MEDICAID MANAGED CARE PURCHASING:
WHAT WORKS AND WHAT DOESN’T

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As always, any remaining deficiencies are the responsibility of the authors.
EXECUTIVE SUMMARY

Risk-based managed care purchasing requires state Medicaid agencies to do business in ways that differ in major respects from the manner in which they have operated in traditional Medicaid fee-for-service (FFS) programs.

THE NEW CHALLENGES OF MEDICAID MANAGED CARE

Some of the ways in which risk-based managed care presents new challenges include:

- **Packages of care vs. pieces of care.** Instead of paying bills for services provided by thousands of different health care providers and suppliers, Medicaid agencies contract with a limited number of managed care organizations (MCOs) that agree to assume responsibility for a wide range of health care services in exchange for a fixed monthly payment for each enrolled beneficiary.

- **Large complex contracts vs. short standard provider agreements.** Instead of contracting with individual providers and suppliers using short, standardized, “take-it-or-leave-it” provider agreements, Medicaid agencies use complex procurement processes to contract with MCOs, often including highly detailed requests for proposals and contract specifications.

- **Complex and volatile MCO payment systems vs. stable provider reimbursement systems.** Instead of operating with provider reimbursement systems that may remain largely unchanged and unexamined for years, Medicaid agencies use complex methodologies to set annual capitated (per-member, per-month) rates. These rates must be sufficient to attract competent MCOs—which often have other options and opportunities in rapidly changing health care marketplaces—while at the same time remaining within federal regulatory rate ceilings and state budgetary requirements.

- **Accountability for access and quality vs. just assuming it.** Instead of assuming that access and quality for beneficiaries is adequate as long as providers are participating and sending in bills, Medicaid agencies are expected to undertake major efforts to monitor and measure the performance of MCOs and hold them accountable on multiple dimensions of access and quality—often in response to frequently changing state and federal legislative and regulatory requirements.

- **Large market-driven business organizations vs. individual health care providers and beneficiaries.** Instead of dealing primarily with individual providers and beneficiaries on specific cases and problems, Medicaid agencies must deal with large private organizations (MCOs) that change rapidly and that are subject to incentives and pressures that state Medicaid agencies may not fully understand. Medicaid agencies must try to understand, respond to, and (if possible) anticipate complex political and market pressures they may not previously have been exposed to.
These new purchasing challenges require leadership and staff skills that go beyond what is normally required in state government. State Medicaid managed care programs are businesses that are purchasing hundreds of millions (often billions) of dollars worth of health care services each year on behalf of some of the nation’s most vulnerable citizens. These programs are expected to be more broadly accountable than most businesses, usually with fewer resources and less flexibility.

The Medicaid managed care marketplace is currently in the midst of significant change, with many MCOs that initially showed great interest in the Medicaid market now dropping out or holding back (although interest remains firm in some states). There is growing evidence that managed care is not producing the “easy” and sustainable budget savings that many anticipated. And many states are now considering and implementing extensions of managed care to disabled and elderly populations with costly, complex, and highly diverse health care and related needs.

States that have operated Medicaid managed care programs for many years have learned lessons that states relatively new to managed care can profit from. In Medicaid, however, context is everything. What works in one state may not work in another. Best practice lessons must be adapted to each state’s historical, political, bureaucratic, fiscal, and health care marketplace context.

To help states learn from each other what works and what doesn’t in Medicaid managed care, and to help put each state’s lessons in context, Mathematica Policy Research conducted this study of nine states: Arizona, Georgia, Indiana, Iowa, Massachusetts, Michigan, New Mexico, Oregon, and Texas. In each of these states, the authors conducted telephone interviews with state Medicaid directors and their staff, as well as with representatives from MCOs participating in the Medicaid program.

THEMES AND LESSONS

The themes and lessons that emerged from this analysis are summarized below, and developed in further detail in the full report.

Partnership and Collaboration

- States should form collaborative partnerships with MCOs, while still maintaining their ultimate responsibility to hold MCOs accountable for performance.

Initial Program Design

- Managed care program design must fit the state’s context and circumstances.

- Primary care case management (PCCM) programs can be a valuable complement to risk-based programs for a state, but they can also make risk-based programs more difficult to operate and less attractive to MCOs.
• “Carving out” specified services and/or providers from risk-based managed care (mental health, substance abuse, prescription drugs) can present significant care coordination and program monitoring problems.

Procurement

• There is a continuum from pure competitive bidding to contracting with any willing and able MCO; where states place themselves on that continuum should reflect state managed care goals and administrative capacity and MCO interest in the Medicaid business.

Rate Setting

• There is also a continuum in the way capitated rates may be set, ranging from open bidding with no pre-set range, to rates set by the state with no discussion or negotiation. Where states place themselves on that continuum should reflect their managed care goals and resources and the state context.

• States should provide potential MCO bidders with as much information as possible on past Medicaid service utilization, including full claims and/or encounter data where possible.

• States should continuously explore ways to make the capitated rates they set reflect as accurately as possible the risks that MCOs assume, and the incentives states want to establish, especially for Supplemental Security Income (SSI) and other disabled and elderly populations.

• Setting managed care rates and monitoring performance will become increasingly difficult in the absence of good encounter data. The best way to assure that encounter data are complete and reliable is to use the data for rate setting and public reporting of MCO performance.

Monitoring

• States should monitor MCO performance in areas that are important to state goals, and should focus on results rather than internal MCO processes.

• States should not collect information they are not able to use, or in forms that needlessly depart from managed care industry standards.

Reporting

• States should regularly and publicly report on state and MCO managed care performance, focusing on areas that the public, MCOs, beneficiaries, and providers care about and can understand.
Refinement and Redesign

- Medicaid managed care is (and should be) a work in progress; the best state programs and MCOs learn from their mistakes and successes and continuously seek to improve.

CONCLUSION

States have developed a wide variety of tools and approaches to meet the new challenges of Medicaid managed care, learning from their successes and setbacks and those of other states. No one set of tools is right for every state, and changing circumstances within states require continuous reexamination of current approaches. To adapt the available tools to their circumstances, states should:

- Think carefully about what the state’s managed care goals are, what administrative and other resources are available to accomplish them, and what the managed care environment is like in the state and how it may change.

- Work collaboratively with the MCOs and providers that are most interested in Medicaid managed care to refine and improve the managed care program over time.

- Remember that accountability is about measurement and results. States can only tell what works and what doesn’t if they keep track of what they are doing and measure its impact.
INTRODUCTION

THE NEW CHALLENGES OF MEDICAID MANAGED CARE

Risk-based managed care purchasing requires state Medicaid agencies to do business in ways that differ in major respects from the manner in which they have operated in traditional Medicaid fee-for-service (FFS) programs. Some of the ways in which risk-based managed care presents new challenges include:

- **Packages of care vs. pieces of care.** In FFS, Medicaid agencies pay bills for services provided by thousands of different health care providers and suppliers (hospitals, physicians, pharmacies, testing laboratories, durable medical equipment suppliers, and the like). In risk-based managed care, Medicaid agencies contract with a limited number of managed care organizations (MCOs) that agree to assume responsibility for a wide range of health care services, in exchange for a fixed monthly payment for each enrolled beneficiary.

- **Large complex contracts vs. short standard provider agreements.** In FFS, Medicaid contracts with individual providers and suppliers using short, standardized, “take-it-or-leave-it” provider agreements. In managed care, Medicaid contracts with MCOs using complex procurement processes that often include highly detailed requests for proposals (RFPs) and contract specifications, with hundreds of millions of dollars over several years at stake. The procurements may involve competitive bidding or negotiation processes that can require extensive comparisons and analyses, and there is often the potential for intense public scrutiny and legal challenges.

- **Complex and volatile MCO payment systems vs. stable provider reimbursement systems.** In FFS, Medicaid operates with provider reimbursement systems that may remain largely unchanged and unexamined for years. In risk-based managed care, Medicaid agencies use complex methodologies to set annual capitated (per-person, per-month) rates that must cover a wide variety of populations and care needs. These rates must be high enough to attract competent MCOs—which often have other options and opportunities in rapidly changing health care marketplaces—while at the same time remaining within federal regulatory rate ceilings and state budgetary constraints.

- **Accountability for access and quality vs. just assuming it.** In FFS, Medicaid agencies assume that access and quality for beneficiaries is adequate as long as providers and suppliers are participating and sending in bills. In managed care, Medicaid agencies are expected to undertake major efforts to monitor and measure the performance of MCOs and hold them accountable on multiple dimensions of access and quality—often in response to frequently changing state and federal legislative and regulatory requirements.

- **Large market-driven business organizations vs. individual health care providers and beneficiaries.** In FFS, Medicaid agencies deal primarily with individual providers and beneficiaries and their representatives, usually focusing on relatively routine specific cases or problems (claims payment, eligibility, access). In managed care, Medicaid agencies must deal with large private organizations (MCOs) that change rapidly and that
are subject to incentives and pressures that state Medicaid agencies may not fully understand. Medicaid agencies must try to understand, respond to, and (if possible) anticipate complex political and market pressures they may not previously have been exposed to.

Not surprisingly, these new purchasing challenges require skills, capabilities, and resources that state Medicaid agencies may find it difficult to develop, attract, and retain.1

Changing Medicaid Managed Care Marketplace

The Medicaid managed care marketplace is currently in the midst of significant change. Many MCOs that initially showed great interest in the Medicaid market are now dropping out or holding back, although interest and participation remains firm in some states. There is growing evidence that managed care is not producing the “easy” and sustainable budget savings that many anticipated. And many states are now considering and implementing extensions of managed care to disabled and elderly populations with costly, complex, and highly diverse health care and related needs.2

DEVELOPMENT OF THIS PAPER3

Seeing these growing challenges for state Medicaid agencies, Rick Potter of Arizona, then-chair of the National Association of State Medicaid Directors (NASMD) Managed Care Technical Advisory Group (TAG), asked the Center for Health Care Strategies (CHCS) in the spring of 1998 for help in identifying “best purchasing practices” among state Medicaid agencies so that states could learn from each other more quickly and effectively. After further discussions with NASMD and others, CHCS commissioned this policy paper in the fall of 1998.

At around the same time, the Federal Health Care Financing Administration (HCFA) published a proposed rule designed to provide guidance to states on the Medicaid managed care provisions included in the Balanced Budget Act of 1997 (BBA).4 This 70-page proposed rule included provisions that could require states and MCOs to substantially increase their managed

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1 For a detailed discussion of these recruitment, staffing, and organizational issues, see James M. Verdier, “Restructuring Medicaid Offices to Deal with Managed Care,” Princeton, NJ: Center for Health Care Strategies, Inc., January 1998.
3 Those with less interest in methodological issues may want to skip or skim this section.
care performance monitoring and reporting efforts, adding further to the challenges (and potentially the costs) of providing managed care for Medicaid populations.

**October 1998 NASMD Workshop**

To further develop the issues surrounding Medicaid managed care purchasing and gain insights from a wider range of state Medicaid officials and staff, a workshop entitled “Medicaid Managed Care Purchasing: What Works and What Doesn’t,” was held at the NASMD Fall Annual Meeting in Bethesda, Maryland on October 27, 1998. The workshop was moderated by Jim Verdier, and featured presentations from Don Herman (Iowa state Medicaid director), Chuck Milligan (New Mexico state Medicaid director), and Donna Checkett, chief executive officer of Missouri Care (a Medicaid MCO) and formerly the Missouri state Medicaid director and chair of NASMD. Their presentations stimulated a fruitful discussion and helped frame many of the issues that are developed in this paper.

**December 1998 Survey of State Medicaid Directors**

To be sure the paper focused on the purchasing issues that were of greatest concern to state Medicaid directors—and to gain more insight into the range and diversity of state managed care needs and experiences—Mathematica Policy Research sent a short two-page survey to all state Medicaid directors in early December 1998. The survey asked them which of a list of purchasing issues they found currently significant; which issues they had useful past experiences with; and if there were other purchasing issues they thought we should examine. We received responses from more than three-quarter of the states. They listed data-related issues (rate-setting and performance monitoring) as the most significant, but there was also substantial interest in other procurement, program design, monitoring, and reporting issues.

**Selection of Nine States for Detailed Study**

The Managed Care TAG and others at NASMD with whom we consulted suggested the following criteria to help us in selecting states for detailed study:

- Include states that try to limit the number of MCO bidders through a competitive bidding process.
- Include states with varying degrees of openness in sharing rate information with MCOs.
- Include states that use only risk-based managed care, and others that have retained a primary care case management (PCCM) option.
- Include states that enroll Medicaid beneficiaries receiving Supplemental Security Income (SSI) in risk-based managed care programs on either a voluntary or a mandatory basis.

We also developed some further criteria of our own. We wanted states from a variety of geographic regions, and with differing degrees of overall managed care penetration. We sought states with relatively extensive experience with risk-based Medicaid managed care, on the assumption that they would be more likely to have developed purchasing strategies that would be useful to other states. We avoided most states with new governors from a political party different from that of the prior governor, since we thought interviewing might be problematic in...
the first months of a new administration. Finally, we looked at whether states were included in studies being conducted or recently completed by other organizations. While we didn’t want to “over-study” states whose managed care programs were generally well reported and familiar to other states, we believed these other studies could provide context and background that would help us better understand states whose Medicaid managed care programs we were analyzing. In the end, eight of the nine states we chose were also included in one or more of these other studies.

The nine states we chose for more detailed study—Arizona, Georgia, Indiana, Iowa, Massachusetts, Michigan, New Mexico, Oregon, and Texas—are shown in Table 1, along with a summary of selected state managed-care-related characteristics.

Interviews With Medicaid State Officials and MCOs

In each state, we interviewed the Medicaid director and/or others whom the Medicaid director recommended. We also interviewed representatives from one or more MCOs with state Medicaid contracts in each state, based on recommendations from our state Medicaid interviewees. We generally followed uniform interview guides that we sent to interviewees in advance. (The interview guides we used for state Medicaid officials and MCOs are reprinted in Appendix A.) All the interviews were by telephone, except for those with Massachusetts state Medicaid officials, which were in-person.

We took detailed notes on our interviews, but did not tape-record them or make verbatim transcripts. We assured all interviewees that their comments would not be attributed to them in ways that identified them by name or affiliation without their permission.

We supplemented our interviews with detailed information sent to us by states and MCOs or available on their Web sites. We also conducted a general literature review at the outset of the study, and supplemented it as the study proceeded.

OVERVIEW OF THE PAPER

The paper begins with one over-arching theme that emerged from a great many of our interviews—the need for states to form collaborative partnerships with MCOs—and then develops twelve additional themes or lessons that are organized around the stages of Medicaid managed care program design and implementation (initial program design, procurement, rate setting, monitoring, reporting, and refinement and redesign). These major themes are set out in the table of contents and the executive summary, and developed in more detail in the remainder of the paper.

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5 The studies we looked at included the Urban Institute’s Assessing the New Federalism study of 13 states, the Center for Studying Health System Change’s Community Tracking Study, which focuses on communities in 12 states, the Kaiser/Commonwealth Low-Income Coverage and Access Project, which includes case studies of Medicaid managed care in seven states, and a study of the development of Medicaid managed care capitation rates in 15 states, completed for the Kaiser Family Foundation by Health Systems Research, Inc. in November 1997.
### TABLE 1

**SUMMARY OF SELECTED STATE MEDICAID MANAGED CARE CHARACTERISTICS AS OF 1998**

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<th>Characteristic</th>
<th>AZ</th>
<th>GA</th>
<th>IN</th>
<th>IA</th>
<th>MA</th>
<th>MI</th>
<th>NM</th>
<th>OR</th>
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<td>IX</td>
<td>III</td>
<td>V</td>
<td>VII</td>
<td>I</td>
<td>V</td>
<td>VI</td>
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<td>Managed Care Penetration Rates (%)</td>
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<td>All Risk-based</td>
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<td>16</td>
<td>14</td>
<td>5</td>
<td>52</td>
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<td>44</td>
<td>41</td>
<td>32</td>
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Total HMO penetration rates are from *The InterStudy Competitive Edge: HMO Industry Report 9.1*. InterStudy Publications. 1999. The data were collected between October 1998 and February 1999. Includes commercial, Medicare, and Medicaid.

Medicaid PCCM and full-risk penetration rates are from *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey*, John Holahan et al., Urban Institute Occasional Paper Number 26. Data were collected in March 1998.

MA also has an 1115 Expansion that began as a mandatory program 7/1/97.

Oregon has an 1115 Expansion that began as a mandatory program in 1994.

As reported by source.

Includes MH/SA programs only.

Aged population program began as a mandatory program in 1998.

Implementation beginning 7/1/98.

Table says both Mandatory and Voluntary alternative to Mandatory PCCM.

All qualified MCOs is used for the Medical managed care program. A single contractor, chosen through a competitive process, is used for MH/SA.

Aged and SSI responses refer to STAR+PLUS only.

12 Acute and 8 LTC.

SSI Population includes SSI Children, Adults Community and Adults Non-Community except where otherwise noted.

Does not include SSI Adults Non-Community.
THEMES AND LESSONS

The themes and lessons that are developed in the remainder of the paper are based on our interviews and document and literature reviews. As we emphasize throughout, however, there is no “one size fits all” approach to Medicaid managed care purchasing that will work in all states and all contexts. Each state’s approach must fit its own context, circumstances, and resources.

The pieces of each state’s overall approach to purchasing must also fit together. It is not prudent, for example, to design a Medicaid managed care program that includes data-intensive performance monitoring requirements without at the same time assessing how likely it is that MCOs will be willing and able to supply the necessary data, and that the Medicaid agency will have the resources needed to analyze and use them. There should also be some relationship between what the Medicaid agency expects MCOs to do and what the agency is prepared to pay for.

We do not expect that all of our interviewees would necessarily agree with all of the themes and lessons we have developed, or with our interpretations of the evidence we have gathered. As always, some of the evidence was conflicting. There are also limits on the ability of outsiders to fully understand and appreciate the details and nuances of each state’s experience.

With these caveats, we set out below our interpretation of the themes that emerged from our study, including best practices to emulate and pitfalls to avoid.

PARTNERSHIP AND COLLABORATION

Theme #1: States should form collaborative partnerships with MCOs, while still maintaining their ultimate responsibility to hold MCOs accountable for performance.

Medicaid agencies that have operated primarily in a fee-for-service (FFS) world have a tendency to follow a regulatory approach and to have somewhat adversarial relationships with providers, an approach that is frequently carried over into their relationships with MCOs. This rule-based regulatory “command and control” approach is common in state government, reflecting both the fiduciary responsibilities and public accountability standards states must meet and states’ relative unfamiliarity with marketplace purchasing relationships.

States following this regulatory approach may include detailed “take-it-or-leave-it” requirements in managed care RFPs, set capitated rates in ways that are not fully explained to MCOs, increase requirements in the middle of a contract period, require reports and documentation in formats that require major MCO system changes, and leave MCOs to fend for themselves when they are criticized by providers, advocates, legislators, the press, and others. The arms-length, us-vs.-them, they-have-to-do-what-we-tell-them attitude reflected in these ways of doing business is characteristic of much of the relationship between Medicaid agencies and providers in a FFS world.
Differences Between Providers And MCOs

This approach, however, ignores several important differences between FFS providers and MCOs:

- **MCOs have assumed many of the state’s prior FFS responsibilities**, including provider network development, claims payment, provider and beneficiary relations, complaints and grievances, quality and access monitoring, and reporting. While state Medicaid agencies remain ultimately responsible for assuring that these activities are properly performed, MCOs function in effect as the state’s agent on a day-to-day basis in a way that individual providers do not in a FFS world.

- **MCOs must often make major up-front investments to participate in Medicaid**, including specialized claims payment, data, and information systems; beneficiary relations and education systems; and extensive initial treatment of enrollees’ accumulated unmet health care needs. As MCOs assume responsibility for SSI, disabled, and other populations with complex care needs, they may need to make investments in specialized staff and systems for needs assessment, case management, care integration, and coordination of medical care with non-medical support systems. MCOs need some assurance that the relationship with the state will last long enough to justify these investments.

- **Most MCOs have other business options they can pursue**, either in non-Medicaid markets within the state or in other states. Since MCOs’ capital and other resources are relatively mobile, they are generally not limited by geographic and state boundaries in the same way that hospitals, physicians, pharmacists, clinics and other providers are. Declining to do business with Medicaid may not be a realistic option for individual providers that operate in areas with large Medicaid populations, and even providers not heavily dependent on Medicaid may be uncomfortable turning away individual Medicaid beneficiaries. Most MCOs are not similarly constrained.

- **The departure of an MCO from Medicaid has more consequences than the departure of an individual provider.** Even when there are other MCOs in an area to whom enrollees, physicians, and other providers can transfer, such large-scale transfers are inevitably disruptive and can interfere with continuity of care for thousands of beneficiaries.

Our interviewees—both state Medicaid agency and MCO representatives—emphasized repeatedly that collaborative partnership relations characterized by frequent and open communication and consultation, trust, and mutual respect were the key to long-term Medicaid managed care success. Given the complexities and challenges involved in Medicaid managed care, our interviewees stressed the importance of having MCOs that understand Medicaid populations and how to deal with them in a managed care context, and the difficulty of acquiring that understanding in a short period of time. Donna Checkett, CEO of a Medicaid MCO and former Missouri state Medicaid director, stated this “best practice” lesson succinctly at the October 1998 NASMD workshop: “Treat plans as long-term partners, not regulatees.”
Arizona AHCCCS staff stressed that bringing in MCO staff early on any changes or new activities, and recognizing that MCOs have expertise in areas where the agency does not, has been crucial to AHCCCS’ success. (See the box below for some of the specific things AHCCCS does to work with MCOs, viewed from the perspective of an MCO.) New Mexico, a relative latecomer to risk-based managed care and a neighbor to Arizona, has adopted a similar partnership approach towards its managed care contractors, and its Medicaid director actively encourages “win-win” problem-solving between Medicaid and MCO staff.

### Arizona AHCCCS’ Approach To Working With MCOs: An MCO Perspective

AHCCCS has several processes in place to ensure good communication with its MCO contractors, according to one of the MCOs we interviewed:

- Any changes that are to be made are communicated to health plan administrators, then to plans’ operating areas. AHCCCS then holds a technical meeting to discuss the changes and to collect feedback from contractors, which it then integrates into its changes prior to the rollout.

- AHCCCS has many task forces that include both plan and agency staff.

- AHCCCS has monthly CEO and medical director meetings with all the plans.

- AHCCCS sends contractors a monthly packet with pertinent communications and other information.

- AHCCCS provides contractors with help and technical assistance when it implements program changes.

- AHCCCS staff are accessible and available to conduct training sessions and provide materials as needed to contractors.

- Plans are encouraged to collaborate informally as well, although this may be less feasible as the program moves more toward competitive bidding.

- Over time, AHCCCS has been able to formalize communications with plans to “level the playing field.” There was a time when the more established contractors were in contact more often, and got more information from state staff compared to newer contractors, but this is no longer the case.

- AHCCCS staff generally are able to provide timely feedback to plans, and are courteous about letting plans know when delays.
Our interviews with state and MCO officials in Arizona, Iowa, Oregon, New Mexico, and a few other states resulted in consistent and positive characterizations of the relationship between the state and the MCOs—a result presumably due at least in part to the fact that the MCO interviewees were suggested to us by state officials. Even so, the same approach to selecting MCOs to be interviewed in other states led to instances in which the MCOs characterized their relationship with the state as less collaborative than our interviews with state officials had led us to believe. In one state, for example, an MCO interviewee told us the state “talks a good partnership game,” but they are “totally top down” in practice, with too much micro-management in their monitoring of implementation and performance. While our limited interviewing in each state did not permit us to resolve such conflicting perceptions, when they occurred they underscored the point that a partnership involves a multi-faceted relationship that extends over time, and that it can be undermined by instances of behavior that are inconsistent with such a relationship.

Although the adequacy of capitated rates (discussed below) is ultimately the most important factor in determining the long-term sustainability of MCO participation in Medicaid managed care, several MCO interviewees noted that they were more likely to “stick it out” when finances were tight if their relationship with the state was open, collaborative, reasonable, and businesslike.

INITIAL PROGRAM DESIGN

Theme #2: Managed care program design must fit the state’s context and circumstances.

States vary substantially in their managed care experience and market circumstances, their administrative and budget resources, and the political and organizational context in which they must operate. All of these factors must be taken into account when designing Medicaid managed care programs.

Managed Care Experience

States have widely varying degrees of commercial managed care penetration rates and MCO interest in the Medicaid business, and Medicaid agencies themselves have varying degrees of managed care experience and resources. States should be cautious about copying features from other states’ Medicaid managed care programs that do not fit well with their state’s context and experience, or that require administrative resources they do not have or cannot obtain. States like Arizona, Oregon, and Massachusetts, for example, with high managed care penetration rates, high MCO interest in Medicaid (at least until recently), and experienced state staffs can be more venturesome in designing new programs than states like Indiana, Iowa, Texas, or Georgia that have fewer of those advantages.

Administrative Resources

States should not design programs they cannot administer. If states are considering programs that could require collection and analysis of complex data for rate-setting purposes, for example, or extensive counseling of beneficiaries on a variety of managed care options, they should
determine up-front whether they have or can obtain the necessary resources either in-house (as in Arizona or Michigan) or by contracting out (as in Indiana or Massachusetts).

**Potential For Budget Savings**

States should be cautious about assuming that significant managed care savings can be achieved if reimbursement rates and/or utilization levels are already low in the Medicaid FFS program. In particular, states should look at FFS hospital inpatient and emergency room utilization and reimbursement, since those are the areas of greatest potential savings in managed care. If managed care is being extended to disabled and elderly populations, there may be potential savings in other forms of institutional care, such as nursing facilities and psychiatric hospitals.

**Political Context**

States should also consider the political context in which they are operating. How much support for Medicaid managed care is there from the governor and the legislature? (Who in the legislature? How influential are they?) What is the main basis for that support? A desire to control costs? Improve access and quality? What if managed care does not achieve those goals? Is support for managed care firm enough that it is likely to last into a new administration? (When does the governor’s term end?) Are key legislative supporters likely to remain in influential positions over time? How much opposition is there to Medicaid managed care? From legislators? Providers? Beneficiary advocates? How much influence do MCOs have in the legislature? The governor’s office? (MCOs’ political influence can be a two-edged sword for Medicaid programs, since MCOs will likely support managed care in general, but may resist efforts to hold them accountable or to limit rate growth.) How much media attention is there likely to be? Favorable or unfavorable? How much ability does the Medicaid agency have to influence all of this? To understand it?

**Organizational Context**

Relationships with other state and local agencies may also be important to the success or failure of Medicaid managed care. Medicaid managed care programs may be dependent on state departments of insurance to monitor MCO solvency; departments of public health to monitor quality of care or provide services (immunizations, primary care); and a variety of other state offices and agencies to help with eligibility determination, enrollment, beneficiary counseling, provision of services, and coordination with other programs providing needed social and ancillary services. Local governments may also play a variety of important roles in Medicaid managed care. Medicaid agencies should not assume that all of these relationships will be smooth, cooperative, and free of conflict. Substantial attention and consultation at the program design stage may head off later problems.

**Options For States With Limited Managed Care Experience**

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States with limited managed care experience and few existing risk-based MCOs should move slowly and cautiously in setting up risk-based managed care programs. States wanting to take a more cautious approach have a variety of options, including:

- Starting with non-risk PCCM programs, especially in rural areas
- Sharing risk with new MCOs, including stop-loss provisions for high-cost individual cases, risk corridors to deal with hard-to-predict overall risks for each MCO, and state-provided reinsurance for MCOs that wish to purchase it
- Phasing in the program by geographic area, starting with urban areas that already have risk-based commercial MCO capacity
- Starting with Temporary Assistance for Needy Families (TANF) and related populations, since they are easier to cover in managed care than SSI and other disabled and elderly populations
- Assuring, to the extent possible, that governors, legislators, and state budget officials do not assume that managed care savings will be large, or achieved quickly

**Issues For States With More Extensive Managed Care Experience**

States with broader and more extensive risk-based managed care experience face a somewhat different set of issues. MCOs, providers, and beneficiaries will be more familiar with managed care, and there may be multiple MCOs with the ability to serve the Medicaid population and an interest in doing so. This generally makes it easier to move more quickly to risk-based Medicaid managed care. There are some risks states should consider, however:

- **Difficulties in limiting the number of participating MCOs.** When many MCOs are interested in participating in a state’s Medicaid business, limiting the number of contracts awarded requires a competitive bidding process or some other way of excluding some interested applicants, such as reasonably demanding technical requirements for network adequacy, data and claims processing systems, financial reserves, and the like. Procurement processes can be structured to accomplish this, but such processes are administratively and legally more time-consuming and resource-intensive than accepting any willing and minimally able MCO. It may also be difficult politically to exclude some MCOs from participation, especially if they include traditional Medicaid providers or have strong political connections in the state.

- **Difficulties in monitoring multiple MCOs and assuring sufficient enrollment.** If there are a number of MCOs participating in the Medicaid managed care program, it may be time-consuming and difficult for state Medicaid agencies to monitor all of them adequately, especially those with small enrollments and/or limited information and reporting systems. MCOs themselves need a minimum number of Medicaid enrollees over whom to spread their administrative costs and medical risk, so dividing a limited number of potential enrollees among a large number of MCOs can make the program less attractive for MCOs.
• **Difficulties in attracting and retaining Medicaid agency managed care staff.** In states with high commercial managed care penetration rates, the competition for qualified staff and managers from private MCOs is likely to be especially intense. Medicaid agencies in such states may be attractive places for young people to obtain valuable managed care experience, but relatively low state salaries may make retention of experienced staff difficult.

• **Risks of over-confidence.** Medicaid agencies in states with high commercial managed care penetration rates may assume that this commercial experience can be readily transferred to Medicaid managed care. States that have successfully included AFDC/TANF and related populations in Medicaid managed care for several years may assume that this experience can be readily applied to SSI and related populations. Neither assumption is necessarily valid. States that have been successful with less demanding forms of Medicaid managed care have sometimes found that the next steps are more challenging than they expected. In Washington State, for example, the state’s program to extend managed care to the SSI population had to be closed down after less than a year of operation because MCOs were unwilling to sign contracts for a second year, citing inadequate rates, higher-than-expected costs, and overly prescriptive state requirements.7

It is a principle of botany that “nature does not proceed by leaps.”8 Neither does public policy. Incremental change usually works better. States should build on what they have. They can hedge against the risks of an unpredictable future by taking relatively modest steps in the direction they want to go, while retaining the option of falling back to less venturesome forms of managed care if they find they have pushed too far.

States should not, however, let caution bog them down in endless and inconclusive planning that tries to anticipate every potential variable and problem. Modest and incremental steps that are actually implemented are generally more useful for learning and program development than ambitious plans that never get off the drawing board. (Michigan characterizes this learning-by-doing approach as “ready, fire, aim.”)

*Theme #3* **PCCM programs can be a valuable complement to risk-based programs for a state, but they can also make risk-based programs more difficult to operate and less attractive for MCOs.**

The State Perspective

From a state perspective, PCCM programs provide beneficiaries with an improved link to primary care providers and an alternative to emergency room care. They are often more feasible in rural areas than risk-based programs. They can provide useful competition for risk-based MCOs when they operate in the same geographic area, increasing beneficiary choice and

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8 “Natura non facit saltus.” (Carolus Linnaeus, 1751).
providing incentives for both MCOs and PCCMs to improve access and quality. They can serve as a “safety valve” to ease provider and beneficiary apprehensions about risk-based managed care. Their availability can increase state bargaining leverage with MCOs, and they can provide a place for beneficiaries (and providers) to go if MCOs decide to pull out of the Medicaid market. Continued operation of a PCCM program also provides current claims data for the state that can be used to help set capitated rates in a risk-based program (with appropriate adjustment for the fact that PCCM programs are likely to have costlier enrollees than risk-based programs when enrollees have a choice). Operating both MCO and PCCM programs in the same geographic area may require that states invest additional resources in educating and counseling beneficiaries on their enrollment options, since their choices may be more complex and selection bias is potentially a greater problem. Massachusetts found that operating both programs side-by-side made enrollment more complex, while Indiana—perhaps because they encouraged beneficiaries to focus more on choosing a doctor than on choosing a delivery system—encountered fewer problems.

The MCO Perspective

From an MCO perspective, PCCM programs can make it more difficult to assemble provider networks and attract enrollees, since both providers and Medicaid beneficiaries may prefer the less restrictive PCCM option. MCOs in Indiana and other states try to offset this provider preference by paying physicians rates that are somewhat higher than those in Medicaid FFS. MCOs we interviewed in Texas and Indiana—where PCCM and risk-based MCO programs operate in the same geographic areas—indicated that reporting and monitoring requirements were much greater for MCOs than for the PCCM program. That, they said, further tilted the playing field in favor of the PCCM program.

In Iowa, by contrast, the MCOs with whom we spoke did not express great concern about competition from the PCCM program, even though the programs operate in the same geographic areas. Several factors may account for this difference between Iowa and the other states:

- MCOs in Iowa are generally not aggressively seeking new members, especially in rural areas where risk-based managed care is not popular and the PCCM program is dominant.
- MCOs say they want enrollees to have a choice and be happy with their choice, since the turnover that can result from enrollee dissatisfaction is costly.
- The state monitors the PCCM program, providing physicians with profiles of their patients’ use of hospitals, emergency rooms, and prescription drugs, and uses beneficiary surveys to compare the PCCM and MCO programs.
- MCOs do not believe the state’s monitoring and reporting requirements for MCOs are unreasonable or unduly burdensome.

Leveling The Playing Field And Improving PCCM Accountability

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9 We did not pursue issues of beneficiary education and enrollment in any detail in our interviews with states. For an excellent analysis of state practices and options in this area, see Mary S. Kenesson, “Medicaid Managed Care Enrollment Study,” Princeton, NJ: Center for Health Care Strategies, Inc., December 1997.
As the Iowa example suggests, a good way of leveling the playing field for MCOs competing with PCCM programs, and at the same time increasing the value of PCCM programs for both beneficiaries and the state, is for the Medicaid agency to hold PCCM providers to some basic access and quality standards. Some states such as Massachusetts are going further, with the state Medicaid agency seeking to function in effect as an HMO with respect to the PCCM provider network.

As of 1998, over 80 percent of the 29 states with PCCM programs reported in a National Academy for State Health Policy (NASHP) survey that they required (and spot-checked) 24-hour-a-day coverage, operated enrollee hotlines, conducted enrollee surveys or focus groups, and performed random medical record reviews. Seven of the states contracted with an outside PCCM network manager to perform some or all of these activities.10

Among the states we interviewed, Massachusetts has developed an ambitious effort to monitor its PCCM program, including profiling of providers, annual enrollee satisfaction surveys, collection of HEDIS11 data, focused quality improvement programs, and comparisons of PCCM and MCO performance. Both Indiana and Texas are also planning to expand PCCM monitoring, responding in part to the MCO concerns about leveling the playing field noted above.

States may find it easier to monitor utilization in PCCM programs than in MCO programs, since FFS claims data are available in PCCM programs, while MCOs in most states are still having difficulty submitting complete and accurate encounter data. Thus, states that want to preserve a PCCM option, while still retaining the attractiveness of the Medicaid market for MCOs, generally have the tools to do so. Even if increasing the level of accountability in the PCCM program does not completely level the playing field, it will likely leave the state with a better PCCM program.

Theme #4: “Carving out” specified services and/or providers (mental health, substance abuse, prescription drugs) from risk-based managed care can present significant care coordination and program monitoring problems.

Excluding services and providers from managed care can be especially problematic when the line between what is and is not included in the capitated rates is inherently hard to draw. (Who, for example, is responsible for treating and paying the costs for a cancer patient’s or a pregnant woman’s depression? Who is responsible for treating a psychotic patient’s drug addiction?) Even when the line may be easier to draw, as in the case of prescription drugs, there can be significant care coordination problems, since the main managed care provider will frequently not know about drugs and services that enrollees are receiving from carved-out providers. Consumers and individual providers may encounter difficulties in determining which services are supposed to be provided by whom. From a state fiscal perspective, monitoring and

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11 Health Plan Employer Data & Information Set. HEDIS 3.0 has been developed by the National Committee for Quality Assurance to help purchasers evaluate the performance of MCOs that serve Medicaid, commercial, and Medicare populations.
controlling costs may be difficult if potentially costly services such as prescription drugs and behavioral health are carved out of managed care.

Some of our interviewees commented on the inadequacies of the information and financial systems among mental health and substance abuse providers, many of whom have traditionally been funded primarily through a variety of grant programs that do not necessarily require detailed accounting for services provided. Unless such providers have prior experience in submitting FFS claims to Medicaid, it may be difficult for either the state or MCOs to adequately track utilization and costs in behavioral health carve-out programs.

Commonly Carved Out Services

As shown in table 2, the 1998 NASHP Medicaid managed care survey indicates that mental health and substance abuse services are the ones most commonly carved out and provided under a separate risk contract, followed by dental services. Prescription drugs are sometimes also excluded from MCO capitated rates and provided separately through the FFS Medicaid program. The NASHP survey reports that 34 of the 45 states with risk-based managed care programs included prescription drugs in the capitated benefit package.\(^{12}\) This is consistent with other surveys that report that approximately ten states with risk-based managed care programs exclude prescription drugs from the capitated benefit package.\(^{13}\)

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of States Providing Service in Risk-Based Managed Care Programs</th>
<th>Number of States Providing Service Through a Carve-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health</td>
<td>32</td>
<td>14</td>
</tr>
<tr>
<td>Inpatient Mental Health</td>
<td>29</td>
<td>15</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Dental</td>
<td>26</td>
<td>4</td>
</tr>
</tbody>
</table>


Why States Carve Out Services

The forces that lead states to carve some services out of risk-based managed care are highly complex, and may sometimes override considerations of clinical care coordination.\(^{14}\) States may be concerned about the ability of MCOs to provide adequate behavioral health services, especially in serious and complex cases, and so may want to leave care in the hands of the FFS providers who have traditionally provided it, despite the boundary line problems that may result. States may also want to respond to the concerns of community mental health centers and other behavioral health providers who fear competition from MCOs. Local dentists and pharmacists may also have concerns about how they would fare under managed care arrangements, and may therefore seek to have dental and prescription drug services excluded from managed care.

Many of those we interviewed indicated they believed that including behavioral health and other commonly carved out services within MCO capitated rates is generally preferable on care coordination and cost containment grounds, but noted the difficulty of doing so in the face of organized provider—and sometimes consumer—opposition.

Potential Compromises and Accommodations

States should try to assess the pressure for carve-outs they are likely to receive from providers and others when developing their Medicaid managed care programs. A variety of compromises or accommodations may be possible at the outset, with revisions over time as experience develops. Oregon and Iowa provide examples:

- **Oregon (initial demonstration, gradual phase-in, multiple options).** Inclusion of mental health benefits in Medicaid managed care was highly controversial when the Oregon legislature first initiated it in 1993, with traditional county-based community mental health centers strongly opposed. The state therefore began with a demonstration program in selected counties in 1995, and has since moved gradually to a situation in which mental health benefits are provided through a variety of different entities in different parts of the state, including full-risk MCOs that also provide physical health benefits, specialized private mental health organizations, and county and other locally based mental health organizations, with a variety of partnerships and contracting relationships developing among the different entities.\(^ {15}\) State officials report that most mental health services remain carved out, with only about ten percent integrated with physical health care, generally reflecting the preference of counties for carved-out mental health services.

- **Iowa (statewide mental health carve-out, later inclusion of substance abuse, state-assisted coordination with other services).** Iowa began planning a statewide

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managed care carve-out of Medicaid mental health services in 1993. Implementation began in 1995 with a single MCO providing mental health services, throughout the state, to all Medicaid beneficiaries (with limited exceptions). Substance abuse services were provided under a separate but coordinated statewide managed care program that also started in 1995. Mental health and substance abuse services were combined in one statewide behavioral health managed care program when the contract was re-bid in 1998. The new contract, which began in 1999, includes provisions requiring the contractor to coordinate behavioral health with other community services, a process the state facilitates by assigning high-level regional state staff to help with coordination. The MCO representatives we interviewed in Iowa who are responsible for Medicaid physical health services report that coordination with behavioral health services generally works well, since the same contractors have been responsible for mental health and substance abuse services since 1995. Most major boundary issues have now been worked out.

Apprehension about new ways of doing things is common and understandable. Moving gradually toward greater integration of services and better coordination of care gives people and organizations time to accommodate and work through the problems that inevitably arise. Over time, states and MCOs can work together to demonstrate the benefits of better care coordination and some of the adverse consequences of not coordinating adequately, using as evidence both individual cases and aggregate data on access and utilization of services. MCOs can also use the time to develop better relationships with carved-out providers.

States that want to move in the direction of greater integration will have to devote resources to solving transition problems, tracking and reporting results, and keeping up the pressure for change. States should remain open to the possibility that more formal integration and coordination of services is not the right solution for their circumstances, but that decision should be based on evidence and experience, not fear of the unknown and the untried.

**PROCUREMENT**

*Theme #5: There is a continuum from pure competitive bidding to contracting with any willing and able MCO; where states place themselves on that continuum should reflect state managed care goals and administrative capacity and MCO interest in the Medicaid business.*

According to the 1998 NASHP Medicaid managed care survey, 30 of the 45 states with risk-based managed care programs accepted all qualified bidders, while the remainder used some form of selection to limit the number of contract awards. States used a variety of selection methods, ranging from periodic competitive bidding based on formal requests for proposals (RFPs) to certification of new contractors as they were needed or as they applied. Contract awards were based most commonly on both price and technical criteria (31 of 45 states), but 14 states used only technical criteria. No state used price alone.16

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Competitive Bidding

Competitive bidding is usually designed to limit the number of MCOs that will be selected. When using this approach, states generally select new contractors only at specific points in time, grant contracts that last for specified periods, and provide that new contractors will not be added during the contract period. Competitive bidding requires states to prepare a thorough and carefully written RFP, provide substantial background information to prospective bidders, and develop a legally defensible selection process. Competitive bidding may result in lower capitated rates, but not if Medicaid FFS rates and the Medicaid upper payment limit (UPL) are already low. Competitive bidding may result in better quality proposals and performance, but only if the state is able to assess and reward higher quality. Finally, competitive bidding is effective only if there are multiple interested and qualified bidders.

Competitive bidding requires more state administrative, analytic, and legal resources than other procurement approaches. However, any approach that awards contracts to some interested MCOs and not to others may be challenged by those not selected; some state resources will have to be devoted to assuring and defending the objectivity of any selection process that excludes interested MCOs. In fact, if concerns about potential legal challenges are an important consideration, a well-run competitive bidding process with clear and defensible selection criteria is more likely to withstand such challenges than other methods of selective contracting, and so may be worth the extra investment of resources.

Any Willing And Able MCO

As noted above, 30 of the 45 states with risk programs reported on the NASHP survey that they accepted all qualified MCO bidders. Some degree of selectivity is implicit in determining which bidders are “qualified,” but those states presumably do not apply criteria other than price and minimum technical standards. Nineteen of the 45 states with risk programs reported that they use some form of certification process to determine which contractors meet minimum technical standards.

This approach of accepting all qualified bidders gives states greater flexibility in adding new contractors, and requires substantially fewer state administrative resources at the selection stage than does competitive bidding. More resources may be required at later stages to monitor quality and performance, however, since there are likely to be more MCOs in the program under this approach than if the state deliberately seeks to limit the number of participating plans. More resources may also be needed to deal with MCOs that fail to achieve enough enrollment to operate cost-effectively, or that encounter financial or performance difficulties due to weaknesses that might have been identified in a more stringent selection process.

Many of the state officials we interviewed acknowledged the potential difficulty in contracting with large numbers of MCOs for geographic areas that might not have enough

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17 The Medicaid upper payment limit is a long-standing federal regulation that provides that “Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent non-enrolled population group.” (42 CFR sec. 447.361)
potential enrollees to support all the MCOs. They indicated, however, that political, administrative, and other constraints limited their ability to be as selective as they would like. Many of them assumed that the market would eventually sort the situation out, with strong MCOs attracting the most enrollees, and others eventually dropping out or leaving the marketplace. Some states reinforce this process by requiring that MCOs have a minimum number of enrollees in order to continue as contractors.

The problem with this somewhat Darwinian approach is that both enrollees and providers in the MCOs that drop out or leave must find other alternatives, sometimes with relatively little notice. MCOs may drop out unexpectedly even in states that seek to limit the number of MCOs from the outset, but it is likely to happen more frequently when the winnowing out process is built into the program design. There may be political advantages in letting the market’s invisible hand select out low-performing MCOs or those with low enrollments—especially if those MCOs have strong political ties—but the burden on enrollees and providers from this approach can be significant. States may feel pressure to ease those burdens by, for example, making special arrangements for beneficiaries to enroll with other MCOs or revert to the FFS program, or providing some form of assistance to providers that encounter short-term financial problems. Again, state administrative resources saved on the front end by using a less selective process may have to be spent on the back end to fix problems that might have been avoided if there had been greater selectivity at the outset.

Unanticipated Consequences

The managed care marketplace is complex and rapidly changing. State efforts to influence it may have unintended consequences. In its 1998 procurement, for example, Massachusetts wanted to limit the number of MCO contractors for two reasons: to simplify its administrative activities, and to achieve greater enrollment volume among contractors, particularly for populations needing specialized care. The state therefore paid close attention during procurement to bidders’ network coverage and capacity—especially in outlying areas where few MCOs offer coverage—and adjusted its scoring to reflect the importance of this component. It also added a number of data and reporting requirements. In order to encourage stability and longer-term collaboration, the state extended the length of the contracts to be awarded from three to five years.

The two commercial MCOs that had been serving the Medicaid population decided not to bid on the contract, including the one commercial contractor (Blue Cross Blue Shield of Massachusetts) that had the potential to cover the entire state. The six MCOs ultimately awarded contracts in 1998 have limited ability to expand enrollment, especially outside the Boston area, requiring the state to rely on its PCCM program to absorb enrollment from the MCOs that dropped out. MCOs in Massachusetts appear to have concluded that plans that specialize in Medicaid have a comparative advantage in dealing with the state, given the special characteristics of the Medicaid population, Medicaid’s extensive reporting requirements, and what the MCOs viewed as relatively low rates. Massachusetts’ growing reliance on specialized

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18 Massachusetts’ 1998 Medicaid managed care capitated rates were second highest among the 36 states in the Urban Institute survey of capitated rates. Holahan, “Medicaid Managed Care Payment Methods and Capitation
Medicaid MCOs may or may not be a positive development, but the current situation does not appear to be one that was fully intended.

**Rural Areas**

States have developed several approaches to increasing competition to cover outlying or rural areas. After evaluating local hospital service areas, for example, Arizona bundled contiguous rural areas to increase enrollment volume for bidders. This action also simplified its own procurement and contract administration. Massachusetts, with a mature managed care market, redistributed payments by increasing the percent of the UPL paid in outlying areas and decreasing the percent paid in urban areas to encourage increased coverage of outlying areas. (As noted above, this did not have the desired result, since the major MCO with the ability to cover outlying areas chose not to bid.) In New Mexico, the state wanted to avoid cherry picking of the urban areas and so required its bidders to cover the entire state. The one bidder that initially excluded rural areas was required to include them.

**RATE SETTING**

*Theme #6:* There is also a continuum in the way capitated rates may be set, ranging from open bidding with no pre-set range, to rates set by the state with no discussion or negotiation. Where states place themselves on that continuum should reflect their managed care goals and resources and the state context.

The 1998 NASHP survey indicates that 35 of the 45 states with risk-based managed care programs used pre-determined state-set rates as at least part of the rate-setting process. Some states set rate ceilings or ranges, and then used competitive bidding or negotiation to settle on final rates. NASHP also reported that 19 states used negotiation and 21 used competitive bidding, sometimes alone and sometimes in combination with some form of state rate setting. Twenty states reported using more than one of the three major methods, often for different programs.19

Based on our interviews, the various different approaches to rate setting are likely to have reasonably predictable results:

- Open bidding on rates with no pre-set ceiling or acceptable range will generally result in bids that are above what the state is prepared to pay and/or the Medicaid UPL. If some bids come in substantially below the Medicaid UPL, states should be concerned that those bidders may not fully understand the program or the responsibilities they are committing to.

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• If the state sets a ceiling without providing any significant benefit to MCOs that bid below the ceiling (more points in the evaluation, more enrollees if selected), most of the bids will likely come in at or just below the ceiling.

• If the ceiling is set too far below the Medicaid UPL, few good MCOs will bid, and those that do will have significant difficulty putting and keeping provider networks together.

• Pure “take-it-or-leave-it” state rate setting is risky. If rates are set too high, there are no managed care savings; if they are set too low, there are no bidders.

• Negotiated rate setting can place large and time-consuming burdens on Medicaid agency staff and MCOs, since the “right” rate will rarely emerge unambiguously from claims and other data and from negotiators’ differing perceptions of market forces and trends.

Based on the state experiences that led us to these conclusions, we offer the following advice for states in different circumstances:

• **States with relatively little managed care experience.** Simpler is better. The state will likely have to rely heavily on outside actuaries to set the rates. The actuaries will not be familiar with the state’s FFS claims data, and state staff will likely not be familiar with actuaries’ needs and what they do. Potential MCO bidders may be skeptical about the state’s actuarial data; keeping the rate-setting methodology simple and straightforward may alleviate some of their concerns. Rate ceilings should be set as close to the Medicaid UPL as state cost containment goals will permit, since MCO risks and start-up costs are high with new programs, and quick savings are generally hard to achieve. If risk sharing is necessary to attract bidders, the state should rely on simpler forms of risk sharing, such as stop-loss arrangements (dollar limits on MCO liability for individual cases). Risk corridors (limits on aggregate MCO liability) are another possibility, but they are somewhat more complicated to administer. If it is politically feasible for the state to do so, the number of MCOs in any geographic area should be limited, based mainly on technical criteria (network adequacy, information system and reporting capacity, administrative infrastructure) that are clearly spelled out in the RFP and objectively applied.

• **States with more managed care experience.** If state managed care experience and penetration rates are relatively high, and if state Medicaid agencies have fairly extensive experience with managed care (including experience with outside contractors who can fill possible gaps in state staffing or expertise), states can be more venturesome in how they set rates and conduct MCO procurements. If capitated rates are close to the Medicaid UPL, competitive bidding or negotiation can perhaps be used to reduce them, or at least to test the market. MCOs that have more experience with the Medicaid market and Medicaid populations may be more willing to accept the risk of lower rates than those that face greater uncertainty. States with a good understanding of their claims and utilization data and MCO capabilities are in a better position to establish pre-set rate

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20 Stop-loss provisions may be especially important to MCOs if SSI and other disabled populations can enroll in managed care on a voluntary basis, since specific individuals may well require unusually expensive care.
ceilings and floors that give guidance to bidders, and to give MCOs incentives to bid below the ceilings (more points in the selection scoring, more enrollees if selected). Such states may be more confident in limiting the number of MCOs in an area on the basis of price as well as technical criteria. They may want to try hybrid rate-setting systems that combine pre-set ranges with negotiation within the ranges. To avoid appeals and lawsuits, however, the RFP and/or the state’s contract with MCOs must specify clearly when and how negotiations may occur. Experienced states may want to try more complex forms of risk adjustment, such as basing rates in part on diagnoses, especially if managed care is being extended to SSI and other disabled or elderly populations.

Openness about rate ceilings, targets, and ranges in selective procurements. We encountered substantial differences among states on the issue of how open they should be about acceptable rate ranges in procurements. Some states, such as Arizona and Michigan, do not reveal to potential bidders the rate ceiling or range for acceptable bids, or the Medicaid UPL, believing that withholding this information increases their leverage or bargaining power. California does not reveal publicly the capitated rates that are paid to MCOs, even after procurements are completed. Other states, such as Indiana and Iowa, believe that procurements are more effective if acceptable ranges are specified in advance, although they often do not disclose how close the upper end of the range is to the Medicaid UPL. States generally make public the rates that are paid to MCOs after contracts are awarded. State public record laws often require it, and confidentiality is hard to maintain in any event, since the rates are paid every month and many people are in a position to know what they are.

Disclosure in advance of acceptable rate ranges. The case for withholding information about acceptable rate ranges does not appear to us to be compelling in most circumstances. In order for this approach to produce cost savings for the state, the following conditions would have to exist: (1) the actual cost of providing good managed care is substantially below the Medicaid UPL, or what the state is potentially able to pay, (2) MCOs know what that cost is, (3) the state does not, and (4) MCOs can be enticed into revealing what they know if the state is sufficiently vague about what it knows (or doesn’t know). There may be states in which all these conditions exist, but we are skeptical. In any event, excessive secretiveness about an issue that is so central to MCOs’ ability to provide adequate care—with a reasonable return on their investment—may undermine efforts to establish the kind of open and collaborative relationship that has been the key to several states’ success in Medicaid managed care. As discussed further in the next section, there may be reasons why a state might not want to be too explicit about exactly how the acceptable range was calculated, but we believe that revealing the range itself in advance of bidding is generally a good practice.

Theme #7: States should provide potential MCO bidders with as much information as possible on past Medicaid service utilization, including full aggregate claims and/or encounter data where possible.

Detailed aggregate data on potential enrollees’ past use of Medicaid services, and the cost of those services, provide the basis for both state and MCO estimates of appropriate future capitated rates. They can also suggest potential ways of managing care more effectively in the future. These data come from past Medicaid FFS claims or from encounter data submitted by MCOs,
and are generally broken down by type of service (hospital inpatient, emergency room, physician, prescription drugs) and by type of enrollee (age, sex, eligibility category). (Data on utilization of services by specific individuals may also be useful in some circumstances, as in the New Mexico example discussed below.)

It is in states’ interest to supply potential MCO bidders with as much current data of this sort as possible. MCOs cannot bid responsibly for Medicaid business without it. States should be skeptical of bidders who think they can.

The state’s actuaries should meet with MCOs at appropriate times in the procurement process to help interpret the data and discuss general rate-setting issues. All potential MCO bidders and participants should have equal access to these sessions to ensure the integrity of the procurement process and to avoid legal challenges.

If a state sets rates on a take-it-or-leave it basis, a good deal may be gained in terms of MCO trust and confidence if the major actuarial assumptions that underlie the rates are explained, along with the methodology used to set the rates. States need not be concerned about potentially undermining competition or negotiation in this situation, since by definition there is none. Even if the state plans to move toward competition or negotiation in future procurements or contract renewals, facts and circumstances are likely to be different enough at that point to make the information revealed in the last round of rate setting only marginally, if at all, relevant.

States that use some form of competitive bidding to set rates may not want their actuaries to be too explicit about how the state has adjusted past claims data to set target rates or ranges, since the managed care savings assumptions that underlie these adjustments are likely to be an important element in distinguishing one bidder from another. (As discussed in the preceding section, there are benefits in being explicit about what the target rates or ranges are, but those benefits can be achieved without being explicit about exactly how the state has calculated the targets.) States that negotiate capitated rates should also not reveal their actuarial managed care savings assumptions, since doing so could undermine the state’s bargaining position.

Other aspects of the rate-setting methodology, such as how past trends are projected into the future, or assumptions about how much claims revenue will be collected from other insurers, are not directly relevant to MCO performance in managing care, so can generally be explained without undermining MCO competition or the state’s bargaining position.

**Helping MCOs Identify Enrollees With Special Health Care Needs**

One of the major challenges Medicaid MCOs face is accurately identifying enrollees with special health care needs and developing an appropriate plan of care. New Mexico’s Medicaid director, Chuck Milligan, reports that New Mexico uses individual-level FFS claims data to help MCOs identify new enrollees with special needs, so the MCOs can get a “jump start” on their care. The state first analyzes its FFS data to identify beneficiaries who have been heavy users of

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21 For more detail on this issue, see Margo Rosenbach and Cheryl Young, “Care Coordination in Medicaid Managed Care: A Primer for States, Managed Care Organizations, Providers, and Advocates,” Princeton, NJ: Center for Health Care Strategies, Inc., forthcoming March 2000.
FFS benefits, including prescription drugs (psychotropics, protease inhibitors, hemophilia medications, chemotherapy), private duty nursing, targeted case management, specialized wheelchairs, and home- and community-based waiver services. Once a beneficiary with special care needs has chosen or been assigned to an MCO, the state provides the individual’s claims history file electronically to the MCO.

In order to protect beneficiary privacy—and to be sure MCOs do not discourage enrollment by those with heavy care needs—New Mexico does not provide this claims history data to MCOs until after the beneficiary selects the MCO. States could provide more aggregated statistical information on special needs beneficiaries to MCOs before that, however, to help them develop their networks and identify needed specialist providers. There could be, for example, a special section devoted to such issues in the data book made available to bidders in the course of a procurement.

Theme #8: States should continuously explore ways to make the capitated rates they set reflect as accurately as possible the risks that MCOs assume, and the incentives states want to establish.

MCOs respond to financial incentives, especially those that are embedded in capitated rates. The incentives in capitated rates can have a broad impact, and they are largely self-enforcing. Since these rates will shape MCO behavior whether states want them to or not, states should think carefully about what incentives their rates establish, and whether the behavior likely to result is behavior they want to encourage. For example:

- **Higher rates for newborns.** If states want to accurately reflect the risks that MCOs assume in Medicaid, they should be sure that the capitated rates for newborns and children under one year of age are substantially higher than those for older children, since actual monthly costs for newborns are several times higher than those for children between age one and the teen years. In a recent national survey of Medicaid capitated rates by the Urban Institute, the median monthly rate for newborns was $268, while the median for children between ages one and thirteen was $63.78. The Urban Institute survey indicates that most states are now making this kind of adjustment, but a few appear not to be. Failing to reimburse adequately for the predictably higher costs of newborns may make MCOs reluctant to bid on Medicaid contracts, or to include hospitals that handle a large number of high-risk pregnancies in their networks.

- **Incentives for pre-natal care.** If states want to encourage good early pre-natal care for pregnant women, they should not average the costs of such care into the capitated rates for all women of child-bearing age, since that dissipates the incentive and gives no reward to MCOs that expend extra resources to provide women with pre-natal care early in their pregnancies. Paying MCOs higher monthly rates for women as soon as they are identified as being pregnant would align the incentives more appropriately. Since it may be administratively difficult to adjust monthly rates this quickly, an alternative approach that many states use is to pay MCOs a lump-sum amount for all pregnancy costs at the

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22 Holahan, “Medicaid Managed Care Payment Methods and Capitation Rates,” p. 30.
time of the child’s birth (sometimes called a “kick” payment). In setting the rates, pregnancy costs are excluded from the capitated rates for all women, and included instead in the kick payments that are made on top of the regular capitated rates.\(^{23}\) These flat lump-sum payments can encourage MCOs to provide good pre-natal care as early as possible, since doing so can minimize the risk of high-cost births. Using kick payments requires that both MCOs and the state have a reliable and timely way of tracking births.

**Risk adjustment of rates for SSI, disabled, and elderly populations.** SSI and related populations have widely varying but often reasonably predictable health care costs, so paying the same monthly capitated rate for all eligible beneficiaries in these categories can lead MCOs to avoid enrolling those with predictably high costs, or to stint on their care after they are enrolled.\(^{24}\) To avoid setting up such negative incentives, states have begun to adjust their capitated rates for these populations by diagnosis or health status. The NASHP reports that as of December 1998, 13 states out of the 37 that are enrolling disabled and elderly populations in risk-based Medicaid managed care were using this form of risk adjustment.\(^{25}\) While such risk-adjustment systems can be complex, extensive work is underway to improve them and make them more usable for states.\(^{26}\)

**Theme #9:** Setting managed care rates and monitoring performance will become increasingly difficult in the absence of good encounter data. The best way to assure that encounter data are complete and reliable is to use the data for rate setting and public reporting of MCO performance.

The starting point for risk-based managed care rate setting in most states (and for calculating the Medicaid UPL) has been FFS claims data. As risk-based managed care becomes more widespread, however, FFS data are increasingly less current, relevant, and available. In states that rely heavily on risk-based managed care, encounter data submitted by MCOs will likely be the only feasible option for Medicaid capitated rate setting in the future. (States that retain PCCM programs can use the FFS claims from those programs as a starting point for MCO rate setting, adjusting for the fact that PCCM programs are likely to have less healthy enrollees when beneficiaries can choose between PCCM and risk-based programs.) As discussed further in later sections, these data are also potentially very valuable for monitoring access to and utilization of services.

\(^{23}\) Out of the 41 states responding to the Urban Institute’s 1998 survey, 13 paid higher capitated rates for pregnant women, 15 made separate lump-sum payments for maternity expenses, and 4 transferred a portion of pregnant women’s maternity costs into the rates for newborns. Holahan, “Medicaid Managed Care Payment Methods and Capitation Rates.” p. 24.


The Balanced Budget Act of 1997 (BBA) requires states contracting with risk-based MCOs for Medicaid services to “develop and implement a quality assessment and improvement strategy” based on a data and information set specified by the Secretary of Health and Human Services.\(^{27}\) The proposed rule implementing this provision of the BBA provides that states must require, at a minimum, that MCOs collect and report to the state data on “services furnished to enrollees through an encounter data system or such other methods as may be specified by the State.” MCOs must ensure that the data they receive from providers are “accurate and complete.”\(^{28}\)

**State Experience**

In the NASHP survey, 44 of the 45 states with risk-based Medicaid managed care programs reported that they were collecting encounter data from MCOs for some or all services. One state reported that it relied solely on aggregate data to monitor utilization. More than half of the states reported that they collected aggregate data on utilization from MCOs as well as encounter data.\(^{29}\)

Nonetheless, our interviews indicate that Medicaid agencies and MCOs are continuing to struggle with the task of obtaining “complete and accurate” encounter data. The NASHP Medicaid managed care guide summarizes the kinds of problems states are having:

> [M]any states find that the data submitted by plans is not complete. In particular those plans that pay their subcontractors in the form of capitation often have difficulty obtaining complete information about all services delivered by these subcontractors, as the subcontractor has no built in incentive to submit encounter records for every service provided. Also, many commercial plans have developed their own coding systems for information such as provider and enrollee identifiers. Some do not use codes such as type of service that many Medicaid agencies require. As a result, plans have experienced difficulty in converting the information they collect into the codes the Medicaid agency uses, creating the potential for high error rates in those encounter records submitted to the agency.\(^{30}\)

Our interviews in Arizona and Oregon indicate that MCOs are able to develop the capacity to submit good encounter data if they know it is going to be used for something serious, like setting rates, and if Medicaid is a significant portion of their business. Using encounter data to report publicly on MCO performance can be an incentive for MCOs to submit good data. The data can be used to compare MCOs to each other and also to PCCM programs and FFS Medicaid, if those programs are operating in the state and if the populations are reasonably comparable to those being served by MCOs. Still, the strongest incentive for MCOs to submit good encounter data is its use for rate setting.

Fining MCOs for not submitting complete and accurate encounter data may have some impact, but such financial penalties are generally only effective in achieving bare-minimum

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\(^{27}\) Section 1932(c)(1)(ii) of the Social Security Act, added by the Balanced Budget Act of 1997.


The state’s goal should be to use encounter data for something important, not just to assure that the data exist in some form.

MCOs that do most of their business with Medicaid appear to find it easier to collect and report good encounter data, since they can develop or purchase specialized systems to do so without having to worry about interfacing with pre-existing data systems designed for commercial managed care purposes. They also do not have the problem of properly allocating overhead and other direct costs among Medicaid and other lines of business. Most of Arizona’s MCOs specialize in Medicaid, and have operated in the state for a number of years, so they have developed over time the ability to respond to the state’s encounter data requirements. MCOs in other states that specialize in Medicaid also told us they believe they are having less trouble submitting good encounter data to states than commercial MCOs are.

States should not underestimate the amount of time and resources needed for both the state and MCOs to develop and use good encounter data. Arizona, the state that is furthest along, has been working with its MCOs to develop good encounter data since 1991. Oregon has also been working on it for several years, and only now reports that it is able to use the data for rate-setting purposes. Wisconsin has been building up its encounter data requirements for MCOs gradually over time, starting with reporting on selected utilization indicators, with full reporting for rate-setting purposes not scheduled to occur until 2001.31

A new report by the Rockefeller Institute on Medicaid managed care management and oversight in five states underscores the kind of effort required to develop good encounter data:

AHCCCS operates regular training programs for plan and provider personnel on data submission requirements, the only agency in this [five-state] sample that does so. There is considerable formal and informal contact at the technical level between AHCCCS and plan personnel on definitional questions and other technical matters to insure comparability between plans. The state performs annual data validation audits to monitor completeness and accuracy of encounter data, and must approve any changes in plan information systems. There are potential financial sanctions associated with failure to implement audit recommendations or for inadequate reporting...32

The Health Care Financing Administration has published a detailed guide to assist states and MCOs with the task of gathering and reporting encounter data. It is available on the HCFA Web site.33

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31 Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, Wisconsin Division of Health Care Financing, Presentation at the National Academy for State Health Policy Annual Conference, Cincinnati, Ohio, August 3, 1999.
Encounter data have limits in terms of monitoring MCO performance and quality. The data only measure inputs—services provided—and do not directly measure quality of care or the impact on health outcomes. They also generally do not record care coordination, case management, and ancillary non-health services that can add significant value to managed care, although there is no inherent reason why the time and dollars spent on these services could not be recorded and reported. Nonetheless, while encounter data do not measure everything that is important in managed care, they do measure a lot, and they do it in a way that utilizes forms and systems that have existed for years in the FFS system and do not have to be invented.

MONITORING

Theme #10: States should monitor MCO performance in areas that are important to state goals, and should focus on results rather than internal MCO processes.

The September 1998 HCFA proposed rule implementing the Balanced Budget Act of 1997 sets out a large number of Medicaid managed care monitoring requirements for states and MCOs.34 While the proposed rule is quite detailed on what should be monitored, states and MCOs are still left with some discretion on how it should be done, and at what level of detail. Since states have limited resources for monitoring and oversight (an issue discussed in more detail in the next section), they must make choices about what aspects of MCO performance are most important for them to monitor.

At a minimum, state monitoring should be aimed at assuring that:

- MCOs provide care that is at least as good as FFS care
- Access to necessary services is available
- Rates paid to MCOs do not exceed the Medicaid UPL and allow the state to meet its cost containment goals
- Any MCO solvency problems come to state attention early enough for the state to make appropriate contingency plans to protect the interests of MCO enrollees

State Medicaid agencies are not capable of effectively micro-managing how MCOs do their day-to-day business, nor should they try. To the extent possible, state monitoring should focus on measures of outputs and outcomes (changes in access and utilization, complaints and grievances, satisfaction surveys) rather than on inputs and processes (credentials of providers and care coordinators, when and how MCOs contact enrollees, who authorizes services and under what circumstances, sub-capitation rates paid to specific providers).35

35 For details on how states monitor MCO access and quality performance, see Kaye, Medicaid Managed Care Vol. I, Part 1, pp. I-95-118.
Network composition, though it might be considered an input, is such an important element of an MCO’s ability to provide adequate access and quality that states should monitor carefully how MCOs develop and maintain their networks. This is especially important for MCOs that enroll SSI and other disabled and elderly beneficiaries, since their care needs can be quite complex and diverse, and the consequences of their not having access to appropriate providers and suppliers can be significant. Care coordination is also especially important for these populations. Nonetheless, once an MCO demonstrates that its network includes an appropriate mix of providers, services, and care coordination resources, given likely enrollee care needs, states can best measure network adequacy and performance over time by monitoring complaints and grievances, conducting periodic enrollee satisfaction surveys, and analyzing utilization and other data, such as HEDIS measures.

Financial Penalties and Incentives for MCO Performance

A number of states are now using financial penalties and incentives (rewards) in their MCO performance monitoring programs. A new NASHP study reports that Massachusetts and Iowa are using this approach extensively in their behavioral health managed care programs, and Rhode Island is using financial incentives and disincentives in its general Medicaid managed care program. These three states illustrate how incentives can be used to link MCO performance to state goals and strategies. According to the NASHP study:

- **Iowa** focuses its incentives on measures that relate to good clinical care, such as reductions in emergency room visits and involuntary hospitalizations; that require a “stretch” on the part of the contractor; and that are consistent with the state’s goal of developing and using community-based services. It focuses penalties primarily on areas where the contractor has significant control over performance, and where at least minimal performance is needed if the contractor is to meet contract terms (timely payment of claims, follow-up on emergency room visits).

- **Massachusetts** uses a more qualitative approach, relying primarily on consumers, family members, and advocacy groups to identify performance targets, and focusing on new service development, service coordination, service protocol development, and training.

- **Rhode Island** emphasizes quantitative performance assessments and improvements over time. The state uses incentives as a vehicle to focus MCO attention on key quality indicators where the state is seeking improvements. Reflecting its philosophy of working as a partner with its contractors, the indicators are developed in collaboration with the MCOs. Penalties tend to focus primarily on administrative areas and on access and quality performance standards set forth in the contract and in regulations.

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36 CHCS has commissioned Suzanne Felt-Lisk of Mathematica Policy Research to prepare a paper to help states improve their ability to assess the adequacy of MCO provider networks, especially for SSI and other vulnerable populations.

As these examples illustrate, effective use of financial penalties and incentives requires that states link them to clear state policy or operational goals, and that the state have a way of tracking and monitoring performance. States also need to consider how estimated net penalty and incentive payments relate to the Medicaid UPL and state budget limits.

Theme #11: States should not collect information they are not able to use, or in forms that needlessly depart from managed care industry standards.

MCOs we interviewed, with few exceptions, said states were requiring MCOs to collect and report much more information than states were able to analyze or use. Few states disagreed. States should therefore consider carefully whether they have the intention or the ability to use data before they ask MCOs to report it. Chuck Milligan, New Mexico’s Medicaid director, made this point succinctly at the October 1998 NASMD workshop and in a subsequent article:

Don’t buy more than you can eat. As prudent purchasers, states need to be careful not to seek more information than they will use to monitor the program. States need to be careful not to compel managed care organizations to generate more information than the states can afford to buy. States must be prudent about the temptation to ask managed care organizations to generate more and more reports, and more and more information system changes, where the cost of generating the information exceeds the benefit derived.38

If states have no one on their Medicaid staff or among their contractors who can analyze and interpret information on, for example, the number of miles each MCO enrollee lives from her primary care provider, or the type of treatment the MCO provides for diabetics, little is gained by requiring MCOs to submit that information. If the state does not intend to do anything with information that is submitted, and/or does not provide MCOs with regular feedback on it, MCOs will quickly stop taking the information submission requirements seriously and the information will soon become useless.

States should work with MCOs to coordinate the state’s information submission requirements with requirements MCOs must meet for their other lines of business (commercial and Medicare). If data compiled for these other purposes comes close to what the Medicaid agency needs, little may be gained by requiring the MCOs to “cross-walk” the data into different forms.

States should be realistic about what they can do with the managed care staff and other resources they have, or are likely to be able to get. In the 1998 NASHP survey, for example, 40 percent of the states responding indicated they had ten or fewer people working on all aspects of Medicaid managed care.39 Even states with large managed care staffs, such as California (180), have only a handful of people working on data analysis issues. Arizona, which makes the greatest use of data for monitoring and rate-setting purposes, is an extreme outlier in terms of

38 Chuck Milligan, “A Purchaser’s Perspective on Medicaid Managed Care,” Managed Medicare & Medicaid, November 9, 1998, pp. 4-5.
total staff: it reported having 1,159 Medicaid managed care staff in the NASHP survey, over four times the number in the next-highest state. (Since Arizona’s entire Medicaid program is under managed care, that number represents the program’s entire staff.)

**Some Examples of State Responses**

Several states we interviewed were making efforts to simplify their quality monitoring requirements in response to concerns that excessive state and federal requirements may be diminishing Medicaid’s attractiveness to MCOs. Texas has eliminated extra medical and behavioral health audits and now requires only one, rather than two, clinical focused studies per year. Texas Medicaid staff also are working with other state agencies (Department of Insurance, Texas Health Care Data Commission) to use existing information submitted by MCOs in order to avoid duplication. Similarly, Michigan is working with an MCO work group to simplify the MCO licensing process and to decrease the burden on providers in clinical focused studies. Michigan also has formed a Clinical Advisory Committee to facilitate the sharing of clinical and utilization information among MCOs when their Medicaid populations are small. Arizona uses the performance and quality data it collects from incumbent contractors in its annual on-site financial and operational reviews in its procurements, which now occur on a five-year cycle. Incumbent contractors that have met state standards in the annual on-site reviews are not required to submit additional information in these areas as part of the procurement process.

Two states we interviewed provided examples of their efforts to work with MCOs to identify reporting formats that are useful and achievable, given variations in MCOs’ information systems. Massachusetts initially asked MCOs to submit the data in ways that fit best with each MCO’s own reporting system. The state then plans to choose the ones that best fit its needs and MCO standards as the standard reporting format. Similarly, Texas staff have indicated a desire to move away from writing detailed reporting specifications to asking MCOs what they have that may fit the agency’s needs.

As discussed further in the next section, data that are going to be used to compare one MCO to another must be collected using standardized formats and definitions, putting some limits on the flexibility that can be allowed. If states and MCOs work together in advance to determine which areas should be emphasized in making these comparisons, however, efforts at standardization can be focused on those areas, while allowing flexibility in others.

**REPORTING**

*Theme #12: States should regularly and publicly report on state and MCO managed care performance, focusing on areas that the public, MCOs, beneficiaries, and providers care about and can understand.*

One of managed care’s main advantages over FFS Medicaid is that there can be greater public accountability for performance in managed care. In the FFS system, most beneficiaries have only a limited basis for comparing one provider to another: primarily their own experience and that of their friends. In managed care, by contrast, there are entities—MCOs and the state—that
can compare providers to each other on a number of dimensions relating to access, quality, and cost.

State Medicaid agencies should therefore regularly publish reports on key dimensions of MCO performance. States with PCCM programs should also report on performance in those programs, as discussed earlier. States should also report on their own performance as purchasers, including the state’s responsiveness to complaints and grievances, requests for information, and the like.

As noted earlier, standardization is important when comparing MCOs to each other. Medicaid HEDIS facilitates this kind of standardization, but not all MCOs are capable of producing the encounter and other data that are needed to prepare reliable HEDIS-based comparison reports. States may therefore want to begin with some more modest measures. Some basic dimensions of MCO performance that can be reported fairly readily include:

- **Access**: number of primary care physicians per enrollee in MCO networks, annual physician visits per 1000 enrollees

- **Quality of care**: childhood immunization rates, emergency room admissions for asthma treatment, prenatal visits for pregnant women

- ** Appropriateness of care**: trends in inpatient hospital and emergency room utilization, prescription drug utilization per 1,000 enrollees

- **Complaints and grievances**: number and type, how resolved

- **Costs**: annual costs per beneficiary in managed care compared to FFS

- **Beneficiary and provider satisfaction**: results of satisfaction surveys

MCOs may be uneasy about having such information published with MCO names attached to the results. Some states publish such “report cards” without identifying MCOs by name. This may be a reasonable compromise, especially if data are still somewhat incomplete and unreliable, or if there are concerns about selection bias in MCO enrollment. But the data will never become better and more reliable if they are not used, or if they do not have real consequences for specific MCOs, so public reporting with MCO names attached should be the ultimate goal.

Some states, such as Maryland, have made major investments in gathering comparative data on MCO performance and publishing the results.40 Such data can be especially valuable for state

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purchasers and for MCOs seeking to improve their performance. There are still challenges in making performance data useful for consumers, however.41

States should of course work closely with MCOs before data of this sort are released to make sure they are as accurate and complete as possible. States should also be sure that MCOs have full notice in advance of any public release of the data. Ideally, the state and the MCOs should release the information jointly, with both emphasizing that the release is part of a continuing effort to improve performance over time and to demonstrate accountability to the public, enrollees, and providers. It should not be an occasion for finger pointing or assignment of blame. If the performance of some MCOs is clearly inadequate, it should be evident enough from the data without invidious comment.

Most states have moved very cautiously in publicly reporting comparative data, however, even states like Arizona that have extensive managed care experience, good data, and good analytic staffs. The Rockefeller Institute found that data reports in the five states they looked at are rarely distributed to plans or to consumers, and there is little explicit comparison of performance. While Arizona does not routinely distribute information to consumers, the Rockefeller study notes that it has several mechanisms that have the effect of encouraging plans to compare their performance to other plans and that provide limited awards for performance:

*The state regularly distributes comparative information on plan and provider performance to plans and providers, with a plan or contractor’s performance rated against the average of other plans or providers or unidentified data from all other organizations. AHCCCS is currently developing an initiative to provide some limited financial awards to high performers and provides some preference to high-performing plans in the contracting process.42*

Arizona Medicaid officials told us they were planning to make more MCO performance data available to consumers, beyond the data on child immunizations that the state has regularly made public. Public reports are planned on well-child visits, cervical cancer screenings, dental visits, member satisfaction, and provider satisfaction. The Arizona officials stressed that, as with the immunization data, the information would be shared with the MCOs before it was made public.

The Arizona MCOs with whom we spoke indicated they did not have concerns with public reporting of comparative data that was closely related to the quality of patient care, such as child immunizations. They did express concern with public release of comparative data on matters they considered “proprietary,” however, such as their costs for particular services, or utilization data such as inpatient days per 1000 enrollees. States should consider whether the value of this kind of cost and utilization data to the public outweighs such MCO concerns. States could of course use the cost and utilization data internally, for purposes of rate setting and negotiation.

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42 Fossett, “Managing Accountability in Medicaid Managed Care,” p. 39.
with MCOs, without making it available to the public or to MCO competitors, assuming that is permitted by state public access rules.

REFINEMENT AND REDESIGN

Theme #13: Medicaid managed care is (and should be) a work in progress; the best state Medicaid programs and MCOs learn from their mistakes and successes and continuously seek to improve.

Medicaid managed care is a complicated business; states and MCOs should not expect to get it exactly right the first time. States should continuously monitor their own performance, learn from their mistakes, avoid being defensive, and never hesitate to change what is not working. States that are visibly working hard to improve, and demonstrating some results, are likely to get more credit than those that react passively, avoid risks, and resist change.

States with long experience in managed care and highly regarded programs, such as Arizona and Oregon, were quite open in their discussions with us about the mistakes they had made and what they had learned from them. This attitude carried over into their relationships with MCOs. The MCOs in these and other generally successful states reported that state officials were open to advice and alternatives, and were good and responsive listeners.

This approach of admitting and learning from mistakes represents a significant shift from the regulatory mode. State regulators are generally reluctant to admit mistakes, in part because doing so could land them in court or require time-consuming re-promulgation of regulations. In their role as purchasers, however, all the states we interviewed said they had found, through trial and error, ways to improve their programs the second and third times around, from streamlining procurement requirements for existing contracts (Arizona) to streamlining their quality assurance processes (Oregon).

Working collaboratively with MCOs as partners, communicating openly with them, and taking their expertise seriously has been a new way of doing business for many states. The level of trust between MCOs and the state that is needed to operate in this way takes time to develop. Both sides must demonstrate through their actions that they really are partners. They need to walk the walk, not just talk the talk.

CONCLUSION

The states we have looked at in this study have met challenges of great complexity and consequence. State Medicaid managed care programs are businesses that purchase hundreds of millions (often billions) of dollars worth of health care services each year on behalf of some of
the nation’s most vulnerable citizens. These programs are expected to be more broadly accountable than most private businesses, usually with fewer resources and less flexibility.

States have developed a wide variety of tools and approaches to meet these challenges, learning from their successes and setbacks and those of other states. No one set of tools is right for every state, and changing circumstances within states require continuous reexamination of current approaches. To adapt the available tools to their circumstances, states should:

- Think carefully about what the state’s managed care goals are, what administrative and other resources are available to accomplish them, and what the managed care environment is like in the state and how it may change.

- Work collaboratively with the MCOs and providers that are most interested in Medicaid managed care to refine and improve the managed care program over time.

- Remember that accountability is about measurement and results. States can only tell what works and what doesn’t if they keep track of what they are doing and measure its impact.

We hope this report will help states continue to learn from each other and from their own experiences.
APPENDIX A

State Medicaid Agency and Managed Care Organization Interview Guides
INTERVIEW GUIDE – STATE MEDICAID AGENCIES

I. GENERAL PROGRAM INFORMATION

1. Managed care experience and penetration43

   (1) Have managed care penetration rates in the state been increasing or declining in recent years? In Medicaid? Medicare? Commercial?
   (3) How many of the state’s Medicaid MCOs are Medicaid-only (90% or more Medicaid business)? How many enrollees or “covered lives” do these MCOs have?
   (4) How much of Medicaid managed care in the state is risk-based (capitated) versus primary care case management (PCCM) fee-for-service (FFS)?

II. PROCUREMENT — RISK-BASED MANAGED CARE

1. Motivation for using Medicaid managed care

   (1) What was the state’s motivation for turning to managed care? What were the basic policy goals behind the decision to use managed care for the Medicaid population?

2. Rate setting

   (1) What method does the state use to set rates? Has the state changed its rate-setting methodology since its last contracting cycle? What prompted these changes?
   (2) Has the state used competitive bidding or negotiation to set rates in the absence of claims data? How does the state assess MCO bids or proposals?
   (3) What has been the rate of change in per-member per-month (PMPM) Medicaid capitated rates in your state over the last few years?
   (4) How close is the state to the Medicaid upper payment limit?44

3. Contract selection

   (1) Please describe the current method the state uses in selecting qualified managed care plans. Has the state changed this methodology since its last contracting cycle? If so, what changes have been made? What prompted the changes?
   (2) How much data on past claims experience does the state provide to MCO bidders and their actuaries?
   (3) How much does the state reveal about the basis for and the methodology of its capitated rate calculations? Does the state reveal the range within which bids will be considered acceptable?

43 We will obtain as much of this information as possible from published sources in advance of the interview.
44 The upper payment limit is a federal regulatory requirement, initially promulgated in 1978 and revised in 1983, that provides that under a risk contract “Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing these same services on a fee-for-service basis, to an actuarially equivalent non-enrolled population group.” (42 CFR sec. 447.361)
(4) How are health plans’ bids evaluated? Does the state have criteria on which proposals are scored, with price as one aspect of the total score? Or, does the state score bids on non-price (technical) items, and then evaluate the cost bid of those that meet a minimum standard?  
FOR PRICE AND TECHNICAL COMBINED SCORING: What weights are given to price and technical components?  
FOR TECHNICAL-ONLY SCORING: What criteria do the state use? How are these evaluated and quantified? 

(5) How are the cost proposals evaluated? Are proposals eliminated if their proposed rates are over a pre-determined limit? 

4. Negotiation and contracting 

(1) Once bids are evaluated, how does the state conduct its negotiation and contracting? What information is given to plans to prepare for negotiation? 

(2) Does the state limit its contracts, or award contracts to all qualified bidders, or sole source contract? 
IF STATE LIMITS CONTRACTING: What is the limit (e.g., per county or geographic region)? How does the state set the limit? 

(3) Are the rates paid to winning bidders made public? What is the likely impact on MCO willingness to bid for Medicaid business of state openness (or lack thereof) on these issues? 

(4) What was the final outcome? Has this process been competitive and is the state satisfied with the final pricing? 

5. Duration of contracts and provisions for periodic re-bidding 

(1) How frequently are contracts re-bid? 
(2) How frequently are capitated rates changed? 
(3) How are capitated rates changed? (Set by state, negotiation, other) 
(4) In the absence of re-bidding, what non-rate changes are permitted? Using what kind of process? Do you think this additional flexibility/uncertainty makes MCOs more or less inclined to bid on Medicaid business? 

III. PROGRAM DESIGN 

1. Risk-based MCOs only, or retain a PCCM option 

FOR RETAIN PCCM STATES: Questions 1-15  
FOR MCO-ONLY STATES: Begin at question 8 

(1) Why has the state chosen to retain a PCCM option rather than go with risk-based managed care organizations (MCOs) only? 
(2) What major changes have been made to the PCCM program since its inception? What prompted those changes?
(3) What are the state’s long-term plans for the PCCM program?

(4) How many staff does the PCCM program have? What responsibilities has the PCCM program chosen to keep versus contract out (e.g., claims processing, customer service)? Is this number sufficient to adequately monitor the program?

(5) Is there collaboration or coordination between the PCCM and MCO programs in areas such as quality monitoring and assurance?

(6) If risked-based MCOs and PCCM operate in the same geographic area, how does the state prevent the sickest and most costly beneficiaries from being inappropriately steered to the PCCM program?

(7) Has the presence of the PCCM program increased the competitive pressure on MCOs?

(8) Why has the state chosen to implement a risk-based managed care strategy? What are the state’s long-term plans for the MCO program?

(9) What major changes have been made to the MCO program since its inception? What prompted those changes?

(10) How many staff does the MCO program have? Is this number sufficient to adequately monitor the various health plans?

(11) What responsibilities has the MCO program chosen to keep versus contract out (e.g., enrollment)?

(12) What kind of relationship does the state have with its managed care plans? Is it a partnership, or more adversarial?

(13) How does the state prevent the sickest and most costly beneficiaries from being inappropriately steered to one or two health plans?

2. Carve-out of specified services

(1) Has the state carved out any services from its capitated payment to managed care plans?

(2) How are these services provided for and reimbursed?

(3) Would the inclusion or exclusion of these services from Medicaid risk-based contracts affect the willingness of MCOs to bid and continue to participate?

IV. MONITORING AND REPORTING

1. Medicaid managed care reporting and monitoring requirements

(1) How does the state monitor quality of care?

(2) What types of information does the state collect from health plans?

(3) How does the state use health plan encounter data? What are the state’s highest-priority uses for encounter data? Does the state require the kinds of encounter data that other purchasers require, and that MCOs should be keeping for their own purposes?

(4) How closely do the state’s requirements correspond to the requirements MCOs must comply with in their commercial and Medicare business?
(5) Does the state report the results of its quality monitoring efforts to the plans or to the public?
(6) What can the state do if it finds a plan that does not meet its quality assurance standards? Has the state imposed any penalties or developed an action plan for health plans that are inadequate? How much time do plans have to resolve problems?
(7) Has the state increased the monitoring, oversight, and reporting requirements for Medicaid managed care organizations (MCOs) in recent years?

2. Public reporting of MCO and PCCM performance data

(1) Is the data on MCO and PCCM performance publicly reported?
    If so, in what format, in what context, and aimed at what audiences?
(2) When does the state expect to have data that are reliable enough to be publicly reported?

V. LESSONS LEARNED

(1) What seems to work and what doesn’t in the current Medicaid managed care purchasing context in your state?
(2) What are some of the potential pitfalls and early warning signs that states should watch for in their purchasing efforts?
(3) What have been the most important mistakes to avoid?
(4) What have been your greatest successes?
(5) What are some of the most interesting new developments to watch in your state?
I. GENERAL PROGRAM INFORMATION

1. Managed care experience and penetration rates

(1) How long has your organization participated in Medicaid managed care in this state?
(2) What percentage of your business is in:
   Medicaid risk: ___________________
   Medicare risk: ___________________
   Commercial (non-ERISA): ____________
(3) How does serving the Medicaid population fit in with your organization’s long-term business plans?

III. PROCUREMENT — RISK-BASED MANAGED CARE

1. Rate setting

(1) Does the state Medicaid agency share how it sets rates with managed care organizations (MCOs) as part of the bidding process? If so, how much does the state reveal about the basis for and the methodology of its capitated rate calculations? Is there anything noteworthy about the method the state uses to set rates?
(2) Has the state changed its rate-setting methodology in any significant ways since its last contracting cycle? If so, what changes were made? What prompted these changes?
(3) How much data on past claims experience does the state provide to MCO?
(4) Does your organization use other data in developing its bid? If so, what are the data?
(5) Does the state reveal the range within which bids will be considered acceptable?
(6) What has been the rate of change in per-member per-month (PMPM) Medicaid capitated rates in your state over the last few years?
(7) Do you know how close the state is to the Medicaid upper payment limit?45

2. Contract selection

(1) How does the state select qualified managed care organizations (MCOs) for its Medicaid program?
(2) Has the state changed this methodology since its last contracting cycle? If so, what changes have been made? What prompted the changes?
(3) How are health plans’ bids evaluated? Does the state have clear criteria on the basis of which proposals are scored?
(4) Does the state share what weights are given to price and technical components?

45 The upper payment limit is a federal regulatory requirement, initially promulgated in 1978 and revised in 1983, that provides that under a risk contract “Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing these same services on a fee-for-service basis, to an actuarially equivalent non-enrolled population group.” (42 CFR sec. 447.361)
(5) FOR TECHNICAL-ONLY SCORING: What criteria do the state use? How are these evaluated and quantified?

3. **Negotiation and Contracting**

   (1) Once bids are evaluated, how does the state conduct its negotiation and contracting? What information is given to plans to prepare for negotiation?

   (2) IF STATE LIMITS CONTRACTING: What is the limit (e.g., per county or geographic region)? How does the state set the limit? Do you think this method is appropriate?

   (3) Are the rates paid to winning bidders made public? What do you think is the likely impact on MCO willingness to bid for Medicaid business of state openness (or lack thereof) on rate issues?

   (4) In general, how would you characterize the aggressiveness and sophistication of the Medicaid agency on price, quality, and data management compared to your commercial clients? How have purchasing priorities for the Medicaid agency changed since the last contracting cycle?

4. **Duration of contracts and provisions for periodic re-bidding**

   (1) How frequently are contracts re-bid?

   (2) How frequently are capitated rates changed? How are the rates changed?

   (3) In the absence of re-bidding, what non-rate changes are permitted? Using what kind of process? Do you think this additional flexibility/uncertainty makes your organization and competing MCOs more or less inclined to bid on Medicaid business?

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**III. PROGRAM DESIGN**

1. **Risk-based MCOs and the PCCM option (For states with PCCM option)**

   (1) In your opinion, has the presence of the PCCM program increased the competitive pressure on MCOs? Has the PCCM program affected MCOs in other ways?

   (2) To your knowledge, is there collaboration or coordination between the PCCM and MCO programs in areas such as quality monitoring and assurance?

   (3) IF RISK-BASED MCOs AND PCCM PROGRAMS OPERATE IN THE SAME GEOGRAPHIC AREAS: Does the state have safeguards to prevent the sickest and most costly beneficiaries from being inappropriately steered to the PCCM program? How effective are these safeguards?

2. **Risk-based MCOs**

   (1) What major changes have been made to the MCO program since its inception? What prompted those changes?

   (2) What improvements or refinements has the MCO program made in its oversight of health plans? In your opinion, does the MCO program have the expertise and staff to adequately monitor the various health plans?
(3) How would you describe the relationship the state has with its managed care plans? Is it a partnership, or more adversarial?
(4) What problem-solving mechanisms exist to solve disputes between the state and the plan?
(5) What kinds of incentives and penalties does the state use with MCOs?
(6) How does the state prevent the sickest and most costly beneficiaries from being inappropriately steered to one or two health plans?

3. Carve-out of specified services

(1) Has the state carved out any services from its capitation payment to managed care plans? Why are these services carved out?
(2) How are these services provided for and reimbursed? How has your organization tracked and managed utilization for these services?
(3) Do you think the inclusion or exclusion of these services from Medicaid risk-based contracts affects the willingness of your organization and fellow MCOs to bid and continue to participate?

| IV. MONITORING AND REPORTING |

1. Medicaid managed care reporting and monitoring requirements

(1) What activities does your organization use to monitor quality of care? How does your organization monitor the special needs of the Medicaid population?
(2) What types of information and data does your organization provide the state?
(3) How does the state use health plan encounter data? Given the state’s needs and analytic resources, how could encounter data reporting requirements be more focused?
(4) How closely do the state’s requirements correspond to the requirements MCOs must comply with in their commercial and Medicare businesses?
(5) Does the state report the results of its quality monitoring efforts to the plans or to the public?
(6) What has the state done if it finds a plan that does not meet its quality assurance standards?
(7) Has the state increased the monitoring, oversight, and reporting requirements for Medicaid MCOs in recent years? What prompted these actions? How has your organization responded to these changes?
(8) What determines your organization’s responsiveness to the state’s initiatives and requests?

2. Public reporting of MCO and PCCM performance data

(1) Is the data on MCO and PCCM performance publicly reported? If so, in what format, in what context, and aimed at what audiences?
(2) If not, when do you think the state expects to have data that are reliable enough to be publicly reported?
V. LESSONS LEARNED

(1) In your opinion, what seems to work and what doesn’t in the current Medicaid managed care purchasing context in your state?
(2) What are some of the potential pitfalls and early warning signs that states and managed care plans should watch for in state’s managed care purchasing efforts?
(3) What have been the most important mistakes for your organization to avoid?
(4) What have been your organization’s greatest successes in working with the Medicaid program? What have been the greatest challenges?
(5) What are some of the most interesting new developments to watch in your state?