



Understanding Medicaid Managed Care Procurement Practices Across States

Medicaid and CHIP Payment and Access Commission

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Agenda

- Context
- Findings from MACPAC study
- Opportunities to improve managed care procurement
- Next steps

Focus of Work

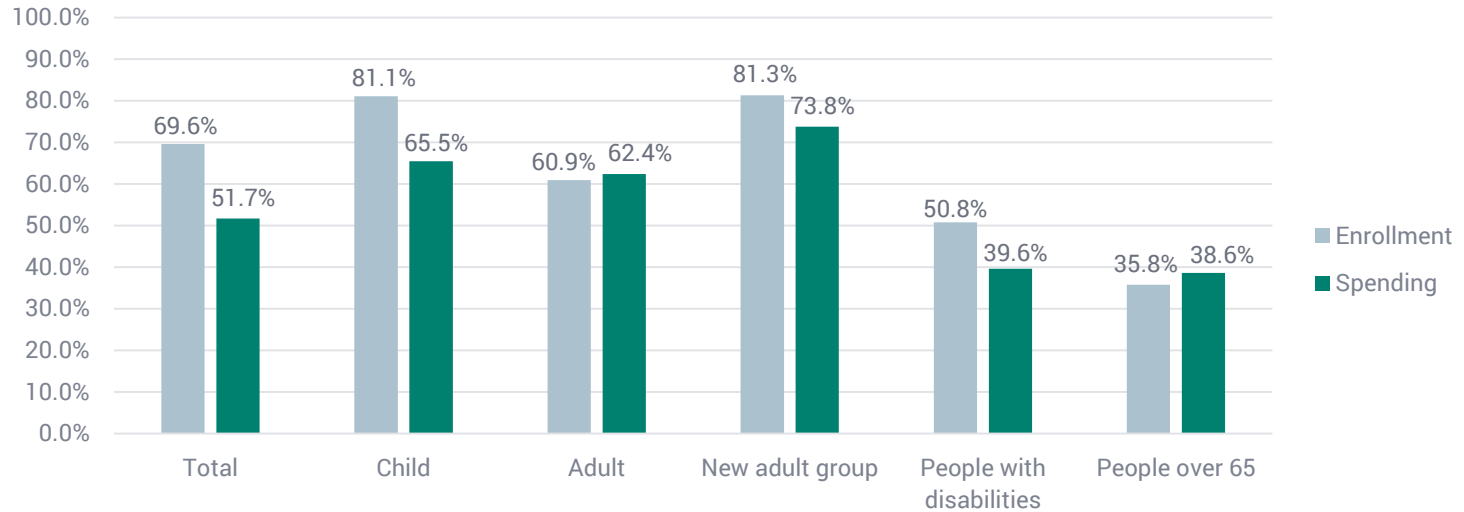
- MACPAC conducted an analysis of the Medicaid procurement process to better understand how the managed care contracting process affects service delivery and achievement of policy goals
 - review of federal statutes, rules, and guidance
 - environmental scan of Medicaid managed care procurements over 5-year period
 - interviews with CMS, state Medicaid officials, managed care organizations (MCOs), policy experts, consumer advocates
- Examined managed care procurement processes to identify gaps and opportunities in current CMS oversight
- Study supports the Commission's ongoing analysis of value in Medicaid managed care

Context

April 8, 2022

Managed Care is the Primary Payment and Delivery System in Medicaid

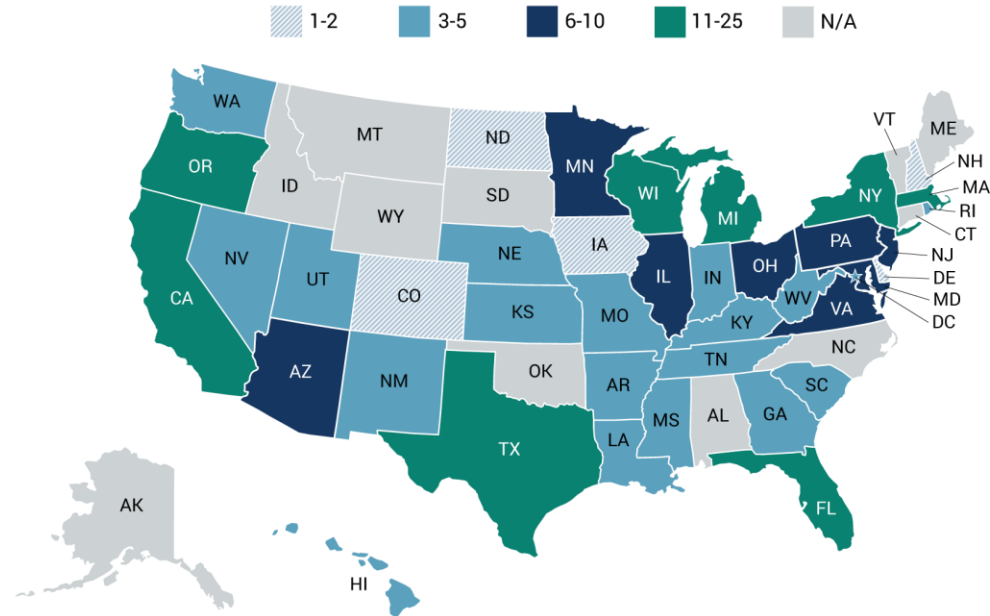
Proportion of Medicaid Spending on and Percentage of Enrollees in Managed Care by Eligibility Group, FY 2019



Notes and sources: see slide 22.

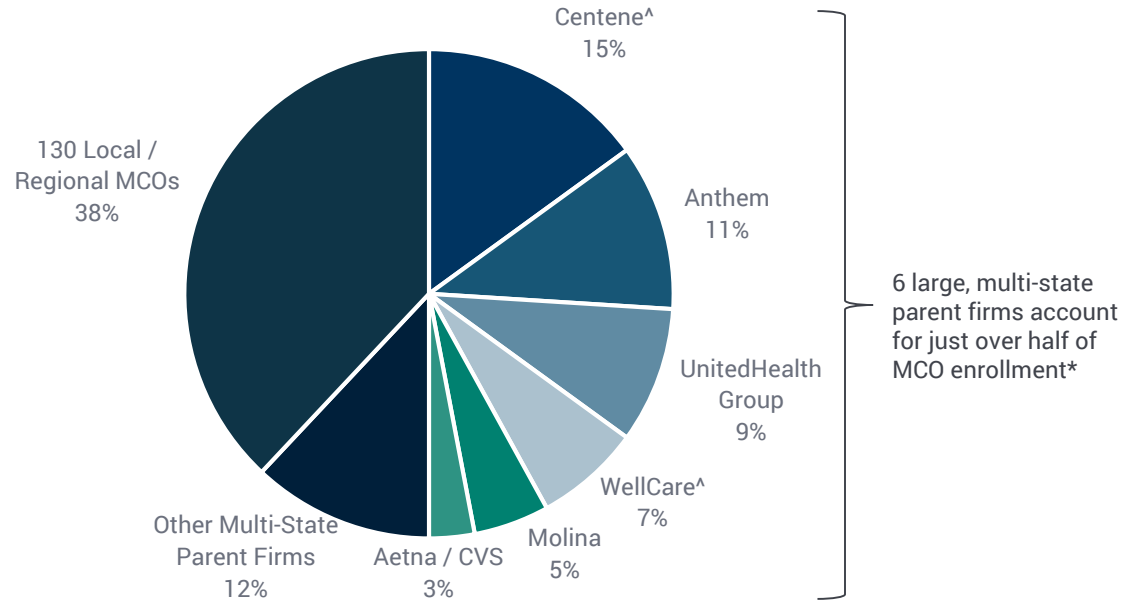
Number of Contracted MCOs Varies Across States

Total Medicaid MCOs by State, as of July 2019



Notes and sources: see slide 23.

Managed Care Enrollment is Concentrated in a Small Number of National Firms



Notes: Data as of July 1, 2019.

^ WellCare was acquired by Centene in January 2020. * Totals do not sum due to rounding.

Source: Hinton, E., Stolyar, L. 2022. 10 things to know about managed care. Washington, DC: Kaiser Family Foundation. February 23, 2022.

<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicare-managed-care/>.

States Use Medicaid Managed Care to Advance Program Goals

- States use comprehensive managed care to achieve a variety of objectives
 - e.g., delivery system flexibility, stronger accountability, budget predictability
- States have extensive flexibility and independence in administering their managed care procurements
 - almost all states use competitive procurements to select MCOs
 - look for MCOs to compete on innovations and program delivery (e.g., integrated care, value-based payment, population health efforts)

Managed Care Procurements are Highly Competitive

- Significant growth in Medicaid beneficiaries served in managed care has occurred since 1997
 - managed care permissible without a waiver
 - elimination of 75/25 rule opened up plan participation
- Managed care procurements are now among the largest state contracts, often exceeding billions of dollars a year
- Size and infrequency of Medicaid contracts makes them an attractive and lucrative business for plans

Key Findings

Federal Role Focuses on Ensuring Compliance with Federal Rules

- CMS has a limited role in state managed care procurements
 - verifies that selected contractors meet federal statutory requirements
 - reviews and approves state contracts with MCOs (no direct relationship)
 - has discretion to exercise more oversight but no processes or rules
- Readiness reviews are required by federal rule, conducted by states
 - states must review MCO readiness when introducing new managed care programs, new MCOs, and new covered populations
 - CMS has developed unofficial guidance for states outlining specific operational areas to evaluate but does not have formal requirements
 - states submit readiness findings to CMS as part of contract review

CMS Plays a Role in Some Procurements, but Not Medicaid Managed Care

- Federal procurement rules do not apply to Medicaid managed care
 - only applicable guidance is conflict of interest policies (42 CFR 438.58)
 - state variations in procurement practices and program maturity makes it difficult to apply uniform federal Medicaid procurement requirements
- CMS is involved in other types of procurements
 - EQRO: requires states to use an open, competitive procurement process to get enhanced federal match
 - MMIS: reviews and approves advanced planning documents for states to get enhanced federal match, including procurement activities
 - Medicare Advantage (MA) and Qualified Health Plans (QHPs): CMS administers annual application/certification process, develops policies and guidance
 - MA: negotiates with prospective plans, has sole authority to approve or deny applications

States Use Procurement as an Opportunity to Advance Programs and Innovations

- Significant changes in policy are hard to implement through contract amendments
- Vision for the program must be translatable into purchasing requirements
- Must be strategic
 - locked into design decisions for several years
 - proposal requirements may affect who responds to the RFP

Managed Care Procurement Is a Resource Intensive Process with Long Timelines

- Entire process usually takes 18 to 24 months
 - 6 to 12 months for planning prior to the RFP release
 - 3 to 6 months for bid submission, review, and award
 - 6 to 12 months for readiness review and implementation
- State staff must be highly involved to ensure that purchasing specifications reflect program goals
 - to support procurement states may add staff, partner with state purchasing agency, hire external contractors
 - states cannot always obtain funding to support or backfill agency staff
- Pressure on timeline can limit public input, response quality, and time for implementation; protests can extend demands on staff

States Connect Program Goals to Purchasing Specifications and Selection Criteria

- Most states have MCOs compete on program elements, not price
 - price competition has potential to lower state costs but comes with risks
 - states are more focused on cost predictability than cost savings
- Increasingly asking bidders to demonstrate results
 - respond to case scenarios to evaluate health plans' approaches to addressing member needs that may be unique to the Medicaid population
 - provide evidence of health plan performance and results
- Also using more rigorous evaluation approaches
 - standard scoring tools, trained evaluators
 - data-driven evaluation questions that can be objectively scored

Practices that Support Effective Procurement

- Longer contracting cycles
 - states have time to plan program changes, plan and execute procurement activities
 - successful bidders have time to test innovations, implement changes, and demonstrate results
 - timing is not always predictable; legislature or governor can direct agency to re-bid sooner than expected; protests or rebid can extend contracts
- Public engagement and transparency
 - success of procurement relies in part on extent to which purchasing approach (requirements, timing) is attractive and reasonable
 - public input and buy-in to state approach/goals is important given long-term nature of MCO contracts, effects on providers and beneficiaries

Market Trends Have a Large Effect on State Procurements and Resulting Program Outcomes

- As states gain experience, they are more likely to leverage their purchasing power
- States take different approaches to how they conduct procurements, but there is no evidence on which approaches are most effective
- Size and infrequency of Medicaid procurements make them attractive opportunities for plans, but also require significant investment
- States are increasingly mindful of the risk of award protests, which disrupt program operations and increase costs, delay the implementation of program innovations, and cause confusion for stakeholders

Opportunities to Improve Managed Care Procurement

April 8, 2022

Potential Policy Options

- Provide states with technical assistance or additional resources to support procurement
 - best practices and other tools to supplement state activities
 - enhanced federal match for procurement activities
- Develop additional federal procurement process requirements
 - minimum public engagement requirements
 - state readiness review prior to procurement
 - additional contract review standards to ensure MCO commitments are incorporated into contracts

Next Steps

- Commissioner feedback on opportunities for potential recommendations on this topic
- Staff will combine with feedback from prior discussions on managed care and present options at a future meeting



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Data Notes and Sources

- Proportion of Medicaid Spending on and Percentage of Enrollees in Managed Care by Eligibility Group, FY 2019
 - **Notes:** Includes federal and state spending. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Managed care includes comprehensive managed care, health insuring organizations, and Programs of All-Inclusive Care for the Elderly (PACE).
 - **Sources:** For spending: Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. Exhibit 18 in *MACStats: Medicaid and CHIP databook*. Washington, DC: MACPAC. December 2021. <https://www.macpac.gov/publication/distribution-of-medicaid-benefit-spending-by-eligibility-group-and-service-category/>. For enrollment: MACPAC. 2021. Exhibit 30 in *MACStats: Medicaid and CHIP databook*. Washington, DC: MACPAC. December 2021. <https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/>.

Data Notes and Sources

- Total Medicaid MCOs by State, as of July 2019
 - **Notes:** Data reflects the MCOs that had contracts with states as of July 1, 2019. North Carolina launched its Medicaid managed care program in July 2021. Data reflects only capitated MCOs providing comprehensive services to Medicaid beneficiaries. Comprehensive services means comprehensive Medicaid acute care services and, in some cases, long-term services and supports as well. Prepaid ambulatory health plans (PAHPs), prepaid inpatient health plans (PIHPs), and Programs of All-Inclusive Care for the Elderly (PACE) are not included. The MCOs counted for Oregon are Coordinated Care Organizations (CCOs), which receive state premium payments on behalf of enrolled Medicaid beneficiaries.
 - **Source:** Kaiser Family Foundation (KFF). 2022. Total Medicaid MCOs, 2019. Washington, DC: KFF. <https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/>.