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Value-based Purchasing for Managed Care Procurements:
A Toolkit for State Medicaid Agencies

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This Toolkit is designed to assist states interested in implementing value-based purchasing (VBP) approaches with their Medicaid managed care organizations (MCOs). Using a VBP approach can mean significant and ongoing changes for a state Medicaid agency and its MCOs. State agencies need to create and utilize detailed purchasing specifications, working collaboratively with MCOs, providers and other stakeholders to achieve objective, measurable improvements in performance.

Tip: *Do not confuse value-based payment with value-based purchasing! Value-based payment is one component of value-based purchasing, albeit an essential one.*

This Toolkit guides Medicaid agencies through key action steps and considerations in four phases of the procurement cycle – 1) strategic procurement planning, 2) solicitation development, 3) bidder selection, and 4) contract management. Throughout the Toolkit, clicking on will bring you back to the proposed timeframe below.

Proprosed Procurement Timeframe

	MCO Request for Proposals (RFP) Task	Timing
Phase 1 (pgs 4-7)	Strategic planning	6-12 months in advance of procurement release.
	Develop model contract and procurement documents, including procurement library	Begin as soon as strategic planning is underway; continue through procurement release.
	Release procurement	Ideally, at least 15 weeks prior to contract award dates and at least 6 months prior to contract effective date.
Phase 2 (pgs 8-13)	Optional step: Receive non-binding intents to bid	1-2 weeks after RFP release.
	Optional step: Hold bidders conference	7- 10 days after RFP release.
	Receive questions from potential bidders on RFP documents	Within 2 weeks of RFP release.
Phase 3 (pgs 14-18)	Respond to questions from potential bidders and make any modifications to procurement documents or timeframe	As soon as possible or 1-2 weeks following receipt of the questions.
	Bid responses due	6-8 weeks after RFP release; may need to be extended if material changes are made to the procurement following bidder questions.
Phase 4 (pgs 19-21)	Selected bidders recommended	4-5 weeks after bid submission, depending on number of bids, complexity of scoring, and length of submissions.
	Award recommendations announced	2 weeks after bidder selection completed.
	Contract management	Execute contracts at least 90 days prior to the operational start date, preferably longer.

Value-based purchasing is a business strategy to maximize benefit received when buying goods or services to improve performance in specific areas valued by the state, starting with the MCO procurement process. A VBP approach involves identifying priority needs of the state agency and its customers. Holding contracted health entities or providers accountable for both the cost and quality of health care provided to individuals is a common focus of VBP of health care services. Value-based purchasers utilize a variety of performance improvement tools, incentives, and disincentives to improve value.

Value-based *purchasing* is broader than value-based *payment*. Value-based payment financially rewards desired behavior and removes any barriers to desired behavior and is an essential component in any purchasing strategy. Value-based purchasing is about changing health plan behavior to improve performance on behalf of Medicaid beneficiaries.

In general, performance change is facilitated by:

- **Leadership:** Creating a clear vision that is shared across Medicaid staff and with stakeholders.
- **A Clear Pathway:** Defining in unambiguous and measurable terms what the state expects of its health plans, and what the plan expects of its providers.
- **A Need for Change:** Identifying reasons for health plans and providers to generate more value for a state.
- **Trust:** Developing a collaborative relationship between state staff and MCOs, leading to a strong partnership.

Using a VBP approach can mean significant and ongoing changes for a state Medicaid agency and its MCOs. State agencies need to create and utilize detailed purchasing specifications, working collaboratively with MCOs, providers and other stakeholders to achieve objective, measurable improvements in performance.

This Toolkit is designed to guide Medicaid agencies through key action steps and considerations in four phases of the procurement cycle – 1) strategic procurement planning, 2) solicitation development, 3) bidder selection and 4) contract management.

PHASE 1

Strategic Medicaid Managed Care Procurement Planning

PHASE 1 | Strategic Medicaid Managed Care Procurement Planning

Tip: *Take the time to define your strategic objectives and vision for the MCO procurement before you get caught up in line-by-line editing of the MCO scope of work. Think big!*

Many states procure large, multi-year Medicaid managed care contracts for most beneficiaries and covered services, making MCO procurements among the largest state procurements. This opportunity to establish, or re-establish, state expectations only comes around every few years. Solid strategic planning and early engagement across involved state departments and agencies will help to create a clear sense of direction and timeframe for the MCO procurement.

☐ **Identify and engage the Medicaid managed care procurement team and key senior executives that will plan for and execute the procurement.**

It is never too early to start planning for your next procurement (or substantive contract amendment) – both operationally and strategically. With new state requirements for ensuring compliance with Medicaid managed care regulations, sufficient procurement planning cannot be overstated.

Developing a value-based Medicaid managed care procurement is an iterative process. To start, it is essential to identify a project sponsor and lead, as well as individual team members who will be responsible for guiding an agency's managed care procurement process and making progress through each phase. Depending on how your state is organized and how it conducts procurements, it may be particularly important to define the role of the Medicaid agency (and the managed care department within the Medicaid agency) along with other state agencies or departments including separate procurement and legal staff. In developing the procurement team, each state should consider the subject matter expertise (SME) and resources needed to support its managed care initiatives and accomplish key goals, both during the procurement and in managing the selected contractors. States should consider whether other agencies need to be involved, such as state departments of insurance, behavioral health, public health and social service agencies in the procurement discussions.

For efficiency's sake, it is important to keep the procurement team as small as possible while being as inclusive as you need in obtaining input from Medicaid agency staff and staff from other agencies. At a minimum, key team members should include:

- Executive Sponsor for procurement (typically the executive team member responsible for the managed care program);
- Project Lead (since the procurement sets the direction for the managed care program, the Lead should be the director of the Managed Care program if possible);
- Individual team members representing particular areas (depending on size of the team, some may serve as SMEs to the team and not as full team members);
  - 1-2 additional representatives of the Medicaid managed care staff;
  - Medical management (important to have clinical perspective - depending on procurement, may be focused on physical health, behavioral health, and/or long term services and supports);
  - Quality improvement staff; and
  - Health information technology staff, depending on the scope of the submission questions.

If available, a procurement specialist should be part of the team and help to manage the process, consistent with state laws and policies. It is also important to involve legal and finance staff as part of the procurement team. All involved staff and their agencies should have a clear and shared understanding of procurement timing, including recognizing and addressing potential conflicts with other state initiatives.

☐ Develop a proposed procurement timeframe.

Be realistic about the time necessary for large Medicaid MCO procurements; it is easy to underestimate times and resources needed. Below is a sample timeframe for consideration. The timeframe assumes about 15 weeks from the release of the requests for proposals (RFP) to the announcement of MCO awards. This timeframe could be shorter or longer, depending on the complexity of the procurement, number of expected bidders, state resource constraints, etc.

	MCO Request for Proposals (RFP) Task	Timing	Description/Tips
Phase 1 (pgs 4-7)	Strategic planning	6-12 months in advance of procurement release.	Develop strategic vision for the procurement and identify procurement team. Develop a target release date, be realistic and consider contractual or statutory deadlines.
	Develop model contract and procurement documents, including procurement library	Begin as soon as strategic planning is underway; continue through procurement release.	Do not underestimate the time it takes to develop procurement documents. Include subject matter experts (SMEs) in process but limit number of people editing RFP.
	Release procurement	Ideally, at least 15 weeks prior to contract award dates and at least 6 months prior to contract effective date.	As part of the strategic planning process, develop a target release date, be realistic and consider contractual or statutory deadlines.
Phase 2 (pgs 8-13)	Optional step: Receive non-binding intents to bid	1-2 weeks after RFP release.	Requiring intents to bid provides the state with an estimate of bids and assists in planning for bid evaluation period.
	Optional step: Hold bidders conference	7- 10 days after RFP release.	A bidders' conference allows the state to present its strategic vision to potential bidders and directly hear questions from bidders early on.
	Receive questions from potential bidders on RFP documents	Within 2 weeks of RFP release.	Be prepared to receive many questions from bidders, particularly related to new MCO requirements and information in the procurement library.
Phase 3 (pgs 14-18)	Respond to questions from potential bidders and make any modifications to procurement documents or timeframe	As soon as possible or 1-2 weeks following receipt of the questions.	Timing for responses will vary based on the amount and type of questions received, and may take more time than estimated.
	Bid responses due	6-8 weeks after RFP release; may need to be extended if material changes are made to the procurement following bidder questions.	Allow sufficient time for bidders to provide thoughtful, organized bids and to clearly articulate how they will approach delivering services. Consider holidays/vacation periods when determining due date.
Phase 4 (pgs 19-21)	Selected bidders recommended	4-5 weeks after bid submission, depending on number of bids, complexity of scoring, and length of submissions.	To ensure a fair and comprehensive review and documentation, provide evaluation team sufficient time to thoroughly and independently review bids before reviewing as a group.
	Award recommendations announced	2 weeks after bidder selection completed.	Allow evaluators time to finalize summary documents justifying their decisions, check math, present selections to state leadership and procurement specialists.
	Contract management	Execute contracts at least 90 days prior to the operational start date, preferably longer.	Establish a clear process for contract management with at least annual performance measurement and review, including in-person meetings with senior executives of state agency and contractors.

Early on, Medicaid agency staff should review roles, assumptions and timing of the procurement and obtain commitments for specific staff participation from involved agencies and departments. Operationally, senior leaders should support the procurement lead in identifying and 'reserving' participation from specific SMEs and others inside and outside of the Medicaid managed care department, including:

- Individuals to be involved in review of draft procurement documents, and
- Individuals to be involved in the proposal review team(s) for determining awardees.

Senior department leaders should do all they can to prioritize the MCO procurement throughout the process and support staff working on the procurement, in addition to other responsibilities.

☐ **Have a *clear vision* of what you want to achieve with your Medicaid managed care procurement, and then figure out how to articulate that vision.**

States often feel they do not have enough time to develop and revise contracts and procurement documents to accurately reflect the state's vision for managed care. Before drafting procurement documents, think strategically about what the state wants to achieve with the procurement. A re-procurement process is an important opportunity to leverage state purchasing power to improve the value that MCOs provide to the state and its beneficiaries. Below is an example of a Medicaid managed care vision statement from Arizona:

Managed care design decisions need to be considered in the state's overall value context. Translating your state's vision statement for Medicaid managed care programs and procurements into actionable, measurable goals and objectives is critical to obtain the best value from its MCOs. The executive sponsor of the RFP and other team leaders should discuss and seek consensus on specific value objectives for the procurement to provide staff drafting the procurement documents with clear direction for improving the scope of work (SOW), RFP response submission questions, and evaluation criteria.

Example: Arizona Medicaid Managed Care Vision Statement (2017)

- Dedicated to continuously improving efficiency and effectiveness of the Acute Care Program while supporting member choice in delivery of highest quality care to its customers.
- Expects the Contractor to implement program innovation and best practices on an ongoing basis. It is important for the Contractor to continuously develop mechanisms to reduce administrative cost and improve program efficiency.
- Will work collaboratively with the Contractor to evaluate ways to reduce program complexity, improve care coordination and chronic disease management, reduce administrative burdens, leverage joint purchasing power, and reduce unnecessary administrative and medical costs.

States should consider which purchasing decisions are most likely to positively affect the care and health status of managed care beneficiaries. Keep the legislative, budgetary and managed care context in mind when contemplating questions such as:

- ☐ What do you want to achieve in your managed care program next year? In three years?
- ☐ Is the state trying to improve access to and/or coordination of certain types of care?
- ☐ Are you focused on improving care to specific beneficiaries or in certain regions?
- ☐ Does the state seek to align the procurement with payment reforms or other innovations?
- ☐ Does the state envision requiring MCOs to participate in state-defined alternative payment models (APMs) and/or to reach a specified minimum threshold of APM use with its contracted provider network?
- ☐ Is the state looking to include new services or populations in the MCO procurement?
- ☐ Is the state hoping to generate Medicaid savings or improve budget predictability?
- ☐ Does the state intend to set the price (rate) or request bidders to submit price proposals?
- ☐ How will provisions in the new Medicaid managed care rule affect your approach?
- ☐ Does the state intend to better integrate care and services for members being served by other state agencies or programs (e.g., public health, justice system, early intervention programs, housing assistance)? For which populations and services?
- ☐ Is the state bound by legislative language, court decisions, and/or specific policy objectives relative to this procurement?

PHASE 2

Medicaid Managed Care Solicitation Development

Tip: To develop integrated RFP documents, the vision statement should clearly link to measurable scope of work requirements. RFP submission questions and evaluation criteria should reflect the value and priorities the state seeks and link to the state's purchasing specifications.

While states use different approaches and acronyms, contracted Medicaid managed care procurements generally include a publicly advertised procurement process, including a SOW or model contract,[1] and a specification-driven assessment of bids based on pre-determined questions and criteria. Some states accept any willing and qualified bidder, but most states limit the number of Medicaid MCOs by implementing a competitive procurement with awards being offered to the highest scoring, qualified bidders.

Once a state has defined its Medicaid managed care vision statement for what it wants to purchase, it is time to focus on the key components of an integrated procurement, including:

- Drafting a high-level summary of the SOW;
- Establishing comprehensive and detailed purchasing specifications that are specific and measurable, including incentives and penalties;
- Defining processes and timelines in the SOW for how the MCO and the state will seek to improve "performance," including regularly negotiating performance goals and working with contractors to meet established goals; and
- Prioritizing items for procurement submission requirements based on SOW requirements that will enable the state to identify meaningful differences across bidder proposals and likely indicators of future performance consistent with the state's vision for its Medicaid MCO program.

The Medicaid Managed Care (MMC) Rule

In 2016, the federal government released its first major overhaul of the Medicaid managed care rule in over a decade. The "mega" rule requires states to include certain provisions within their managed care contracts, so it is essential that states pay attention to the new MMC rule and provision effective dates which range from immediately upon release to multiple years after the rule release including 2018 and beyond.[2]

In developing a SOW, identify priority needs of the agency and its beneficiaries before, during, and after the procurement process. The SOW included as part of the procurement is the roadmap for your managed care expectations, your assessment of proposals, your future contract requirements and your management of contractors.

It is easy to get lost in the weeds of Medicaid managed care contract language and federal regulations when developing or revising a SOW. While it is important to include all aspects of an MCO's responsibility within the SOW, the state should focus on developing a SOW which improves purchasing specifications and overall value in priority areas defined by the state. The SOW should include formal aspects of the relationship between the state and the MCO, and include both state and contractor responsibilities. For example, the Florida Medicaid managed care core contract includes both MCO and state responsibilities in the background section.[3]

Scope of Work should clearly delineate:

- Which Medicaid beneficiaries are being enrolled in MCOs – both mandatory and voluntary - and how enrollment information will be communicated to the MCOs;
- Which services the MCO is responsible for providing and/or coordinating;
- Network adequacy requirements by provider type/covered service;
- Requirements to ensure efficient and effective management of covered services;
- How the MCO will be paid by the state;
- Parameters the MCO is expected to use in paying its providers;
- Requirement for the MCO to monitor quality performance, including measures to report, performance target expectations and consequences/rewards based on performance;
- Requirement for the MCO to implement an annual quality improvement plan;
- Systems and data sharing requirements; and
- MCO reporting requirements, including related to clinical performance, network adequacy, and priority areas reflecting the value the state is seeking from contractors and the managed care program overall.

Overall, the SOW should align MCO requirements with the state's value expectations. For example, the following excerpt from the TennCare MCO contract includes quality management and quality improvement (QM/QI) program requirements which are linked to specific MCO performance improvement reporting requirements and performance targets associated with financial and non-financial incentives and penalties for contracted MCOs.

Example: TennCare MCO Scope of Work Requirement (2017)

At a minimum, the Contractor's QM/QI program shall:

- Address physical health, behavioral health, & long-term care services;
- Be accountable to board of directors and executive management;
- Have substantial involvement of a designated physician and designated behavioral health practitioner;
- Have a QM/QI committee that oversees the QM/QI functions;
- Have an annual work plan;
- Have staffing, data sources and analytical resources devoted to it;
- Be evaluated annually and updated as appropriate; and
- Be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the contractor.

☐ **Identify high-level goals, and then specific agency objectives related to the value of the services being purchased on behalf of state Medicaid beneficiaries.**

In developing objectives for your state's Medicaid managed care program, consider available data, particularly if you are re-procuring managed care contracts:

- In what areas are MCOs or providers performing farthest from best practice or defined desired performance?
- Are there MCO or region-specific opportunities for improvement?
- To what extent can MCOs/providers influence improvement in different areas?
- Can the state use the procurement process to address specific managed care program issues or expectations raised by providers, beneficiaries and other stakeholders? Which ones?
- Does the inclusion or exclusion of certain services or populations in the managed care approach affect other state or local health agencies that are purchasing or providing services to Medicaid beneficiaries?
- Which MCO program improvements are priorities for the state?

Once senior leaders have reached consensus on priorities, it is essential to articulate specific, measurable Medicaid agency objectives – first for the managed care procurement team and then for selected MCOs and the Medicaid managed care program going forward.

Consistent with the prior Tennessee MCO QM/QI program example cited, TennCare identifies high priority clinical areas and sets program-wide goals as part of its quality strategy.[4] The state's quality strategy lays out a series of specific and measurable goals for the MCO program across priority areas that are incorporated into its MCO contracts. The following is one example of a state clearly specifying the timing of a statewide managed care performance goal, the measures and the data sources to be used to assess performance toward the goal.

TennCare 2016 Quality Assessment and Performance Improvement Strategy

Physical and Behavioral Health Goals

Goal 1: Assure appropriate access to care for enrollees

- **Objective 1.1:** By 2019, the statewide weighted HEDIS®[5] rate for adolescent well-care visits will increase from 41.6% to 47.6%.[6]
- **Objective 1.2:** By 2019, the CMS 416 EPSDT[7] screening rate will increase from 71% to 90%.[8]
- **Objective 1.3:** By 2019, 97% of TennCare heads of household and 99% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).[9]

Improving value for state Medicaid agencies and beneficiaries might mean examining ways for MCOs to improve care for populations with special health care needs and new requirements or initiatives aimed at:

- Increasing care coordination across health plans, providers, and different settings;
- Enhancing the use of and impact of patient centered medical homes (PCMHs);
- Better integrating medical and behavioral health services;
- Improving population health, such as enhanced coordination with vendors that manage carved-out benefits such as behavioral health, transportation, dental and pharmacy; and
- Implementation of APMs.

Currently, many states are focused on increasing MCO use of APMs with their providers to improve the value of care delivered to Medicaid beneficiaries. States use a variety of models and approaches to meet this objective. Some states,

such as Pennsylvania, require an increase in MCO use of APMs.[10] Other states, such as Rhode Island, both require MCOs to increase the use of APMs and dictates that MCOs must contract with state-certified Accountable Entities as one type of APM.[11] To enable monitoring of whether MCOs are meeting these objectives, SOWs must include specific language requiring MCOs to report on their progress in using APMs. In addition to new APM reporting requirements, some states, such as Pennsylvania for example, will impose a financial penalty on MCOs that do not meet APM requirements.

Make a stronger business case for MCO and provider performance improvement.

States should establish clear MCO performance incentives in targeted areas. In addition, it is important to create meaningful consequences – both positive and negative – for performance, and follow through. Consider having a menu of different types and levels of incentives and sanctions in the SOW and utilizing a variety of financial and non-financial tools – including peer pressure, profiling and transparency with MCOs in order to improve performance.

☐ **Procurement questions**

Tip: *Spend time identifying the exact scope and wording of RFP procurement questions. If the submission questions do not clearly and consistently reflect how the state determines "value," the state will miss opportunities to differentiate bidders likely to achieve the agency's core objectives.*

One of the most important pieces of procurement development is developing questions to ask potential bidders and the related reports or sample documents to review. Responses to RFP questions are used to evaluate bidders' qualifications, and in the case of a competitive bidding process, to help the state compare bidders' potential to perform in high value areas.

Typically, asking bidders to respond to about 10-15 carefully identified and worded questions (some of which may include sub-questions) should be sufficient to assess bidder qualifications. Submission questions should be linked to contract specifications in the SOW and help distinguish the qualifications, proposed innovations and overall responses of bidders to support more effective evaluation of bids. Resist the temptation to ask too many RFP questions. Sometimes more questions mean more work for respondents and reviewers but no added value for the procurement or contract management process. Avoid broad, descriptive questions of processes that are likely to be lengthy to read, with similar boilerplate responses across bidders.

Design questions that ask for a bidder's proposed approach to do or achieve "X" within "Y" timeframe, including specifying expected results. Later, use bidder responses to these questions in managing future contracted Medicaid plans.

Do not ask a question about every scope of work component. Consider:

- How will the RFP question help the state to distinguish among potential bidders?
- Does the RFP question help to identify likely future performance under this contract?
- How will the RFP question be scored?

To the right are some sample questions from Medicaid MCO RFPs related to quality improvement and clinical initiatives.

Example:
Florida MCO RFP (2017)

The respondent shall describe its organizational commitment to quality improvement, including active involvement by respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of their results.

Example:
Michigan MCO RFP (2015)

Describe in detail at least one data-driven clinical initiative that bidder initiated within the past 24 months that yielded improvement in clinical care for a managed care population comparable to the populations described in this RFP.

Require bidders to follow consistent numbering and format for responding to questions. The more consistent the presentation of the information, the easier it will be for reviewers to assess differences across bidders without wading through pages of text or attachments. Specify page limits in the response instructions, overall and/or for specific questions. Consider limiting the number/types of attachments that will be reviewed as part of any bid.

After the RFP submission questions are drafted, think about how each section will be allocated points and scored as discussed in Phase III of this Toolkit. Revisit and revise the questions as needed once the scoring allocations, criteria and review process is finalized, and before the RFP is released. It is important that the submission questions are developed in a manner that allows responses to be fairly and effectively evaluated using the state's proposed scoring approach.

☐ Additional documentation to be released with procurements

Release procurement libraries as part of your procurement to provide potential bidders with information on the history of the Medicaid and managed care program in the state; data books that describe populations to be covered; distribution of eligible members geographically; Medicaid beneficiary service history; and utilization. These documents are particularly important to potential new bidders or when bidders must submit price bids as part of their MCO proposals. Even if bidders are not required to submit a price as part of their bid, data books should provide sufficient, recent information to allow potential contractors to assess their ability to manage the contract successfully under the price being established by the state.

Do not underestimate the time that it will take to collect the appropriate materials and data to be included in the procurement library. Begin thinking about and planning for the procurement library as other procurement documents are developed.

Often bidders will raise specific questions about materials shared, including financial and utilization data. Be prepared to answer questions regarding the procurement library in a bidder's conference and during the bid question and answer period.

PHASE 3

Bid Review and Selection

Tip: Consider the bid review, evaluation criteria and selection process early in the procurement development process.

Before procurement documents are posted, consider how reviewers will evaluate bidder responses to specific questions. As you draft evaluation criteria and review tools, circle back to the model contract and make sure that expectations related to submission questions are clearly reflected in the contract. If there is a submission question that does not align with any SOW requirement, either the question is not appropriate, or the SOW needs to be modified before the procurement responses are due.

☐ **Identify and effectively utilize RFP evaluation teams with appropriate expertise.**

The specific members and size of your RFP review team, or Evaluation Panel, should be discussed early on with involved state agencies and department leaders as noted in Phase I:

- Identify an odd number of qualified voting members to participate in the bid review – preferably no more than five voting members. Teams larger than this may be less efficient.
- If the procurement is for an existing Medicaid managed care program(s), at least one senior manager overseeing the current MCOs should be included as a voting member.
- If there is a price component to the bid, or if bidder's financial data is being reviewed, individuals with financial expertise should review the financial components of the bid.
- Consider whether staff from another state agency, such as the behavioral health department or public health department, should participate in the review.

Not every member of the review team needs to be a voting member of the Evaluation Panel. The Panel should be supported by subject matter experts (SMEs) who provide special reviews of individual sections of the proposals and present their summary analysis and scoring recommendations to the Evaluation Panel. SMEs are particularly helpful for reviewing certain proposal sections, such as submissions related to clinical quality (e.g., HEDIS measures) and financial stability.

The responsibilities of the subject matter experts differ from that of the Evaluation Panel members:

- SMEs may not be required to review all bid submissions.
- SMEs are advisers, not voting members, though they may recommend scores.
- SMEs should report their review findings to the Evaluation Panel in writing.
- SMEs may be invited to attend Evaluation Panel meetings, respond to questions, and/or provide oral presentation to the Panel.

The state should screen Evaluation Panel participants and SMEs to ensure that they have no conflicts of interest or close personal relationships with any bidders and require all participants to be trained related to fair procurement processes and the need for confidentiality.

☐ **Develop evaluation criteria, a scoring rubric, and review tools reflecting the value the state seeks from its contracted MCOs.**

Managed care procurement documents should inform bidders – at a high-level – of evaluation criteria, and general information on how proposals will be evaluated and scored. Scoring rubrics and review tools should provide more detail. Below is an example of a scoring rubric from Florida's Medicaid managed care procurement related to a patient centered medical home submission question.

In developing procurement documents, the state must determine whether, and to what extent, the evaluation should include price. Some states use only technical criteria and set the price, such as risk-adjusted per member per month (PMPM) rates for MCOs. Other states request price proposals and then only consider technical proposals from bidders that meet certain cost parameters. Given new rate requirements in the Medicaid managed care rule, states utilizing competitive bidding will need to make modifications in future rate setting approaches.[12]

As part of the procurement development, identify key evaluation criteria, any mandatory pass/fail requirements, the maximum number of points a proposal can earn, and the order of importance of various subsections that will be scored.

- For applications where bidders need to meet minimum requirements, be specific about the minimum criteria for bid awards.
- For competitive bids, make sure the number of possible points in each scored section and overall is sufficient to enable the review panel to have meaningful differences in scoring across bids reflective of the quality of the responses.

The total number of points available and the scoring weights assigned to questions are critically important. Avoid allocating too many or too few points to one question or section. An overly weighted question can make the results of reviewing other questions meaningless in selecting winning bidders. If a question does not need to be allocated many points, then the question may not need to be asked.

Do not have too few points overall – or too many questions where bidders are likely to score similarly. It is harder to defend competitive award decisions where the difference between bidders is very small.

Example:

Florida Medicaid MCO Procurement - PCMH Questions and Evaluation Criteria (2017)

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvements in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

Score: Section worth a maximum of 25 raw points with each of the components [or subcomponents] being worth a maximum of 5 points each.

Evaluation Criteria:

1. Extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
   - enhanced access
   - coordinated and/or integrated care; and
   - achievement of improved quality outcomes
2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.
3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

Give the Panel - and the state - the opportunity to contract with strongest organizations, promote competition and react optimally to proposals received. The review tools and process should allow for some flexibility (e.g., including multiple topics and questions for each subcategory) for review panels to allocate points related to specific submission materials in a manner that reflects the Panel's perception of the value each bidder offers to the state.

Below is a sample summary of point distribution for technical components of a competitive Medicaid managed care procurement:

	Evaluation Components - SAMPLE	Points
1.	General Proposal (mandatory attestations, bidder organization forms, conflict of interest, etc.)	Pass/Fail
2.	Technical Proposal	
a.	Bidder Staff, Experience and References	50
b.	Network Adequacy and Network Management (contracted providers, geo-access maps, timeliness of care/access)	60
c.	Quality Improvement and Performance (HEDIS, etc.)	50
d.	Alternative Payment Models	75
e.	Primary Care (Patient-centered medical homes) and Population Health	60
f.	Behavioral Health Services/Integration	60
g.	Populations with Special Health Care Needs/Long-term Services and Supports (LTSS)	75
i.	Encounter Data and Health Information Technology	50
Total		480 points

☐ **Establish, utilize, and document a systematic and fair bid review process.**

Create evaluator trainings and RFP review tools that help reviewers differentiate bids with concrete commitments from vague but well-written responses. Select RFP responses should be reviewed by staff that serve as SMEs and offer guidance to reviewers. Seek consensus on scoring, rather than averaging individual scores that may vary widely.

Proposals typically are hundreds of pages and can be quite difficult to review. To make the process easier for the Evaluation Panel, create tools that provide clarity for consistent scoring of each scored subsection. In general, reviewers should consider:

1. Has the bidder demonstrated that it has successful, relevant experience with this aspect of the required SOW?
2. Has the bidder demonstrated that it is willing and likely to successfully provide the required SOW for this particular state/region/population/service?
3. Relative to the SOW and expected value standards, what did the bidder promise to do, by when, how often/how much and with what commitment of resources?

The Evaluation Panel must strictly adhere to a clear and logical bid review process to help protect the state agency against challenges from bidders that are not selected. All bids meeting submission standards and mandatory requirements should be treated in the same manner and be given equal consideration. Build steps into the review process to protect against potential bias in the evaluation, and to ensure comprehensive documentation in support of Evaluation Panel's recommendation.

Ensure that scoring is applied consistently across proposals. To do this, it is helpful to have a facilitator for the Evaluation Panel meetings who is focused on maintaining the fairness and consistency of the review process. Prior to the Evaluation Panel meetings, each reviewer should independently read and comment on each proposal using the review tool as a guide.

Evaluation Panel members should receive consistent instructions and guidelines, such as:

- Review all proposals and all elements of the response fully and thoroughly (even if a SME is also available and scoring);
- Evaluate content - not style - of proposals;
- Focus on evaluation criteria set out in the procurement documents;
- Examine bidder performance data to identify gaps relative to standards and objectives specified in the model contract;
- Although information may not be in the correct location in the procurement materials, make sure it is taken into account when reviewing a bidder's response to a standard question;
- Take clear and concise notes on strengths and weaknesses or deficiencies that are identified as part of the individual review process; and
- Request SME input if necessary to understand a bidder's response.

PHASE 4

Contract Management

PHASE 4 | Contract Management

Tip: Think of the MCO Contract Management Process as an extension of the procurement process – because it is!

Using a VBP approach can mean significant and ongoing changes for a state Medicaid agency and its contracted plans. As part of your routine MCO management process, create a schedule and expectations for reviewing documentation and meeting with individual plans to determine whether the Contractor is implementing improvements promised, according to the timelines and parameters required under the contract and/or proposed by the Contractor.

☐ **Leverage the procurement process to prioritize performance improvement.**

Use information obtained in the procurement to prioritize performance improvement efforts for the initial MCO contract year(s). Similarly, use plan RFP submissions as the foundation for ongoing MCO contract management priorities. Bidders are trying to win your business and will promise to do things in their proposals, more so than once they have been awarded a contract. Create mechanisms in your contract management approach to hold successful bidders to those promises. Establish a system and a timeline for revisiting plan performance to specified activities and timelines identified in their bids. For example, a state that asks bidders to commit to increasing APMs in the RFP could ask plans to prepare and present changes they have made in their APMs six months after the operational start date of the new contracts.

☐ **Appropriate leadership to support proactive contract management.**

Holding vendors accountable is more than just creating good contracts, incentives, and penalties. To effectively manage the MCO contracts, Medicaid staff responsible for oversight of plan contracts need to be able to engage plan leadership on equal footing. The state Medicaid managed care program director should be a senior department leader with oversight over skilled contract management staff. Medicaid agencies can utilize the following steps to implement VBP strategies with managed care plans.

☐ **Establish MCO contract management teams and new internal accountability.**

To effectively oversee and manage plans, engage more staff and partners in different ways. Many Medicaid agency staff can and should have a role to play in MCO contract management. They should:

- Consider new accountability structures for state staff and re-focusing of staff resources to support a VBP approach with contracted MCOs;
- Identify skill sets and/or individuals that could play a larger role in the state's oversight and engagement of contracted MCOs;
- Sponsor MCO meetings and work groups to foster collaboration and performance improvement; and
- Encourage interagency collaborations in monitoring and managing plans.

Some states have developed MCO contract management teams in a matrix management approach with members from across the agency, including staff with expertise in contracting, quality, clinical, finance, managed care, behavioral health, pharmacy, and/or data analytics. All senior managers and teams should both be empowered and held accountable for assigned plans achieving annual performance improvement goals. Consider tying annual state agency goals, and potentially individual staff performance measurement, to MCO performance on contractual improvement goals. Medicaid MCO work groups can be staffed and led by agency employees with specific expertise inside or outside Medicaid managed care departments, (e.g., quality, information technology, pharmacy, behavioral health and maternal and child health.) Work groups enable states to leverage MCO and other state staff expertise to improve performance of the managed care program. Work groups make use of the state's power as a convener of plans and stakeholders to address common challenges and solve problems.

☐ **Develop structure for ongoing quality conversations and meetings.**

States should establish regular processes that focus on plan performance to pre-established objectives and targets in high priority clinical and service areas. It is important to focus on results rather than internal MCO processes. An MCO performance dashboard can be used to regularly investigate and act on MCO performance when it differs from established goals or contract expectations. Two levels of the dashboard can be created: 1) MCO program performance overall; and 2) MCO-specific dashboards to use in contract management and in individual plan performance meetings.

Establish regular, substantive in-person meetings on MCO performance and provide substantial internal and external transparency on plan-level performance regarding the extent to which each health plan is meeting expected performance levels for quality, efficiency, or other priority measures (e.g., using the dashboards to support the discussions). In advance of these meetings, states should identify the specific MCO performance areas to be discussed, the process and timeline for reviewing performance in the future, and specific performance goals. In Arizona and Tennessee, for example, senior Medicaid managed care staff regularly meet with senior leaders at each plan individually and in small groups to discuss strategic and performance expectations, challenges, and trends in performance. Staff from these states emphasized the importance of having structured performance-focused meetings (not during rate meetings) with MCO C-suite executives and state Medicaid leadership on at least a semi-annual basis.[13]

Conclusion

Implementing a statewide, competitive procurement for Medicaid managed care is one of the more important things state purchasers do to improve value. Using a VBP approach requires significant and ongoing focus on performance improvement in each phase of the procurement cycle: 1) strategic procurement planning, 2) solicitation development, 3) bidder selection, and 4) contract management.

Throughout the process, both the state and plans must remain focused on the big picture: improving the health of vulnerable populations while being sensitive to the prudent use of taxpayers' dollars. States should use the procurement process to identify areas where wide variability in MCO and provider practice exists and where gaps between current practices and knowledge can be closed during the contract period. States should consider annual or bi-annual performance improvement goals, including Medicaid managed care baseline, mid-cycle, and final evaluation periods to track improvement gains at the plan and program level. Initially, and over time, states should seek additional value – such as improvements in population health, health equity, quality and safety as well as improvements in Medicaid managed care processes and efficiencies.

States must effectively collaborate – both internally and externally – to define and add value to Medicaid managed care programs. Think creatively about how to staff and support your Medicaid managed care program. In reviewing bids, focus on identifying plan partners likely to meet your value expectations. Work with the successful contractors to create and implement incentives and supports to reward high-value providers. Finally, do not overlook opportunities to coordinate your Medicaid VBP efforts with other purchasers, such as aligning performance measures to reduce the noise for plans and providers.

Endnotes

1. In this document, we will use the term scope of work (SOW).
2. The Medicaid managed care rule and related materials including a timeline can be found at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Because aspects of the old Medicaid managed care rule remain in effect, states may need to reference it. It is available at: https://www.medicaid.gov/medicaid/managed-care/downloads/managed-care-regulations-42-cfr-part-438.pdf.
3. For an example of MCO SOW sections and content, see the table of contents and purchasing specifications in the Florida Medicaid Managed Care contract: http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml.
4. www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf; For example, by 2016, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 59.14% and the state will maintain a total statewide EPSDT screening rate of at least 80%.
5. The Healthcare Effectiveness Data and Information Set (HEDIS), a tool to measure performance on dimensions of care and service, is a registered trademark of the National Committee for Quality Assurance (NCQA).
6. Data Source: A Comparative Analysis of Audited Results from TennCare MCOs. See for example: https://www.tn.gov/assets/entities/tenncare/attachments/hedis15.pdf.
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Medicaid benefit that provides comprehensive and preventive health care services for children under age 21.
8. Data Source: A Comparative Analysis of Audited Results from TennCare MCOs. See for example: https://www.tn.gov/assets/entities/tenncare/attachments/hedis15.pdf.
9. Data Source: The Impact of TennCare: A Survey of Recipients. See for example, http://cber.haslam.utk.edu/tncare/tncare16.pdf.
10. Pennsylvania will impose a 2% premium withhold if MCOs do not have 7.5% of the medical portion of the capitation expended through an APM in 2017. This percentage increases to 15% in 2018 and 30% in 2019.
11. In their recent RFP, Rhode Island requires MCOs to have 30% of provider payments made through APMs by June 2017, 60% of provider payments made through APMs by June 2019 and 80% of provider payments made through APMs by June 2020.
12. Under the new Medicaid managed care rule, if MCO rates differ by plan, the rates must be developed independently and in accordance with new development and certification requirements of the rule to demonstrate that the rates are actuarially sound. For more considerations related to procurements with competitive versus fixed price bids for Medicaid managed care, see: http://www.milliman.com/uploadedFiles/insight/2015/fixed-offer-competitive-bid.pdf.
13. Arizona and Tennessee report that senior Medicaid managed care staff regularly meet with senior leaders at each plan individually and in small groups to discuss strategic and performance expectations, challenges, and trends in performance.

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This Toolkit was prepared by Mary Beth Dyer and Beth Waldman. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.