



A Guide for Health Care Advocates: Medicaid Managed Care Procurement

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Overview

Most Medicaid beneficiaries in most states are enrolled in managed care organizations (MCOs). (See text box, “What’s a Medicaid MCO?”) State Medicaid agencies contract with MCOs to assemble networks of health care providers to furnish services to program beneficiaries and protect them from medical debt. Simply put, if an MCO does not do its job, Medicaid does not work for its enrollees. The easiest way for a state Medicaid agency to make sure MCOs do their job is to contract only with high-performing MCOs. So, how does a state Medicaid agency choose the MCOs with which it contracts? Can that selection process protect beneficiaries (and the agency) against low-performing MCOs and incentivize high-performing MCOs to do even better? What are the potential leverage points for child and maternal health advocates?

The purpose of this Guide is to help advocates use the procurement process to improve the performance of Medicaid MCOs for children and families. Procurement is only one of several [tools available to beneficiary advocates](#) for improving MCO performance—administrative advocacy, [transparency](#), state legislative oversight, and litigation are also options. Unlike these other advocacy tools, however, procurement is an occasional, not an ongoing, opportunity. Once a procurement is concluded, the state Medicaid agency, beneficiaries, and providers will, as a practical matter, have to live with the MCOs selected (and the new contracts under which they operate) until the next procurement comes around. The interval between procurements can be several years or more, so it is particularly important for advocates to help ensure that the state Medicaid agency chooses wisely.



Medicaid is famously state-specific. As much [flexibility](#) as states have in designing eligibility, benefits, and provider reimbursement policies, they have even more in managing MCO procurements. This Guide does not try to capture all of this variation. Instead, it explains how procurements work in general, why they matter to children and families, and what the potential points of leverage are for advocates.

In short, this Guide is a starting point. It includes some suggested action steps, but advocates will have to tailor their strategies to their state's unique process and their own bandwidth.



WHAT'S A MEDICAID MCO?

A Medicaid managed care organization (MCO) is an entity that contracts with a state Medicaid agency to deliver covered services to beneficiaries. It can be public, nonprofit, or for profit. As of March 2022, a total of [283 MCOs](#) were operating in 40 states and the District of Columbia. Of these, 118 were owned by one of the [five national publicly-traded companies](#).

Under the contract, the state agency pays the MCO a fixed amount each month (known as a capitation payment) for each beneficiary enrolled, regardless of whether the beneficiary uses services during that month. In exchange for this capitation payment, the MCO is responsible for assembling and maintaining a network of providers to deliver the services

covered under the contract to its enrollees. It's also responsible for ensuring that its network providers do not balance bill enrollees for furnishing covered services.

The purpose of capitation is to reverse the incentive of a fee-for-service delivery system for providers to increase the volume of services they deliver in order to generate more revenue. Under capitation, the incentive for the MCO is to reduce the volume of services that it pays for by managing the care delivered by its network providers to its enrollees. At this point in the story, things start to get very complicated very quickly; for additional resources, see Appendix 3.





What is Medicaid MCO procurement and why does it matter to children and families?

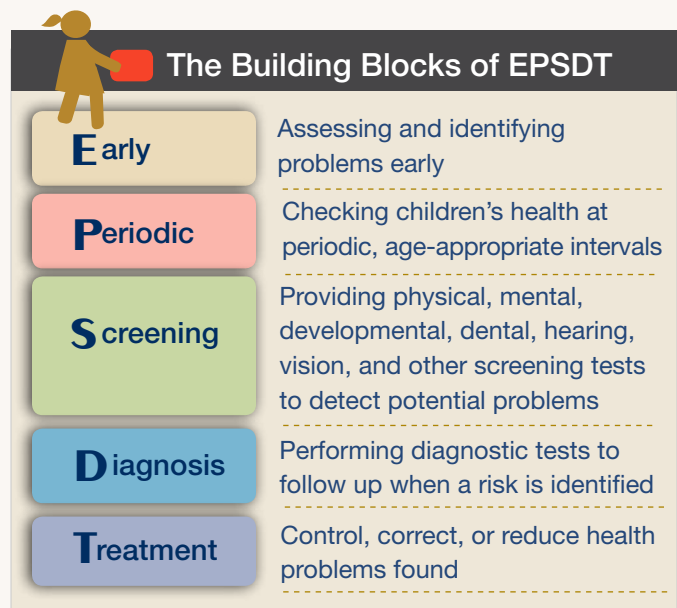
State Medicaid programs have broad discretion to decide whether to contract with MCOs and if so, for what populations and what services. *Procurement—also known as re-contracting or re-procurement—is the process that managed care states use to decide which MCOs they will contract with, and what the requirements of those contracts will be.*

Why does procurement matter? Because the MCO in which a beneficiary enrolls is, for all intents and purposes, the Medicaid program for that beneficiary. State Medicaid agencies pay MCOs to build and maintain provider networks and manage the use of services by enrollees through reviews of provider claims and care coordination. If an MCO performs well—if enrollees have access to the services they need when they need them, and the services are of high quality—Medicaid works. If an MCO performs poorly—if the provider network is limited, if the services furnished by network providers are of poor quality, if the MCO constantly denies provider claims for payment, etc.—Medicaid does not work.

In the case of children, whether they receive the EPSDT services they need depends almost entirely on how well the MCO and its provider network perform (see text box, “EPSDT Services”). For pregnant women, access to prenatal, delivery, and postpartum services is heavily dependent on the composition and quality of the MCO’s provider network. For all enrollees—children, pregnant women, and other adults—how effectively an MCO identifies and addresses racial and ethnic disparities among its enrollees will affect whether those disparities are reduced.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SERVICES

Every child enrolled in Medicaid is entitled to a comprehensive pediatric benefit: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. (For the purposes of EPSDT services, a child is any individual under age 21.) Entitlement to EPSDT services exists regardless of whether the state uses a managed care delivery system or a fee-for-service (FFS) delivery system for its Medicaid program. States are required to inform all Medicaid-eligible children (or their families or caregivers) of the availability of EPSDT services, provide or arrange for the provision of screening services, and arrange for any treatment that is determined to be necessary as a result of these screenings. This can include assisting with making appointments, making referrals for corrective treatment, and arranging for transportation to services. States can conduct this outreach themselves or include it in their contracts with MCOs. For additional information about EPSDT benefits, please see Appendix 3.





How can procurement strengthen managed care performance for children and families?

Procurement offers two opportunities for a state Medicaid agency to reset its program. First, procurement gives the agency a chance to strengthen its contracts with MCOs to improve access and health outcomes for beneficiaries and reduce racial and ethnic disparities (see text box). Second, procurement gives the agency an opening to part ways with a low-performing MCO and replace it with a high-performing MCO. It also allows the agency to keep low-performing MCOs out of its program in the first place by awarding contracts only to better-qualified competitors.

Given the realities of the procurement process (see next section), whether a state Medicaid agency can take advantage of these opportunities is an open question. But there is no question that the procurement process is potentially a way in which advocates can leverage improvements in state Medicaid policy for children and families, create requirements for improved performance by individual MCOs going forward, and encourage the state to weed out substandard incumbents.



MCO PROCUREMENT AND RACIAL AND ETHNIC DISPARITIES

In its June 2022 [report to Congress](#), the Medicaid and CHIP Payment and Access Commission (MACPAC) observes that “Health disparities have long existed between Medicaid beneficiaries of color.” It recommends that “Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes.” Racial and ethnic disparities are an issue in managed care as well as fee-for-service states. [Research](#) on differences in health care spending and utilization in three managed care states in 2016 found that Black enrollees used fewer services than White enrollees but had higher emergency department use. Among children 18 and younger, annual spending on Black children was 14 percent lower than on White children, and primary care encounters were 23 percent lower for Black children than White children.

MCO procurement is one policy lever available to state Medicaid agencies to address racial and ethnic disparities. (Use of this policy lever is optional for states; federal managed care regulations are silent on this point.) Among states

that are using MCO procurement to advance health equity, there is no standard approach. The requirements some state agencies have included in their MCO contracts (sometimes accompanied by financial incentives) range from developing health equity plans, to addressing Social Drivers of Health, to reporting quality measures by race, ethnicity, and language. ([Advocates in Florida](#) helped to persuade their legislature to require each MCO to publicly report performance measures by age, race, ethnicity, primary language, sex, and disability by 2026.) The National Committee on Quality Assurance (NCQA), which developed quality measures that are commonly used in Medicaid managed care contracts, has added [breakouts by race and ethnicity](#) for four of those measures, including child and adolescent well care visits and prenatal and postpartum care, starting in 2022. For a compendium of state MCO contract provisions designed to advance health equity, see the [scan](#) commissioned by State Health & Value Strategies (SHVS).



Revising and Improving State Contracts with MCOs

In states where most Medicaid beneficiaries are enrolled in MCOs, a key vehicle for state Medicaid policy is the risk contract between the state Medicaid agency and the MCOs (see text box, “MCO Risk Contracts”). The requirements in that contract spell out what the state expects of the MCO in exchange for the monthly capitation payments the state makes: what services the MCO must provide, how robust the provider network has to be, what performance metrics the MCO will be held to, etc. Some policy advocates see state contracting with MCOs as an opportunity to advance broader delivery system reforms—both [by states](#) (in contracting with MCOs) and by [MCOs](#) (in subcontracting with network providers). For more detail on MCO contracts, see Appendix 2.



MCO RISK CONTRACTS

An MCO risk contract is the legal document that sets forth the terms of the agreement between a state Medicaid agency and an MCO. It’s called a risk contract because the state Medicaid agency is, at least in theory, transferring the financial risk of paying for health care services to which beneficiaries are entitled from itself to the MCO. The transfer occurs because the state agency pays the MCO a fixed capitation payment for each enrollee each month—for example, \$641 per month for an infant under age 1, \$282 per month for children ages 1 through 20, \$377 per month for non-disabled, non-expansion adults ages 21 through 64. The key is that the payment amount does not change if the enrollee uses more (or fewer) services than expected. How much risk is actually transferred depends on the details of the contract and the mechanisms for distributing financial losses (or gains) between the state agency and the MCO. For more information on risk contracts, see Appendix 2.

Some state Medicaid agencies are quite intentional about how they want MCO procurement to drive policy changes. For example, in February of 2022, California’s Medicaid agency published an [issue brief](#), “Transforming Medi-Cal Managed Care Through Statewide Procurement.”

In the brief, the agency makes clear that its objective in the procurement process is to select MCOs “that demonstrate their commitment and ability to meet ... new and enhanced contract requirements” relating to transparency, quality, access, increased health equity, and accountability for the performance of physician groups and other entities with which the MCO subcontracts. A number of these new contract requirements, such as the requirement that MCOs train their network providers on the EPSDT benefit, reflect input from [600 organizations](#) led by child health advocates.

In revising the contracts, the state can also include mechanisms to improve the performance of selected MCOs going forward. For example, the state agency can write higher performance requirements designed to [reduce racial and ethnic disparities](#) into the new contracts. It can adjust its reimbursement methods to create stronger incentives for the new MCO contractors to meet those higher performance requirements. And, it can strengthen the performance reporting requirements in the new contracts and increase public [transparency](#) of the data reported.

Dropping low-performing MCOs

Procurement is an opportunity for a state Medicaid agency to weed out low-performing MCOs simply by not awarding them a new contract. For example, as Medicaid managed care expert Allan Baumgarten [explains](#), by 2018 Kansas had been contracting with three national MCOs for a few years: Amerigroup/Anthem, Centene, and United Healthcare. But, in a reprocurement that year, the state awarded new contracts to Centene and UnitedHealthcare and replaced Amerigroup/Anthem with another national MCO, Aetna Better Health. Of course, not renewing the contract of an incumbent may not be so simple. AmeriGroup/Anthem protested and sued the state, but it was unsuccessful in obtaining a new contract.

If an MCO has been performing poorly year after year, there’s little reason for the state Medicaid agency to continue to contract with it. In fact, giving that MCO another three- or five-year (or longer) contract would send exactly the wrong message: rather than being held accountable, low-performing MCOs would be rewarded with a contract extension. Fortunately, there’s

an alternative: a rigorous “Request for Proposal” (RFP) that asks all bidders, both incumbents and potential new entrants, for detailed performance data for the preceding three- to five-year period, combined with an evaluation system that is keyed to those answers. To reward good past performance, the state agency could weight the scores to favor the MCOs with the best performance (see text box, “Scoring Rubrics in RFP Evaluation”). In the case of children, the state’s RFP could ask questions like:

- Have you served children eligible for Medicaid (or CHIP) in this state? If so, what evidence do you have that these children received the EPSDT services to which they are entitled?
- Has the use of EPSDT services by enrolled children varied by race and/or ethnicity? If so, what are the causes of these disparities and how will you address them going forward?
- If you are a subsidiary of a parent company that participates in other state Medicaid programs, please provide answers to these questions for each subsidiary.



SCORING RUBRICS IN RFP EVALUATION

In states that use a scoring system to evaluate the proposals they receive, the agency will usually release a scoring rubric along with the initial RFP. The scoring rubric can be designed to reward bidders for innovation in serving children and families.

For example, in [Hawaii’s 2021 procurement](#), bidders’ answers were rated on a scale of zero to five, with zero being “Very Poor” and five being “Excellent.” Each question in the RFP was given a certain number of points, with important questions worth more. The zero to five rating determined the share of points the MCO could collect for a given answer; plans rated zero would earn no points, plans rated one would receive 25 percent of possible points, plans rated three would receive 75 percent of possible points, etc.

Table 1 shows a hypothetical example using questions from Hawaii’s RFP. The question with the greatest weight, 75 points, relates to both health equity and EPSDT. Even though a rating of 3 gives the MCO the same 75 percent of possible points, a rating of 3 on this question gives an MCO more points than a rating of 3 on the bottom question, which is only worth 50 points.

Table 1. Illustrative Scoring for Two Hypothetical MCOs

RFP Question	Max. points (weight)	MCO 1		MCO 2	
		Rating	Points	Rating	Points
Describe the Health Plan’s experience, innovative approaches providing covered benefits and services [...] The response shall specifically include: 1) Addressing the needs of the unique populations of Hawaii, including Native Hawaiians and Hawaii residents from Micronesian Nations Under the Compact; and 2) Approaches to providing EPSDT services.	75	3	56.25	4	66
The Health Plan’s specific approach to increase investment in, incentivization of, and medical spending on primary care providers in support of advancing primary care.	25	5	25	3	18.75
The Health Plan shall describe its experience and proposed innovative approaches to the following: 1) Supporting and evaluating Providers in conducting quality improvement activities; 2) Increasing the rate of high value care and reducing variation from evidence-based standards; and 3) Leveraging Performance Improvement Projects (PIPs) to support wide-scale adoption of successful practices.	50	3	37.5	3	37.5
	150	–	118.75	–	122.25



How does Medicaid MCO procurement work?

All states have procurement processes for purchasing goods and services ranging from highway construction to fleet vehicles to office supplies. These procurement laws and practices [vary widely](#). In some states, all procurements are conducted by a Central Procurement Office (CPO), commonly the Department of General Services or Department of Administrative Services. In others, some purchasing authority is delegated to other state agencies, such as the state Medicaid agency. In short, if you've seen one state's Medicaid MCO procurement process, you've seen one state's Medicaid MCO procurement process. See Appendix 1 for state-specific detail on CPOs and procurement laws.

CMS does not set minimum standards for state policies and procedures as they apply to MCO procurement. Federal [regulations](#) require only that the state “must follow the same policies and procedures it uses for procurements” in purchasing goods and services with its own funds. (Local governments, Indian tribes, and nonprofit organizations are subject to additional requirements, such as prohibitions on conflicts of interest and requirements for “full and open” competition).

Although CMS reviews the risk contracts a state Medicaid agency enters into with MCOs as well as the capitation rates that the state pays them, CMS does not review the way in which a state selects MCOs. According to a February 2021 report by the [Government Accountability Office](#) (GAO), “CMS has not overseen the Medicaid procurement process in any state or territory.”

Within the framework of their own procurement laws, state Medicaid agencies have broad latitude in designing their procurement of MCOs. They determine—among other things—when a procurement occurs; how many years run between one procurement and the next; how many MCOs they will contract with in a given procurement cycle; which regions of the state will be open for contracting; which populations will be enrolled; which services will be covered; the contract requirements that bidders will be expected to meet; and how proposals will be evaluated and scored. The variation in state MCO procurement practices and policy choices is extensive.



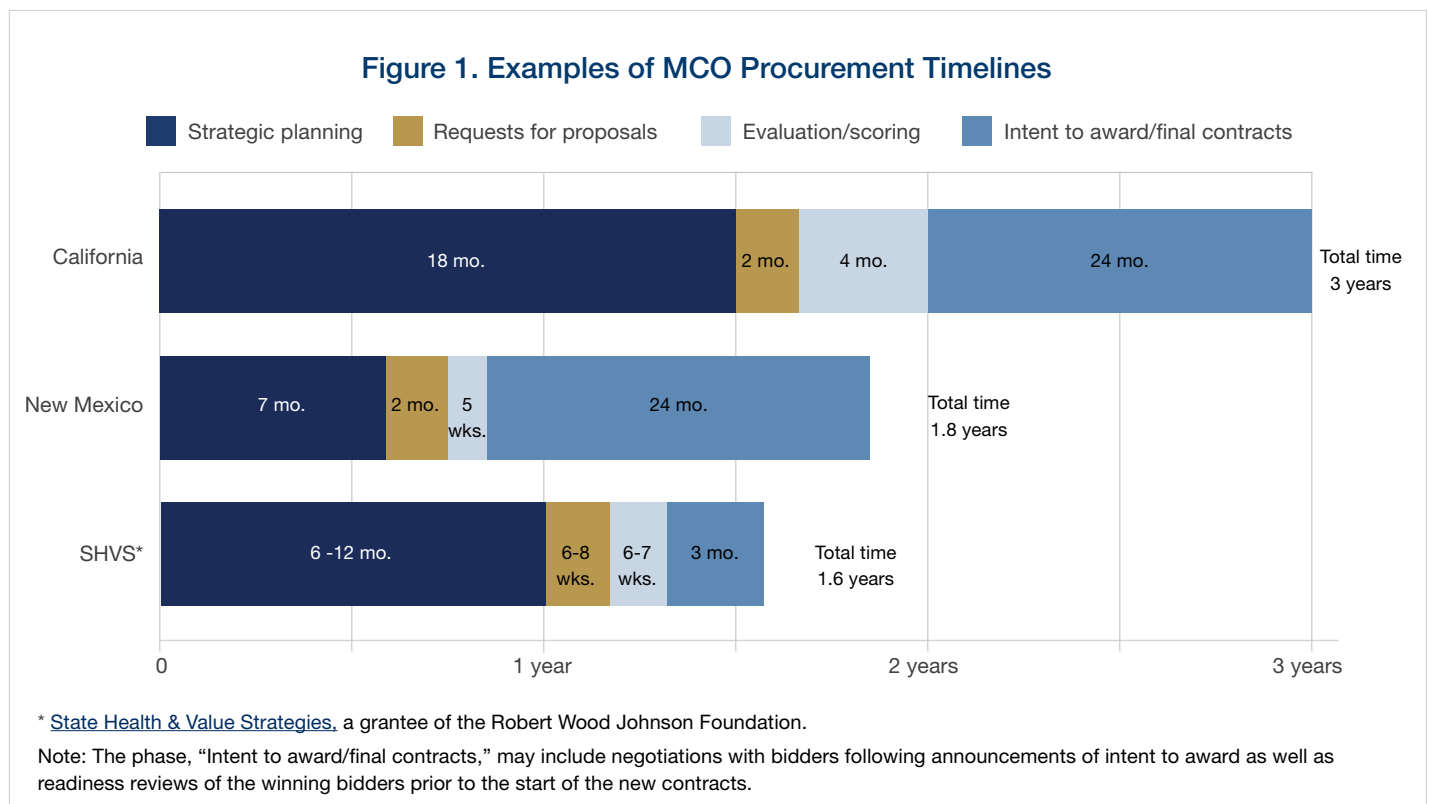


The MCO Procurement Timeline

Broadly speaking, an MCO procurement has five phases:

1. **Strategic planning** (i.e., the Medicaid agency decides what policy goals it wants to achieve through the procurement, ideally soliciting public input through an RFI (Request for Information) as part of this process).
2. **Development of the solicitation of bids**, often known as an RFP (Request for Proposal), which describes what performance the state expects of MCOs under the new contracts (in some cases the RFP can be the final contract).
3. **Evaluation of the proposals** submitted in response to the RFP (often based on a scoring system) and identification of the winning bidders.
4. **Announcement of intent to award contracts** to the winning bidders, often followed by a period during which losing bidders can file protests.
5. **Negotiation of final contracts**, “readiness reviews” of the newly contracted MCOs, followed by implementation of the new contracts.

There’s no standard timeframe for these five phases. In Figure 1, we summarize the timelines for two procurements that are currently underway, one in [California](#) and one in [New Mexico](#), along with a timeframe outlined by the consultancy Bailit Health for [State Health & Value Strategies](#) (SHVS). To simplify the comparisons, the Figure consolidates phases 4 and 5. Keep in mind that if there is a protest of the awards by losing bidders, the implementation of the new risk contracts may be delayed by months or even years (see text box, “It’s Not Over ‘Til It’s Over”).





States’ procedures vary a lot. A [survey](#) conducted by Allan Baumgarten for the Robert Wood Johnson Foundation offers an excellent overview of this variation. But there are some common threads.

First and foremost, there is a lot of money on the table. *Because of the size and duration of state risk contracts with MCOs, these procurements are often the largest that a state undertakes.* The California procurement, which involves only certain areas of the state, has an estimated value of [\\$13 billion](#) per year. Georgia’s upcoming procurement is worth over [\\$4 billion](#) per year. Ohio’s recent procurement was priced at [\\$22 billion](#) over five years. Judging from the [financial performance](#) of publicly-held insurance companies that dominate the Medicaid market, MCOs are not losing money. This, in turn, explains three other threads.

First, Medicaid MCO procurements are highly competitive. Incumbent MCOs do not want to lose their market share. And non-incumbents want a piece of the action. For the national parent companies competing in the Medicaid market, the win-loss record on state procurements is a point of emphasis with shareholders during earnings calls. For example, the CEO of Molina Healthcare [cites](#) re-procurements in Ohio and a new award in Nevada as part of his company’s “profitable growth strategy.”

Second, Medicaid MCO procurements can be highly political in both senses of the term. There is the question as to which branch of state government—the executive or the legislative—controls the process. And there is the potential for sharp partisan differences. While most of the pulling and tugging is usually under the radar, it occasionally breaks out into public view. The most recent example is Kansas, where the Republican-controlled legislature sent a bill to the Democratic Governor [delaying](#) a scheduled procurement until after the November 2022 elections, then overrode [her veto](#) of that legislation. The legislation effectively grants a non-bid, one year contract extension to the three incumbent MCOs.

Finally, procurements can be a long march, one that drags on for years. It is not unusual for losing bidders to ask the agency or even the courts to overturn the procurement decisions that excluded them from the lucrative Medicaid market (see text box, “It’s Not Over ‘Til It’s Over”).



IT’S NOT OVER ‘TIL IT’S OVER

In Louisiana, the state Medicaid agency in August 2019 [announced](#) the winners of a procurement for contracts starting January 1, 2020. [Protests](#) by losing bidders led the state to cancel those awards and start a new procurement. The initial procurement began in early 2019; the results of the restart were not announced until [February of 2022](#).

In Kentucky, the most recent procurement began with [one Governor](#) in December of 2019, was repeated by [his successor](#) in May of 2020 with the same bidders prevailing, was modified by a [state court](#) in October of 2020 to reinstate a losing bidder, and was ruled “arbitrary and capricious” by the [same state court](#) in April 2021.

Other notable procurement sagas have occurred recently in [North Carolina](#) and [Pennsylvania](#) (three resets over six years).

There is a lot of money on the table. Because of the size and duration of state risk contracts with MCOs, these procurements are often the largest that a state undertakes.



What can advocates do to leverage their state's Medicaid MCO procurement process for children and families?

MCO procurement is an important opportunity for advocates to improve the performance of MCOs for children and families. (For examples of MCO performance requirements in current contracts see Appendix 2.) Critically, this opportunity doesn't come around very often. Because of the amount of state funds at stake and the sheer complexity of the process and political pressure that comes with it, the demands of a procurement on state Medicaid agencies are huge. Understandably, the agencies want at least a few years of stability in their managed care programs before starting another procurement. So, advocates will want to make the most of the opportunity when it does come around.

What can advocates do to maximize the chances that the MCOs selected are the best available for children and families? The variation in MCO procurement policies and practices from state to state means that one playbook will not fit all. Advocates will need strategies and tactics tailored to their state's unique procurement procedures, Medicaid program, provider landscape, health insurance market, and political context.

Procurement is not a magic bullet; it may not be able to fix all areas of a state's Medicaid managed care program that need improvement. Advocates will have to identify and prioritize which problems can be fixed through procurement—e.g., improving the provisions of the current risk contract going forward—and which can't—e.g., improving state agency oversight of MCO compliance with the current risk contract.

As a general rule, advocates are more likely to be able to affect the provisions of the RFPs that their state Medicaid agency issues (and the selection criteria those RFPs imply) than the MCOs to which the state eventually awards the contracts. With this in mind, here's a checklist to help advocates get started.

- ✓ **Figure out what problems you want the procurement to fix.**
- ✓ **How can you know what the problems are?**
- ✓ **Find providers who want to fix the problems and collaborate with them.**
- ✓ **Figure out where in the process you and other stakeholders can intervene.**
- ✓ **Find an interested reporter (or get one interested).**
- ✓ **Ask for support from state health care foundations.**
- ✓ **Mine procurement postings for information about the bidders.**





Figure out what problems you want the procurement to fix.

What are the most important problems that need to be solved for beneficiaries? Lack of access to primary care services? Lack of access to behavioral health services? Failure to comply with EPSDT screening and referral requirements? Poor care coordination for medically complex beneficiaries? Racial and ethnic disparities in access to care or health outcomes? Obviously, depending on the circumstances in your state, this could be a very long list. It will likely be necessary to prioritize, since it will probably not be practical to engage the state agency on every issue.

How can you know what the problems are?

Given the general lack of transparency about the performance of individual MCOs, that may not be so easy. One publicly available source is the Annual Technical Report prepared by the External Quality Review Organization (EQRO) that each state Medicaid agency is required to post on its website (see text box, “External Quality Review”). The [Center for Community Solutions](#) in Cleveland reviewed reports about the MCOs with which Ohio contracts and concluded: “Taken in totality, the current managed care performance ranges from good in specific ways, mediocre in most ways, and deeply concerning for particular populations, most notably children and adolescents.” This analysis launched a conversation on solutions that might be achieved through procurement.

Advocates should also recognize that some problems, like lack of transparency, can be solved without procurement; for example, there is nothing that prevents an agency from standing up a [child health dashboard](#) before, during, or after a procurement.

Find providers who want to fix the problems and collaborate with them.

Many of the problems that children, families, and other beneficiaries experience in Medicaid managed care can be traced to a shortage of qualified providers in MCO networks willing to treat them. If, for example, children are having trouble accessing EPSDT services because not enough practitioners are available to

conduct the required screenings or provide the necessary treatments, a procurement could address this going forward by upgrading MCO network adequacy requirements, increasing the incentives for meeting them, tightening the penalties for not meeting them, and requiring MCOs to pay their primary care providers adequate rates. Primary care practitioners—pediatricians, family medicine doctors, etc.—who want to provide EPSDT services will have a [strong interest in solving the problem](#). Because of their formal and informal channels to state policymakers, they and their state trade associations can be important allies.

EXTERNAL QUALITY REVIEW

[Federal regulations](#) require that state agencies contract with at least one independent, external entity ([the EQRO](#)) to assess MCO performance and quality. Each year, the EQRO prepares a technical report detailing each MCO’s activities and performance on quality metrics in the previous year. The regulations set forth minimum oversight activities the EQRO must complete, including validating performance improvement projects and compliance with availability of services and grievance and appeal standards. State agencies have the option to include additional oversight activities in their contracts with EQROs, including analyzing and reporting additional quality measures. As part of their quality strategy, states can decide which performance measures MCOs collect and report (these usually include one or more [Core Set measures](#)). Once validated by EQROs, the data reported by MCOs can highlight disparities, target areas for improvement, and enable advocates to monitor progress being made by individual MCOs toward attainment of child and maternal health priorities and health equity. For additional resources and information on the EQR process and quality measures, see Appendix 3.



Figure out where in the process you and other stakeholders can intervene.

Your state will have a formal procurement process with a fixed timetable. To keep the process fair and open, the state Medicaid agency or the state Central Procurement Office (or both) should let all potential bidders, as well as the general public, know what that timetable is, both through formal notices as well as stakeholder engagement activities like listening sessions. How transparent this information actually is to the public, however, may vary from state to state. Some state agencies (and their websites) are more accessible and forthcoming than others. It pays to keep a close eye on both the state website and national sources that are aimed at potential bidders, such as the weekly newsletter from the consulting firm [Health Management Associates](#).

The formal procurement process is likely to include at least one opportunity for public input—for example, commenting on a Request for Information (RFI) that is used as the basis for the final Request for Proposal (RFP) on which the MCOs bid. The comment period, however, may be as short as 30 days. Advocates and the providers with whom they are working will want to take advantage of that public comment opportunity by submitting suggested improvements to the proposed language. Examples of such comments are those submitted to the California Medicaid agency by [The Children's Movement of California](#), [California Coalition for Youth](#), and a [coalition](#) of 12 provider and children's advocacy organizations.

Another opportunity for input into the procurement process is the Medicaid agency's Medical Care Advisory Committee (MCAC). It's an ongoing, formal channel of communication with the state agency that can be useful as the procurement process unfolds. It is also an opportunity for informal communications with providers, MCOs, and other stakeholders on the MCAC (see text box, "Medical Care Advisory Committees").

MEDICAL CARE ADVISORY COMMITTEES

A Medical Care Advisory Committee (MCAC) is a group of people that advises the state Medicaid agency's director about medical services and other health related topics. States are [required by federal law](#) to have a MCAC and the costs of administering and running the MCAC (e.g., transportation and childcare costs for members) are eligible for federal match. MCAC members are appointed by the Medicaid agency director and must include members of consumer groups, state officials, Medicaid beneficiaries, and physicians and providers who work with low-income people. MCACs help develop Medicaid policies and give ideas about how the program should be run. Although MCACs' role is advisory, they can be influential and effective parts of the state's Medicaid program. For example, the [Pennsylvania Medical Assistance Advisory Committee](#) (MAAC) meets ten times per year and has several subcommittees, including the Consumer Subcommittee and the Managed Care Delivery System Subcommittee. The Consumer Subcommittee has been involved in matters such as Medicaid contracting, managed care quality, and access to services. Every state is different, so advocates should contact their state Medicaid agency to find out their MCAC membership, meeting times and procedures, conflict-of-interest rules, and ask for a copy of the MCAC by-laws as well as past meeting agendas and minutes if they are not available online. For additional MCAC resources, see Appendix 3.

Find an interested reporter (or get one interested).

Procurement is more likely to produce good results if the state Medicaid agency, the incumbent MCOs, and potential new entrants all know that the public is watching. Journalists are essential to transparency of the process. It's important that journalists (and their editors) understand what is at stake in the procurement process: how much taxpayer money is in play, the relationship between the bidding companies and the state government, how many beneficiaries will be



affected, and the potential implications for the health of particular populations (children, pregnant women, other adults) and the communities in which they live and work.

However, from the journalist’s standpoint (and that of their editors), Medicaid MCO procurement is not an obvious candidate for a story. Medicaid is complicated, Medicaid managed care is even more complicated, and adding the procurement process into the mix doesn’t simplify matters. Nonetheless, depending on the facts on the ground, there could be many compelling story lines—“[conflicts of interest](#),” “[accountability for taxpayer dollars](#),” “[sweetheart deals](#)”—for investigative and business reporters. Similarly, health reporters may be interested in the potential of the procurement to address issues they are already covering, like maternal, infant, and toddler health, or access to mental health and substance use disorder services.

These stories can [educate the public](#) about the state’s MCO procurement. They can also hold public officials accountable for less-than-transparent decisionmaking during the procurement process. For example, following The Columbus Dispatch’s [reporting](#) on managed care plans’ use of pharmacy benefit managers at significant taxpayer expense, the state significantly [revamped](#) its pharmacy benefit manager rules, went through a [new procurement cycle](#) to choose a single pharmacy benefit manager for all MCO plans, and added significantly more transparency and accountability levers in the contracts.

 **Ask for support from state health care foundations.**

Medicaid MCO procurement is a long game, and effective advocacy for children and families will require support—not just financial, but also analytical and communications. One potential source advocates should explore is foundations that focus on health issues in their states. An example of the different types of support a state foundation can provide is this [collection of procurement resources](#) compiled by the California Health Care Foundation over the past four years. CHCF has engaged consultants to prepare [analyses of other states’ approaches](#) to contracting

with MCOs; [testified](#) before the state legislature about those analyses; posted the numerous comments of stakeholders in response to the state Medicaid agency’s [draft RFI](#) and its [draft RFP](#); held a [webinar](#) to discuss the comments; and posted a [summary](#) of the comments to make them more accessible to the press and broader public. Similarly, the [George Gund Foundation](#) in Ohio provided financial support to the Center for Community Solutions in Cleveland for advocacy on improving children’s behavioral health policy, part of which involved [the state’s MCO procurement process](#).

 **Mine procurement postings for information about the bidders.**

Just as there is variation in procurement procedures, there is variation in transparency. Some states make more information available than others. California offers an example of full-on transparency. Its [February 2022 RFP](#) states: “Any person or member of the public can inspect or obtain copies of *all* proposal materials... On or after the date [the state Medicaid agency] posts the Notice of Intent to Award *all* proposals...become public records. These records shall be available for review, inspection and copying during normal business hours” (*emphasis added*). This allows MCOs that do not receive awards to review the state’s decision and decide whether to appeal.

But it will do more than keep the procurement process in California honest. It will also enable child health advocates in California and other states to learn more about the performance of subsidiaries of the national companies that submit proposals in California. That’s because under [the RFP](#), proposers must submit detailed information about their track records in all states in which they operate a Medicaid plan, including quality performance measures, any enforcement actions taken against the proposer for performance in the last five years, and primary care utilization data for children (including percentage of children who did not see a PCP) stratified by race/ethnicity and age for each measurement year 2017 through 2019.



Conclusion

State MCO procurement is a complicated, high-stakes, and often lengthy process for deciding which MCOs are most qualified to arrange for the delivery of covered services to a state's low-income children and families. Since there are often more bidders than slots, competition for a limited number of lucrative, multi-year contracts can be fierce. Ultimately, the question is whether this competition can

produce successful bidders that will deliver high quality, accessible services to beneficiaries and help the state Medicaid program achieve broader policy goals such as reducing racial and ethnic disparities. Hopefully this Guide will help advocates make the most of these every-so-often opportunities.

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Appendices

Appendix 1: State Procurement Laws and Regulations

A state-by-state table of procurement laws, regulations, and links to state Medicaid Agency website pages on procurement is available [here](#).

A listing of Chief Procurement Officers (CPOs) in each state can be found [here](#). State-specific findings of a 2020 survey of CPOs about their agencies' procurement practices are available [here](#).

Appendix 2: Contract Provisions

MCO risk contracts can be very long—they can run hundreds of pages—very dense and legalistic, and very hard to navigate, even for lawyers. They can even be hard to find: although federal regulations at [42 CFR 438.602\(g\)\(1\)](#) require state Medicaid agencies to post their MCO risk contracts on their websites, compliance is [uneven](#).

There's no standard format for Medicaid risk contracts. Not only does each state have its own set of Medicaid managed care policies, but it has its own public contract law requirements and its own drafting style. That said, there are some commonalities.

Federal Minimum Requirements

All MCO risk contracts have to be approved by CMS before federal matching funds will be made available to states for capitation payments made to MCOs under the contract. CMS has a [117-page guide](#) for state Medicaid agencies describing what provisions a risk contract must include in order to be approved. The requirements are based on the [federal Medicaid managed care regulations](#). They range from beneficiary protections like prohibiting balance billing of beneficiaries by network providers to requirements that the MCO undergo annual EQRO reviews to provisions relating to program integrity.

Every state's risk contract will contain these required provisions, although the language may vary.

Beyond the required provisions, CMS's Guide leaves lots of room for state discretion. It does not, for example, speak to performance requirements for the provision of child or maternal health services or the reduction of racial or ethnic health disparities. States can decide whether to fill in those blanks and, if so, how.

For example, on EPSDT services (see text box), the Guide says only that the contract "should be clear as to whether the [MCO] is responsible for providing the full range of EPSDT services" and that MCO must use a model enrollee handbook developed by the state that includes information about EPSDT and "how to access component services." This leaves much of EPSDT policy—screening protocols, the special definition of "medical necessity," specialist referrals, etc.—for each state Medicaid agency to build out.

Filling in the Policy Blanks

We are not aware of any model MCO risk contracts for children and families. There are, however, some databases and checklists that advocates may find helpful.

- **Primary care.** The Commonwealth Fund has a [database](#) of state MCO risk contract provisions relating to primary care that were in effect in 39 states and the District of Columbia as of October 2019. The database is searchable by state and by topic (for example, primary care payment method, social determinants of health, network adequacy, etc.)



- **EPSDT.** The National Health Law Program has prepared a [checklist](#) of 30 essential elements relating to EPSDT that should be included in a risk contract. The elements, framed as questions, relate to outreach (8), screening services (10), treatment and provider participation (10), and reporting (2).
- **Racial Disparities.** State Health and Value Strategies at Princeton University has assembled (and periodically updates) a [compendium](#) of language in risk contracts or RFPs relating to health equity or health disparities from 17 states and the District of Columbia. The compendium also contains examples of procurement questions related to health equity and disparities reduction.

Appendix 3: Resources

MCO Basics

- The best portal into managed care is the Kaiser Family Foundation's "[10 Things to Know About Medicaid Managed Care](#)" (February 2022)
- You also can find the current Medicaid MCO landscape in your state on the [KFF Medicaid Managed Care Market Tracker](#).
- CCF's Medicaid Learning Lab offers a basic introduction to Medicaid managed care via [video](#) and [slides](#).

EPSDT Information & Advocacy

- CMS's summary of the EPSDT benefit can be found [here](#).
- CMS has issued a [Guide for States](#) on EPSDT and an [Informational Bulletin](#) on EPSDT service delivery and outreach through managed care.
- Two joint webinars from the American Academy of Pediatrics (AAP) and CCF [explain the EPSDT benefit](#) and how providers, medical-legal partnerships, and legal service organizations can [advocate for children enrolled in MCOs](#) to ensure they receive the EPSDT services to which they are entitled.
- In 2016, child health advocates in Illinois and Iowa engaged in extensive advocacy around the provision of EPSDT services for children enrolled in MCOs. Case studies of these efforts are available [here](#) (Illinois) and [here](#) (Iowa).
- The National Health Law Program has prepared a [checklist](#) to help advocates track how EPSDT is working in states that contract with MCOs. NHeLP has also published a [chartbook](#) on statewide EPSDT data through 2019.

External Quality Review & Quality Measures

- For an in-depth overview of the EQR process and links to every state's annual technical reports, see the National Health Law Program's [ongoing series of briefs](#).
- For more information about state and plan-level data and how it can be utilized in the EQR process to encourage plan improvement and compliance with Medicaid regulations, see [this helpful brief](#), also from the National Health Law Program.
- For more background on the Child Core Set and quality measures in Medicaid and CHIP, see the CCF Medicaid Learning Lab, [Session 12](#).



Medical Care Advisory Committees

- For best practices and advocacy strategies for making your state's MCAC diverse, representative, and effective, see the National Health Law Program's [brief guide](#).
- For a discussion about the use of MCACs as a beneficiary engagement strategy and their potential for health equity advancement, see Chapter 6 of the Medicaid and CHIP Payment Access Commission's [June 2022 Report to Congress on Medicaid and CHIP](#).
- For detailed action steps toward meaningful consumer and community engagement, see [this brief](#) from Community Catalyst.

MCO Procurement

- For a thorough discussion of state procurements, including findings from interviews with advocacy groups, see Allan Baumgarten's [2020 study](#) posted by the Robert Wood Johnson Foundation.
- For a basic guide to procurement from the state Medicaid agency perspective, see [this toolkit](#) from Bailit Health and State Health & Value Strategies at Princeton University.
- [This presentation](#) from MACPAC's April 2022 public meeting offers a brief overview of the procurement process and presents top-level findings from interviews with CMS, state Medicaid officials, MCOs, experts, and advocates.
- National Academy for State Health Policy's 2016 piece, "[Managing Medicaid Managed Care: New State Strategies to Promote Accountability and Performance](#)," dives into value-based payment arrangements with providers and state oversight structures.
- The advocacy tips in National Association of People with AIDS and Kaiser Family Foundation's "[Guide to Help Consumer Advocates Participate in Strengthening HIV/AIDS Provisions in Managed Care Contracts](#)" from 2000 remain highly relevant after all these years.

Reducing Racial and Ethnic Disparities through MCO Procurement

- For a detailed analysis of ways in which state Medicaid programs can leverage MCOs to advance health equity, including through procurement, see "[Promoting Health Equity: A Guide for States](#)" prepared by Bailit Health for State Health & Value Strategies at Princeton University.
- For a compendium of relevant language from risk contracts and RFPs see "[Medicaid Managed Care Contract Language: Health Disparities and Health Equity](#)" (January 2022) prepared by Bailit Health for State Health & Value Strategies at Princeton University.