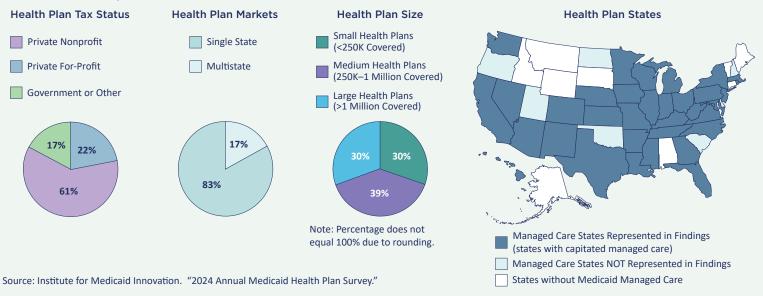


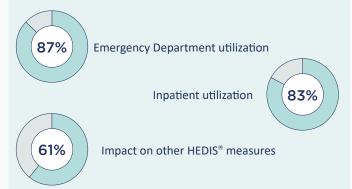
# Annual Medicaid Managed Care Organization Survey **High Risk Care Coordination**

#### **Demographics**

In its seventh year, the 2024 survey findings represent health plan data from almost every state with Medicaid managed care. The annual survey collected information at the parent company/corporate levels and is intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. The survey respondents are representative of the national demographics of all Medicaid health plans.



#### HEDIS® Measures Health Plans Currently Use to Track Effectiveness of High-Risk Care Coordination



Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey."

Notes: HEDIS®—Healthcare Effectiveness Data and Information Set. Other HEDIS Measures responses included: Follow-up after Hospitalization for Mental Illness (FUH); Hemoglobin A1c Control for patients with diabetes (HBD), Glycemic Status Assessment for Patients with Diabetes (GSD); Controlling High Blood Pressure (CBP); Blood Pressure Control for Patients with Diabetes (BPD) and Transitions of Care (TRC), Prenatal and Postpartum Care (PPC), Breast Cancer Screening (BCS), and Colo-rectal Cancer Screening (COL).

Non-HEDIS® Measures Health Plans Currently Use to Track Effectiveness in High-Risk Care Coordination	All Health Plans
Total spending	100%
Members' experience survey results (e.g., Consumer Assessment of Healthcare Providers and Systems® survey)	91%
Emergency Department utilization (unrelated to HEDIS® measure)	87%
Inpatient utilization (unrelated to HEDIS® measure)	87%
Outpatient primary care utilization	87%
Complaints and grievances	83%
Preventive care utilization	78%
Provider experience survey results	70%
Other*	9%

Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey." Notes: \*Other includes health risk assessments, follow-up post d/c from ED. HEDIS®—Healthcare Effectiveness Data and Information Set.



Barriers Medicaid Health Plans Experience When Providing Effective High-Risk Care Coordination		
Ability to contact member	100%	
Members' access to behavioral and mental health care	96%	
Members' willingness to engage with high-risk care coordination	91%	
Members' access to primary care	65%	
Members' access to specialty care	83%	
Access to information from previous providers (e.g., mental health)	65%	
Provider willingness to engage with high-risk care coordination	74%	
Members' ability to navigate multiple care coordinators from health systems, provider practices, clinics, etc.	83%	
Members' unmet social determinants of health	91%	
Churn (member- or eligibility-related)	74%	
Members' knowledge of managed care	57%	
Ability to share information with service providers	39%	
Availability of social supports	78%	
Ability to connect individuals to necessary nonclinical social supports	57%	
Language barriers	39%	
Other*	13%	

Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey."

Note: \*Other includes immigration status-based fears, ability to share data between state and MCOs, and member compliance with treatment plan.

## Additional Information or Categories of Data That State Medicaid Agencies Could Provide to Help Health Plans Better Administer High-Risk Care Coordination

	General Background Data	
100%	Contact data (e.g., phone numbers, email addresses)	C
87%	Demographic data (e.g., age, sex, education level)	<b>B</b>
87%	Household data (e.g., power of attorney, guardian, head of household information, or household composition)	
78%	Language	(A)
74%	Gender identity	<b>*</b>
<b>74</b> %	Race	
74%	Ethnicity	
70%	Sexual orientation	
57%	Pronouns	<b>(A)</b>
22%	Other*	•••

Notes: \*Other includes veteran status, contact preference, and physical address. No health plan

selected "none."

High-Risk Care Coordination		
	Medical Systems Data	
96%	Behavioral health diagnoses, treatment, or providers (including mental health and substance use disorder)	₩
91%	Historical claims data and clinical encounters	<u>e</u>
91%	Special health care needs indicators	÷
91%	Chronic medical conditions or diagnoses (e.g., sickle cell disease, HIV/AIDS)	
87%	Case management or social work encounters	
83%	Health status indicators	00E= 00E=
83%	Smoking, vaping, or nicotine or tobacco use	
4%	Other*	•••
Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey."		

Social Determinants of Health Data		
91%	Participation in other state programs (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children – WIC)	Ğ
91%	Housing situation or stability (e.g., unhoused)	
83%	Child welfare involvement	5-4
74%	School enrollment	
74%	Criminal justice system involvement	र्बी
65%	Juvenile justice system involvement	बी
17%	Other*	•••
Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey."		
Notes: *Other includes community-based organization involvement, and housing, food, and		

employment issues. Four percent (4%) of health

plans selected "none."

Notes: \*Other includes food insecurity and dental

data. No health plan selected "none."

### Medicaid Health Plan Staff Titles for Nonclinical High-Risk Care Coordination Team Members

87%	Community health worker
74%	Care coordinators
52%	Health educator
44%	Case management assistant
39%	Peer support worker
35%	Community health navigator
30%	Perinatal community health worker
30%	Doula
26%	Other*

Source: Institute for Medicaid Innovation. "2024 Annual Medicaid Health Plan Survey."

Note: \*Other includes connector, care systems manager, resource coordinators, maternal health navigator, wellness coaches, outreach navigators, RN Care team manager, enhanced care management RN, care manager, and housing navigator.