transition… This can include hormone therapy, gender affirmation surgery, referrals, resources, and support groups. Gender affirming care is sometimes called trans/nonbinary care."
- **Gender identity**—"A person's inner experience of their gender. Some gender identities include genderqueer, man, woman, nonbinary, and many more."
- **LGBTQ+**—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. This common acronym is used to describe people who have non-heterosexual and/or non-cisgender identities.
- **MCO**—Managed care organization.
- **Reproductive justice**—"The human right to maintain personal bodily autonomy, have children, not have children, and parent the children [one has] in safe and sustainable communities."
- **SDOH**—Social determinants of health, also referred to as "social influencers of health." 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 (e.g., 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 recognise 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 realisation of sexual and reproductive rights, which are based on the human rights of all individuals. *To read the full definition please visit the Guttmacher–Lancet Commission report on sexual and reproductive health.*
- **Sexual orientation**—"Identities that describe what gender(s) a person is romantically and/or sexually attracted to. There are many sexual orientations. Some common sexual orientations include gay, lesbian, straight, and bisexual."
- **SOGI**—Sexual orientation and gender identity.

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

1. 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 SOGIs
   - [ ] State-specific confidentiality laws
   - [ ] State-specific restrictions for contraceptive care
   - [ ] State-specific restrictions for family planning services
   - [ ] State-specific restrictions for transgender care
   - [ ] None, we do not experience any barriers
   - [ ] Other, specify: _____

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.
   Check all that apply.

   - [ ] Freestanding family planning providers
   - [ ] Planned Parenthood health centers
   - [ ] Freestanding birth centers
   - [ ] Telehealth platforms
   - [ ] None
   - [ ] Other, specify: _____

3. For all of your Medicaid markets, please identify which of the following data points you are tracking related to sexual and reproductive health care?

   - [ ] Number of providers who provide gender affirming care
   - [ ] Number of providers who have LGBTQ+ competency training
   - [ ] Number of alternative birth centers (e.g., nonhospital)
   - [ ] Grievances from members who indicate not being able to access gender affirming care
   - [ ] Grievances from members who indicate not being able to access LGBTQ+ competent care
   - [ ] Grievances from members who indicate not being able to access an alternative birth center
   - [ ] Grievances related to abortion access
   - [ ] None
   - [ ] Other, specify: _____

4. Please indicate how state Medicaid agencies could further assist health plans in addressing the sexual and reproductive health needs of members. ***Check all that apply.***

- ☐ Improve data sharing between state and health plans
- ☐ Improve quality of data shared between state and health plans
- ☐ Improve data sharing between government agencies (e.g., child welfare system, justice system) and health plans
- ☐ Improve data sharing between health plans and CBOs
- ☐ Improve data sharing between health plans and provider groups
- ☐ Increase technical assistance resources
- ☐ Increase resources to support facilitation of partnerships
- ☐ Facilitate contracting with CBOs
- ☐ Remove coverage restrictions for reproductive health care
- ☐ Advocate against legislation that restricts access to abortion
- ☐ Advocate against legislation that restricts access to gender affirming care
- ☐ Monitor network adequacy specific to related group of services (e.g., measure network adequacy of reproductive health care providers)
- ☐ States cannot provide further assistance
- ☐ Other, specify: _____

5. Across all of your Medicaid markets, what contraceptive quality measures are your health plan monitoring? ***Check all that apply.***

- ☐ Contraceptive care—most and moderately effective methods
- ☐ Contraceptive care—access to long-acting reversible contraception
- ☐ Contraceptive care—postpartum most and moderately effective methods
- ☐ Contraceptive care—postpartum most access to long-acting reversible contraception
- ☐ Person-centered contraceptive counseling measures
- ☐ None
- ☐ Other, specify: _____

6. For all of your Medicaid markets, does your health plan provide coverage for treatment of perimenopause- and menopause-related symptoms?

- ◯ Yes
- ◯ No, but considering
- ◯ No, and not considering
- ◯ No, it is not permitted by state agencies

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

- [ ] Software the health plan uses does not maintain or display SOGI data
- [ ] Response options on forms are not comprehensive or inclusive of all identities
- [ ] Members express concern with sharing SOGI data
- [ ] Health plan receives incomplete SOGI data from state data files
- [ ] Health plan staff express concern with collecting SOGI data
- [ ] Medicaid enrollment forms do not collect SOGI data
- [ ] We do not experience any barriers
- [ ] Other, specify:

8. For all of your Medicaid markets, what are your health plan's data sources for members' gender identity? ***Check all that apply.***

- [ ] State Medicaid enrollment files
- [ ] Inputted from other data sources
- [ ] Members' self-report collected by the health plan
- [ ] Data feed 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 gender identity separate from sex
- [ ] Other, specify:

9. For all of your Medicaid markets, what are your health plan's data sources for members' sexual orientation? ***Check all that apply.***

- [ ] State Medicaid enrollment files
- [ ] Inputted from other data sources
- [ ] Members' self-report collected by the health plan
- [ ] Data feed 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 sexual orientation
- [ ] Other, specify:

10. Across all of your Medicaid markets, what percentage of your member data includes the following SOGI options below?

	0–25%	26%–50%	51%–75%	More than 75%	Unknown or unable to answer	Not Applicable
Gender identity options are only male or female	○	○	○	○	○	○
Gender identity options include nonbinary, male, and female	○	○	○	○	○	○
Gender identity reported separately from sex	○	○	○	○	○	○
Sexual orientation	○	○	○	○	○	○

11. 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
- ☐ Adult behavioral health (e.g., treatment for gender dysphoria or incongruence)
- ☐ Adult mental health assessments needed for access to gender affirming services
- ☐ Youth medical care (e.g., hormone therapy)
- ☐ Youth surgery
- ☐ Youth behavioral health (e.g., treatment for gender dysphoria or incongruence)
- ☐ Youth mental health assessments needed for access to gender affirming services
- ☐ It is not permitted by state agencies
- ☐ None
- ☐ Other, specify: _____

12. Please identify how state Medicaid agencies could further assist health plans in addressing the gender affirming health care needs of members. ***Check all that apply.***

- [ ] Facilitate contracting with nontraditional medical practices (e.g., electrolysis providers, laser therapy) to increase access to services
- [ ] Facilitate SOGI data sharing between health plans and providers
- [ ] Require or allow health plans to cover gender affirming health care
- [ ] Advocate against legislation that restricts access to gender affirming care
- [ ] Develop standards for health plans to collect data on SOGI
- [ ] Monitor network adequacy specific to related group of services (e.g. measure network adequacy of gender affirming health care providers)
- [ ] Establish guidelines and certification process for qualified providers
- [ ] Provide gender affirming care education for health care providers
- [ ] Provide gender affirming care education for health plans
- [ ] Partner with other existing CBOs and governmental entities to develop gender affirming best practices for Medicaid operations
- [ ] States cannot provide assistance
- [ ] Other, specify:

13. Please indicate the barriers that your health plan experiences across any of your Medicaid markets related to abortion health care needs of members. ***Check all that apply.***

- [ ] Not an allowable or covered benefit by state
- [ ] Lack of clarity around state policies
- [ ] Lack of providers in geographic areas
- [ ] Provider confusion around state policies
- [ ] Providers no longer providing care due to fear of losing medical license
- [ ] Long wait time for members
- [ ] Wait time restrictions
- [ ] Age restrictions on consenting for abortion health care services
- [ ] Restrictions on when abortion health care services can be provided
- [ ] None
- [ ] Other, specify:

14. For all of your Medicaid markets, please describe how state abortion policies have impacted your provider networks.

- **Reproductive justice**—"The human right to maintain personal bodily autonomy, have children, not have children, and parent the children [one has] in safe and sustainable communities."

15. Please describe any actions your health plan is taking or is planning to take to advance reproductive justice.

16. Please identify how state Medicaid agencies could assist health plans in advancing reproductive justice.

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

Whom can we contact for more information?

Name:		Title:	
Email:		Phone:	

18. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs provide sexual and reproductive health services and any issues that are encountered.

Section I. Child and Adolescent Health

Definitions and Acronyms

- **CBO**—Community-based organization.
- **MCO**—Managed care organization.
- **SDOH**—Social determinants of health, also referred to as "social influencers of health." 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 (e.g., housing, food, and public safety).

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 yes, proceed to question 2. If no, skip to section J.

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 health plan
- [ ] Engaging family members to address SDOH
- [ ] 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 or departments of juvenile justice for children engaged with child welfare or juvenile justice systems
- [ ] Barriers related to child welfare system
- [ ] Immigration status of parents or caregivers
- [ ] Families express lack of transportation to health care location
- [ ] Families express inability to access telehealth
- [ ] Other unmet social needs expressed by families
- [ ] Carved-out benefits
- [ ] None
- [ ] Other, specify: _____

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, but considering
- ◯ No, and not considering
- ◯ No, it is not permitted by state agency

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 or 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)
- [ ] We do not experience any barriers
- [ ] Other, specify:

5. In any of your markets, please identify how state Medicaid agencies could further assist health plans in addressing child and adolescent health. ***Check all that apply.***

- [ ] Improve data sharing between state and health plans
- [ ] Improve quality of data shared between state and health plans
- [ ] Improve data sharing between government agencies (e.g., child welfare system, criminal justice system) and health plans
- [ ] Improve data sharing between health plans and CBOs
- [ ] Improve data sharing between health plans and provider groups
- [ ] Increase technical assistance resources
- [ ] Increase resources to support facilitation of partnerships
- [ ] Facilitate contracting with CBOs
- [ ] Streamline data sharing between providers and CBOs
- [ ] Champion policies to facilitate data sharing between payers and providers
- [ ] Provide better education for providers on state and health plan expectations for child and adolescent health initiatives
- [ ] Carve in school-based services to managed care
- [ ] States cannot provide further assistance
- [ ] Other, specify:

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

Whom can we contact for more information?

Name: Title:

Email: Phone:

7. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs provide child and adolescent health services and any issues that are encountered.

Section J. Managed Long-Term Services and Supports

Definitions and Acronyms

- **ADL**—Activities of daily living.
- **CBO**—Community-based organization.
- **IADL**—Independent activities of daily living.
- **MCO**—Managed care organization.
- **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 MLTSS?

   ◯ Yes
   ◯ No

If yes, proceed to question 2. If no, skip to section K.

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 or IADL requirements that are too low or too high to support appropriate utilization)
   ☐ Churn (member or eligibility related)
   ☐ Operationalizing electronic visit verification requirements
   ☐ None
   ☐ Other, specify: _____

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.***

	Data exchange	Bed availability	Availability of caregivers	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 to support caregivers
Nursing facility to hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hospital to nursing facility	☐	☐	☐	☐	☐	☐	☐	☐	☐
Home to hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐
Home to nursing facility	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Data exchange	Housing availability	Availability of caregivers	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 to support caregivers
Nursing facility to home	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hospital to home	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. In any of your markets, please identify how state Medicaid agencies could further assist health plans in addressing MLTSS. ***Check all that apply.***

- ☐ Improve data sharing between state and health plans
- ☐ Improve quality of data shared between state and health plans
- ☐ Improve data sharing between government agencies (e.g., office on aging, child welfare system, criminal justice system) and health plans
- ☐ Improve data sharing between health plans and CBOs
- ☐ Improve data sharing between health plans and provider groups
- ☐ Increase technical assistance resources
- ☐ Increase resources to support facilitation of partnerships
- ☐ Facilitate contracting with CBOs
- ☐ Streamline data sharing between providers and CBOs
- ☐ Address backlogged waiver approval processes
- ☐ Implement policies to increase long-term-care and direct-care workforce
- ☐ Facilitate alignment of Medicare and Medicaid requirements
- ☐ States cannot provide further assistance
- ☐ Other, specify: _____

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

_____

Whom can we contact for more information?

Name: _____ Title: _____

Email: _____ Phone: _____

6. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs provide MLTSS services and any issues that are encountered.

Section K. Social Determinants of Health

Definitions and Acronyms

- **CBO**—Community-based organization.
- **MCO**—Managed care organization.
- **SDOH**—Social determinants of health, also referred to as "social influencers of health." 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 (e.g., 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 or youth transitioning to adulthood
- ☐ People experiencing homelessness or housing insecurity
- ☐ Adults with a substance use disorder
- ☐ Adults transitioning from institutions (e.g., nursing homes, assisted living facilities, rehabilitation)
- ☐ Child welfare—or 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 eligible)
- ☐ People with limited English proficiency
- ☐ Children or adolescents with behavioral health diagnoses (mental health or substance use)
- ☐ Children with disabilities
- ☐ Long-term services and supports population
- ☐ Our SDOH programs are open to all members
- ☐ We do not have SDOH programs for specific populations
- ☐ Other, specify: _____

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 Community Toolkit by American Academy of Family Physicians
- [ ] Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE)
- [ ] Social Needs Screening Toolkit, HealthLeads USA
- [ ] Social Determinants Screening Tool, AccessHealth Spartanburg, Center for Health Care Strategies version
- [ ] Self-Sufficiency Outcomes Matrix, OneCare Vermont, Center for Health Care Strategies version
- [ ] Arizona Self-Sufficiency Matrix
- [ ] Vulnerability Index—Service Prioritization Decision Assistance Tool (VISPDAT)
- [ ] Centers for Medicare & Medicaid Services Accountable Health Communities Health-Related Social Needs Screening Tool
- [ ] Tools embedded in provider electronic health record
- [ ] 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:
- [ ] We do not use SDOH screening tools
- [ ] Other, specify:

3. In any of your Medicaid markets, in what ways do states 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 or regulatory changes to support SDOH initiatives
- [ ] Submit and receive approval for a Medicaid waiver that included support of SDOH initiatives
- [ ] Provide support for cultural and linguistic competency
- [ ] States do not support SDOH initiatives
- [ ] Other, specify:

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
- [ ] Percentage of eligible population impacted by services offered
- [ ] No performance metrics are used
- [ ] Other, specify:

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 health plans
- [ ] Improve data sharing between government agencies (e.g., child welfare system, criminal justice system) and health plans
- [ ] Improve data sharing between health plans and CBOs
- [ ] Improve data sharing between health plans and provider groups
- [ ] Increase financial resources from state to health plans
- [ ] 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 CBOs
- [ ] Standardize 834 enrollment file to include social needs information
- [ ] Purchase tools and resources that require a license and provide access to all health plans
- [ ] Apply for and implement Medicaid work requirement waiver
- [ ] States cannot provide any further assistance
- [ ] Other, specify:

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

Whom can we contact for more information?

Name:		Title:	
Email:		Phone:	

7. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs assist in addressing SDOH needs for members and any issues that are encountered.

Section L. Health Equity

The Institute for Medicaid Innovation recognizes and respects 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 American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, white, 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

- **CAHPS**—Consumer Assessment of Healthcare Providers and Systems.
- **CBO**—Community-based organization.
- **CG-CAHPS**—"The CAHPS Clinician & Group Survey … asks patients to report their experiences with providers and staff in primary care and specialty care settings."
- **Discrimination**—"The unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age, or sexual orientation."
- **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 between different 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 or 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+**—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. This common acronym is used to describe people who have non-heterosexual and/or non-cisgender identities.
- **MCO**—Managed care organization.
- **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 identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice." Instead, it 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 or African American individuals
- [ ] Indigenous individuals
- [ ] Hispanic, Latinx, or Latine individuals
- [ ] Asian or Pacific Islander individuals
- [ ] Refugees
- [ ] Individuals without United States citizenship
- [ ] LGBTQ+ individuals
- [ ] Individuals with justice involvement
- [ ] None
- [ ] Other, specify:

Provider groups

- [ ] Reproductive health providers
- [ ] Behavioral health providers
- [ ] Substance use disorder providers
- [ ] Primary care providers
- [ ] Federally qualified health centers
- [ ] Rural health centers
- [ ] School-based clinics
- [ ] None
- [ ] Other, specify:

Other groups

- [ ] Health plan internal staff
- [ ] Community-based partnerships
- [ ] None
- [ ] Other, specify:

2. 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.***

- [ ] Pediatric primary care providers
- [ ] Adult primary care providers
- [ ] Hospitals
- [ ] Specialty care providers
- [ ] Reproductive health providers
- [ ] None
- [ ] Other, specify:

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

- [ ] Formal workgroup or committee that focuses on addressing the impact of structural racism externally (e.g., members)
- [ ] Organization messaging internally acknowledging the impact of structural racism
- [ ] Organization messaging externally acknowledging the impact of structural racism
- [ ] Required trainings for internal staff to identify and address the impact of structural racism
- [ ] Required trainings for providers to identify and address the impact of structural racism
- [ ] Required trainings for external contractors or vendors to identify and address the impact of structural racism
- [ ] Collaboration with CBOs related to social investments or advancing racial equity
- [ ] Review of existing policies and programs to identify if they perpetuate racial inequities
- [ ] Revisions to existing policies and programs to address the impact of structural racism
- [ ] New policies and programs to address the impact of structural racism
- [ ] Nothing at this time
- [ ] Other, specify:

4. Across all of your Medicaid markets, what action is your health plan taking, if anything, to advance health equity? ***Check all that apply.***

Internal

- ☐ Establishing a workgroup or committee focused on health equity and internal business operations (e.g., policies, processes)
- ☐ Hiring staff with dedicated health equity portfolio
- ☐ Setting staff training requirements
- ☐ Assessing and updating data capture and analytical capabilities
- ☐ Creating health equity framework or assessment for business functions to apply to all activities
- ☐ Establishing education and communication platform focused on health equity
- ☐ Monitoring health equity metrics along with other clinical or quality indicators
- ☐ Developing products with a specific focus on advancing health equity
- ☐ Focusing on achieving health equity by addressing social determinants of health
- ☐ None
- ☐ Other, specify: _____

External

- ☐ Establishing a workgroup or committee focused on health equity and external actions (e.g., partnerships, investments)
- ☐ Setting provider expectations (e.g., detect and correct bias, implement culturally and linguistically appropriate services, incentives to implement quality improvement)
- ☐ Implementing performance improvement projects to reduce disparities and with an equity focus
- ☐ Targeting investments in communities to reduce disparities and with an equity focus
- ☐ Prioritizing working with vendors who align with health plan's health equity plan
- ☐ None
- ☐ Other, specify: _____

5. 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) into your operations to address disparities? ***Check all that apply.***

- ☐ Data received were incomplete and/or inconsistent
- ☐ The data available do 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 is not available in public data sources
- ☐ We do not experience any challenges
- ☐ Other, specify: _____

6. 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)?

- ◯ Yes
- ◯ No

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

6a. If yes, for what purposes 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: _____

7. 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 question 7a. If no, skip to question 8.

7a. 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
- ◯ We continue using the same algorithms, policies, or models. Please explain why:

  _____

- ◯ Other, specify: _____

8. Across any of your Medicaid markets, does your health plan have NCQA Health Equity Accreditation status?

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

9. For multistate health plans, what proportion of your individual Medicaid markets have NCQA Health Equity Accreditation status?

- ◯ Less than 50%
- ◯ 50% or more
- ◯ These data are not tracked at the parent organization level
- ◯ Not applicable. We are not a multistate health plan.

10. Across any of your Medicaid markets, does your health plan have NCQA Health Equity Accreditation ***Plus*** status?

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

11. For multistate health plans, what proportion of your local health plans have NCQA Health Equity Accreditation ***Plus*** status?

- ◯ Less than 50%
- ◯ 50% or more
- ◯ These data are not tracked at the parent level
- ◯ Not applicable. We are not a multistate health plan.

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

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

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

- ☐ Cost tracking
- ☐ Quality (e.g., HEDIS)
- ☐ Utilization
- ☐ Members' experience or satisfaction
- ☐ Grievances
- ☐ Members' health outcomes (e.g., functional status)
- ☐ Members of health care team
- ☐ Provider or network characteristics
- ☐ Members' characteristics
- ☐ Members' SDOH needs
- ☐ Health plan staff or leadership
- ☐ None of the above. Please explain why:
- ☐ Other, specify:

14. Across all of your Medicaid markets, what percentage of your member data includes race, ethnicity, and language?

	0–25%	26%–50%	51%–75%	More than 75%	Unknown or unable to answer	Not applicable
Race separate from ethnicity	○	○	○	○	○	○
Ethnicity separate from race	○	○	○	○	○	○
Race and ethnicity, if combined	○	○	○	○	○	○
Language	○	○	○	○	○	○

15. Across all of your Medicaid markets, what are your health plan's data sources for member race and ethnicity data? ***Check all that apply.***

	Race data	Ethnicity data
State Medicaid enrollment files	☐	☐
Inputted from other data sources	☐	☐
Members self-reported as collected by the health plan	☐	☐
Data from provider organizations	☐	☐
Data from 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:	☐	☐

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

	Track	Share with members
Race	☐	☐
Ethnicity	☐	☐
Sex (e.g., male, female)	☐	☐
Gender identity (e.g., man, woman, nonbinary)	☐	☐
Language or languages spoken	☐	☐
Sexual orientation or sexual identity (e.g., LGBTQ+)	☐	☐
None	☐	☐
Other, specify:	☐	☐

17. Across all of your Medicaid markets, please describe barriers your health plan encounters when collecting and sharing provider characteristics with members.

Collecting information

Sharing information

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

Whom can we contact for more information?

Name:		Title:	
Email:		Phone:	

19. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs assist in addressing health equity and any issues that are encountered.

Section M. Telehealth

For this survey, the Institute for Medicaid Innovation will use the definition of "telehealth" provided in the box below. "Telehealth" and "telemedicine" are terms that some states and organizations use interchangeably, but others define them differently. "Telehealth" usually refers to a wider range of services, while "telemedicine" focuses on clinical care. Some states have specific legal and regulatory definitions for both terms. See the Center for Connected Health Policy for a full list of federal and state definitions.

Definitions and Acronyms

- **Broadband**—Internet speeds that meet the Federal Communication Commission's benchmark speeds for advanced telecommunications capability. The current benchmark speed is 25 Mbps download and 3 Mbps upload.
- **CBO**—Community-based organization.
- **eConsult**—Asynchronous, consultative, provider-to-provider communications within a shared electronic health record or web-based platform.
- **MCO**—Managed care organization.
- **Remote care modalities**—The inclusive use of synchronous and asynchronous communication, including eConsult, remote patient monitoring, and telehealth.
- **RPM**—Remote patient monitoring. Uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.
- **Store and forward**—Electronic transmission of medical information to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.
- **Telehealth**—The use of digital information and communication technologies, such as telephone, computers, and mobile devices, to access health care services remotely.

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 or telephone
- ☐ Live text chat
- ☐ Live video visits
- ☐ Provider-to-provider eConsult
- ☐ RPM (e.g., blood pressure monitoring, digital scales, blood glucose monitoring, heart rate, oxygen saturation)
- ☐ Use of a health portal (e.g., for online appointment scheduling, obtaining test results, and secure messaging with one's provider)
- ☐ Store and forward (e.g., receiving digital images of a patient's skin condition)
- ☐ None
- ☐ Other, specify: _____

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
- ☐ Information technology systems
- ☐ Broadband internet access
- ☐ Computer or 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
- ☐ Lack of training on telehealth best practices
- ☐ Insufficient internet speed for telehealth
- ☐ None
- ☐ Other, specify: _____

Member barriers

- ☐ Access to broadband or an internet subscription
- ☐ Insufficient internet speed to allow for live telehealth interaction
- ☐ Limited data plans or insufficient data or minutes covered by smartphone plans
- ☐ Technology or communication devices (i.e., laptop, smartphone)
- ☐ Health literacy
- ☐ Computer or technology literacy
- ☐ Lack of interpreter services
- ☐ Lack of awareness of or interest in telehealth as an option for accessing providers
- ☐ Quality concerns from the members
- ☐ None
- ☐ Other, specify: _____

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 emergency department 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 or abuse
- [ ] Increased duplication of services
- [ ] None
- [ ] Other, specify:

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 or technology literacy education for members
- [ ] Digital literacy or 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
- [ ] Supporting community telehealth access points
- [ ] Leveraging or promoting the Federal Communications Commission's Affordable Connectivity Program
- [ ] Leveraging or promoting the Federal Communications Commission's Lifeline Program
- [ ] Partnering with telecom companies to offer low-cost internet to members
- [ ] Connecting members to CBOs who support access to technology or devices
- [ ] Connecting members to CBOs who support access to internet services
- [ ] Connecting members to CBOs who support interpretation for needed languages
- [ ] None
- [ ] Other, specify:

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 RPM
- [ ] Incentivize for evidence-based RPM
- [ ] Remove restrictions on the type of entity that can be reimbursed for RPM (e.g., limiting reimbursement to home health agencies)
- [ ] Reimburse for provider-to-provider consultations, including eConsults that leverage asynchronous 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, rural health clinics, Indian Health Service clinics, and community mental health centers to serve as both origination and distant site providers
- [ ] Reimburse nontraditional providers for facilitating telehealth appointments (e.g., Emergency medical service providers facilitating a telehealth visit versus transporting a low-acuity patient to the ED)
- [ ] Remove site restrictions that limit where members can be located during a telehealth visit
- [ ] Enable health plans to support CBOs with telehealth technology to support members' telehealth appointments
- [ ] Support school-based health services delivered via telehealth, including behavioral health services
- [ ] Enable health plans to create innovative reimbursement models
- [ ] None
- [ ] Other, specify: _____

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

Whom can we contact for more information?

Name: Title:

Email: Phone:

7. OPTIONAL: Did we miss anything? Please share any information that might be helpful in understanding how Medicaid MCOs use telehealth and any issues that are encountered.

Thank you for completing the survey.

Please submit your response via our online platform by March 15, 2024.

You may also return your completed survey as a pdf document to the Survey Project Team at MCOSurvey@MedicaidInnovation.org.

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