Managing Medicaid Managed Care: New State Strategies to Promote Accountability and Performance

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As the scope of State Medicaid agencies becomes wider and more complex, states are increasingly turning to managed care organizations (MCOs) to cover Medicaid enrollees, including those with complex needs. This shift from a fee-for-service, volume-based payment model requires states to effectively manage MCOs and other vendors. With states facing tight budgets, limited staff, and limited resources to manage these changes, many are seeking new information and resources to help them transition to more effective oversight. The steady geographic growth of MCOs and Medicaid expansion under the ACA brings a new urgency to many states as they search for new and better strategies to maximize their MCOs.

Managing Medicaid managed care programs requires continued state agency focus and vendor management. Even states that have successfully implemented managed care evolve to increase program effectiveness over time and improve the state’s partnership with their plans. To assure these programs achieve effective and efficient care, states are moving to value-based purchasing (VBP). Under VBP the purchasing agent (i.e., Medicaid agency) seeks to manage vendors (i.e. MCOs) to produce maximum value for Medicaid. A VBP approach holds vendors accountable for outcomes. It is not a single strategy but rather an approach that requires complex new financial arrangements, different oversight and engagement, and new procurement and contracting strategies.

This new purchasing arrangement requires Medicaid agencies to establish clear goals, create new procurement and contracting strategies as well as oversight procedures to hold vendors accountable for outcomes. This brief reports on a discussion of strategies that states use to successfully implement VBP among ten state Medicaid agencies and Bailet Health Purchasing, LLC.

In October of 2015, the National Academy for State Health Policy (NASHP) and State Health and Value Strategies (SHVS) with support from the Robert Wood Johnson Foundation convened a meeting of state officials to discuss their experiences with transitioning to value-based purchasing strategies. Twenty-six state officials representing 10 states with experience in operating Medicaid managed care programs convened to share challenges and lessons learned.
Introduction to Vendor Management under Value-Based Purchasing

Under VBP, vendors (i.e., MCOs) are managed in a way that will ultimately result in maximized value for the purchasing agent. VBP focuses on achieving objective, measurable improvements in performance—understanding that performance is a continuum and seeking to move vendors along that continuum. It requires coordinated activity across agency functions (contracting, clinical, quality, finance, analysis) and active collaboration to motivate high performance by MCOs.

Goals that are clear to both Medicaid agency staff and the MCOs are critical to VBP. If MCOs do not correctly understand what the Medicaid agency wishes to achieve, they will not be able to focus on achieving it. Similarly clarity of goals within the agency will support coordinated activity across agency functions. State Medicaid agencies pursuing VBP should begin by identifying a senior agency official who will lead the MCO contracting process. These leaders can then create a vision that can be shared across the Medicaid agency and with stakeholders, as well as woven into the MCO selection process, contract, and contract administration. Also, MCOs will read intent into action, or inaction, so state Medicaid agencies need to make sure that the actions they take to manage MCOs do not signal conflicting priorities.

MCO performance under VBP also relies on a set of incentives and disincentives that reinforce the state’s goals and focus on outcomes. Clearly this set includes any financial penalties or incentive payments specified in the contract. But, as meeting participants discussed, the incentives and disincentives at states’ disposal go beyond standard pay for performance incentives. For example, some states use...
increased enrollment to reward Medicaid MCO performance. These states assign a greater percentage of beneficiaries who do not choose a plan to MCOs with better performance. Recognition of good performance is another type of reward—and some will respond more strongly to praise than to money. Tips for success that arose during the discussion, include: clearly linking financial incentives to broader goals; ensuring that all contractors understand the specifications and data sources that will be used to produce performance measures used to award incentives; using standardized, validated measures when possible; and tying incentives and disincentives to performance which is in the control of the MCO.2

Trust between the state staff and contracted MCOs also is critical to VBP success. A collaborative and active relationship between the Medicaid agency and the MCOs is key to developing a successful partnership wherein each side is working towards shared goals. Meeting participants identified ways to foster collaboration and help improvement. Some ideas included:

- Sponsor plan and provider meetings or work groups, and provide expert resources and support to providers.
- Encourage MCOs to collaborate with each other and share plans and models with each other.

States seeking to shift to VBP need to be able to collect and analyze data to identify areas for improvement and track progress. Each year the Medicaid agency will want to evaluate MCO performance relative to the agency’s priorities to determine areas on which the state and MCOs will seek improved performance over the coming year. States will want to consider their priorities for the program, which will stem from the goals they set for the program, where MCO performance falls short of expectations or best practice, the extent to which MCOs can foster improvement, and the support that the state can provide to MCOs. Medicaid agencies will also want to consider whether the opportunities for improvement are statewide or differ by geographic region or contracted MCO.

Meeting participants also discussed limiting the number of measures used to assess MCO performance to reinforce the importance of the improvement area. This approach enables both the Medicaid agency and MCOs to focus their administrative resources, including data collection and analytic capacity on identified priorities. Participants observed that even though the program might limit the number of areas on which it focused in any one year, that an annual process would enable Medicaid and MCOs to improve performance in different areas over the course of the contract.
Tennessee: Implementing Payment and Delivery System Reforms Strategically

Following an abrupt transition from fee-for-service to MCOs in 1994, Tennessee faced many challenges with Medicaid managed care. Of the 12 MCOs that began, many were unprepared for the financial requirements and within 10 years a number of them became insolvent due to a lack of experience and capital. The state faced challenges in requiring MCOs to meet quality standards because the plans were unprepared to monitor and report utilization.

By 2015, the state transitioned to three statewide MCOs. The state also refined quality monitoring and moved to integrate behavioral health and later long-term care services and supports for elderly and physically disabled populations. It has also made substantial improvements in customer satisfaction, from 61 percent in 1994 to 95 percent in 2015.

Over the years, Tennessee has learned several lessons in managing its vendors and MCOs:

- Gradual implementation to prepare for system wide transformation may be better.
- Build robust data infrastructure that allows data-driven decision making and data sharing with plans and providers.
- Allow your experienced MCOs to contribute when appropriate. With their expertise, they can develop creative solutions to complex problems.
- Fewer MCOs enabled the state to build stronger relationships and provide appropriate oversight to all.
- Don’t stop innovating and looking for best practices.
- Effective contracting is important. MCO procurement process and implementation must be well thought out, and contracts must be detailed sufficiently to properly convey expectations, with each requirement carefully defined and appropriate reporting/monitoring to ensure compliance.
- Contracting staff should have a “regulator” skill set – they need to review/amend contracts and have access to a variety of incentive and disincentive mechanisms to motivate behavior.

Staffing and Operations

As previously mentioned, moving to VBP will almost certainly require the Medicaid agency staff to take on new roles and to work more collaboratively across all agency functions. Administering VBP contract management may require a different type of staff engagement and skill set to support operations. Partnering with MCOs to jointly seek to improve performance is more demanding for state health purchasers than traditional contractor oversight. MCOs may benefit from, or even require, technical assistance to succeed in achieving the state’s goals. For example, to enable MCOs and the state to be successful in meeting certain VBP priorities, state staff may convene collaborative workgroups for MCOs and providers.

Medicaid MCO oversight in VBP requires involvement of the Medicaid agency’s senior levels and the support of a diverse staff with the skills to engage MCOs and hold them accountable. Managed care contract managers need to be able to deal with their MCO counterparts as equals. Their knowledge of what they are managing should be on par with the knowledge of the MCO staff. A diverse staff drawn from a variety of departments within the agency will enable contract managers to draw on each other’s knowledge as they interact with the MCOs on a variety of topics. Some agencies have benefited from a matrix management approach or moving away from separate managed care and fee-for-service departments to functional departments (e.g., contracting, data and analytics, clinical, finance) that oversee both the managed care and fee-for-service delivery system. Some Medicaid agencies appoint a contract...
Nearly all Medicaid services in Ohio are delivered to the more than 2.5 million recipients through MCOs. Those enrolled with MCO’s include all Modified Adjusted Gross Income (MAGI) eligible individuals, non-institutionalized aged, blind, and disabled populations, not enrolled in 1915(c) waivers, and dual eligibles-in the duals demonstration MyCare Ohio. (MyCare Ohio also includes dual eligibles residing in institutions and enrolled in a 1915 C Waiver).

In 2011, the state realized that it was not structured to support effective oversight of the MCO’s. At the time, nearly 75 percent of its Medicaid enrollees were in MCOs, but the Bureau of Managed Care (BMC) had limited authority and resources to provide effective oversight of the MCO’s.

BMC was with a staff of approximately 10 people who all reported to the Director of Policy. Unfortunately there was a division between the BMC and the Policy Bureau. The BMC operated in a silo, and the Policy Bureau traditionally thought of themselves as developing and implementing only fee-for-service policy. However, MCO’s are required by contract to follow fee-for-service policy. This often led to problems as the MCO’s had too little time to implement major changes.

To improve oversight of the MCO’s and leverage internal resources, the state made the following changes:

- Moved the Medicaid office out of the Department of Job and Family Services to become the Ohio Department of Medicaid (ODM), its own cabinet-level agency.
- Moved the BMC from the policy office to the office of operations and hired new bureau leadership. Managed care information technology was also consolidated under BMC.
- BMC resources were enhanced by repurposing some existing staff, but the most effective tool was establishing an agency-wide matrixed management approach allowing the BMC to draw on Medicaid employees across all offices as needed.
- ODM modified its structure to ensure there was no division between fee-for-service and MCO oversight staff.
- Reinforced the concept that managed care is everyone’s responsibility by inviting and sometimes requiring staff across all offices of the agency to participate in monthly Managed Care Plan CEO meetings.
- Finally, Ohio analyzed other state managed care models, which helped staff learn different ways of managing and providing oversight.

Ohio: Adjusting Oversight Structures and Skill-Building

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VBP Procurement

According to Beth Waldman and Mary Beth Dyer, of Bailet Health Purchasing, LLC, the managed care contracting process is divided into four phases:  

1. strategic procurement planning,  
2. development of solicitation materials,  
3. bidder selection and  
4. contract administration.

As previously discussed, VBP is woven into all phases of contracting and a VBP contracting process does not end with contractor selection. This discussion focused on strategic procurement planning and the development of solicitation materials.

Strategic Procurement Planning

During strategic procurement planning the Medicaid agency should establish its goals and identify its priorities for the program. It chooses a team to conduct the procurement and creates broad program parameters. For example, the agency determines the beneficiaries to be served by the program, the regions of the state in which the program will operate and the services that will be covered. The agency also decides whether it will accept all qualified bidders or limit the number of contractors, as well as the time period for the contract. Meeting participants observed that limiting the number of MCOs can decrease administrative burden and noted longer contract periods could incent MCOs to devote more resources to achieving the agency’s objectives.

At the start of the process the procurement team will want to think critically about what is needed. Questions to consider include:

- What does the Medicaid agency hope to achieve by contracting with MCOs?
- What is the role in the contracting process of Medicaid and the various departments within Medicaid, especially the managed care department?
- What are the other agencies that will need to be involved throughout the process, including legal counsel?

The team needs to engage with a variety of staff in different departments and at different levels early on in the process. This early planning is critical to creating the framework that underlies VBP. At the end of this phase the entire team should have a clear understanding of criteria for success of the contracting process. Agency leadership will also want to work with the team to ensure they have the resources needed, including sufficient staff with the right skills, for procurement, vendor selection and protests related to bid awards. They will need to track that the timing of the process takes into account the procurement and Medicaid agency staff workloads.

In this phase state leadership will need to identify the priority performance objectives of the agency and its customers. They will return to these decisions at multiple points in the contracting process to ensure that performance expectations as expressed through requests for proposals (RFPs), contracts, and oversight are aligned with these objectives. These priorities need to be clearly communicated to the procurement team so that they can incorporate them into the bid review and contracting process.

Although it is important to adhere to a consistent message it is also important to explicitly recognize that contracting objectives may change over time, and should be periodically updated. With each shift or update in priorities leaders will need to make a concerted effort to communicate those shifts to the team,
and, once selected, the contracted MCOs.

**Development of Solicitation Materials**

An RFP is best thought of as a problem statement, for which the state is seeking the best solution for the best value. MCOs will gain their first understanding of the Medicaid agency’s expectations through the RFP. It needs to include comprehensive purchasing requirements that are as specific and measurable as possible in addition to detailing the selection process and parameters. An RFP will include a vision statement, the statement of work, a model contract, and any needed exhibits. The RFP will detail the scope of covered services and provide a list of prioritized items to be included in an MCO’s submission.

The RFP should also include a set of performance measures that aligns with the state definition of value for Medicaid. The specifications should be initially set at best-practice level, and then adjusted during each contract year and new procurement. These measures have multiple purposes and can be used over time to support performance improvements.

**Challenges and Strategies in the Procurement Process**

Conducting the procurement and contracting process can be difficult from a logistical standpoint. Meeting participants reported that lack of institutional memory can make each new Medicaid MCO procurement a challenge. In addition, staffing for a large procurement is often not adequate, both in terms of amount and training. Medicaid managed care program staff can find it difficult to “clear the decks” when they have multiple ongoing responsibilities, in order to focus on a time-limited task like procurement. State procurement staff may not be sufficiently familiar with Medicaid or managed care to anticipate and plan for modifications to standard state procurement approaches.

Some participants observed that complex decision-making processes within busy state agencies could pose a challenge to making strategic MCO procurement decisions in a short timeframe. They identified several strategies that state Medicaid staff could employ to help ease the process. For example, starting to plan early for upcoming procurements will minimize the effect of slow decision-making processes. In addition, involving the agency’s legal team and state procurement staff early in the contracting process will enable a RFP with minimal revisions due to legal or procurement staff concerns. The evaluation and selection process requires that the procurement team be organized from the first steps of writing the RFP and may require knowledge and skills that are not often used in the day-to-day work of assigned staff. Identifying subject matter experts with detailed knowledge on critical topics (e.g., financing, data analysis, or behavioral health) that the procurement team may call on as they move through contractor selection will effectively augment staff expertise. Many states try to obtain information during contract selection from MCO references. While references are often willing to provide information, it can be challenging to obtain useful information from MCO references. Some participants had found that the reference process benefitted from preparation such as developing a list of specific questions on capacity prior to speaking to references and informality, including gathering information via phone call instead of in writing encouraged candor.

**Summary**

In many states, Medicaid MCO procurements are now among the largest, and MCO contracts account for growing portions of the state Medicaid budget. During the course of the day, participants discussed ways that agencies seek to continually improve their VBP approaches and leverage their purchasing power to achieve better results for Medicaid MCO members and state taxpayers. This meeting gave
participating state leaders the opportunity to discuss best practices in VBP and to examine different strategies for tackling MCO oversight and VBP management.

VBP begins with a set of clear, incentivized goals. Priorities should be clearly communicated through the contracting process from the Medicaid agency to vendors and regularly assessed to ensure that contracts are being utilized to their fullest. Partnering with MCOs, while rewarding, can be demanding on state Medicaid agencies and require staff to take on new roles and responsibilities. States may find that they need to modify the structure of their offices to enable greater collaboration across agency functions. Successful implementation of VBP is made easier by a strong contracting and procurement process. A comprehensive RFP that details specific contracting priorities and expectations for MCO performance sets a tone for the contracting period.

The expanding scope of MCOs and complex needs of many beneficiaries means that states need to implement new or enhanced approaches to oversight to ensure that they are maximizing value. The experiences of Ohio and Tennessee demonstrate how effective these strategies can be in improving the ability of state MCOs to deliver high-quality care. Opportunities such as this meeting give states the ability to explore how to leverage the experiences of other states to determine how to improve their own MCO oversight and contracting processes.

End Notes

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