



California Health Care Foundation



## **Raising the Bar:**

How California Can Use Purchasing Power and Oversight to Improve Quality in Medi-Cal Managed Care

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## About Bailit Health

Bailit Health Purchasing, LLC (Bailit Health) is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies. The firm primarily works with states to take actions that positively influence the performance of the health care system and support achievement of measurable improvements in health care quality and cost management.

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## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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# Executive Summary

Over the past decade, the California Department of Health Care Services (DHCS) has dramatically increased the reach of the Medi-Cal managed care program through the successful expansion of Medicaid under the Affordable Care Act, the integration of the Children’s Health Insurance Program into Medi-Cal, and a significant expansion of managed care to seniors and persons with disabilities and to rural areas of the state. With 10.8 million enrollees and expenditures of \$49 billion, the Medi-Cal managed care program is larger than the entire budget of all but two other states.

To ensure that Californians are getting the best value possible from this critically important program, it is imperative that oversight and monitoring of Medi-Cal managed care by DHCS is effective and efficient. With this goal in mind, the California Health Care Foundation (CHCF) engaged Bailit Health to research and make recommendations for how DHCS could strengthen its purchasing strategy and oversight of Medi-Cal managed care plans (MCPs).

In approaching this work, Bailit Health drew from its value-based purchasing perspective, consultations with CHCF, knowledge of other states’ Medicaid managed care contracts, prior experience as state Medicaid managed care staff, consulting experience with many Medicaid agencies, and knowledge of other state and private purchasers’ use of tools with contracted MCPs. Value-based purchasing is an ongoing process that begins with defining a procurement approach and vision, and then continually monitoring, measuring, and modifying the approach to improve quality and outcomes, including using financial and nonfinancial incentives and penalties. At its core, the value-based purchasing model encourages purchasers to move beyond a compliance-based oversight model to one in which they have a collaborative partnership with MCPs to help improve performance and advance the purchaser’s vision.

Bailit Health employed a multipronged research approach, including identifying potential types of health care purchasing tools and strategies, reviewing managed health plan contracts of select public purchasers, and interviewing public purchasers and stakeholders in California as well as senior Medicaid managed care staff in select other states. The authors conducted research in the fall of 2018, prior to Governor Newsom’s administration taking office. This research work was informed

by examining health plan contracts and other available material from Medi-Cal, Covered California, and the California Public Employees’ Retirement System (CalPERS) as well as interviewing staff responsible for oversight of these purchasers’ MCP contracts. Similarly, the authors reviewed Medicaid MCP contracts in Florida, Massachusetts, Tennessee, Texas, and Washington. To supplement the authors’ knowledge, interviews were also conducted with Medicaid staff from those states and Oregon.

## MCP Monitoring and Oversight Process

### Strengths

DHCS’s recent success implementing a significant expansion of Medi-Cal and several innovative pilots through a series of groundbreaking Section 1115 waivers speaks to the strength of the Medi-Cal managed care program upon which these achievements were built. Similarly, the agency’s recent implementation of significantly increased oversight of MCPs to implement the 2016 revisions to the federal Medicaid managed care rule, codified in California’s Assembly Bill 205, demonstrates DHCS’s capability to develop, coordinate, and execute large-scale change in its monitoring and oversight approach. Given the size and scope of the Medi-Cal managed care program, the state’s ability to “keep the trains running” during these multiple changes is a significant accomplishment. Implementation of any changes, including modifications to Medi-Cal benefits, involves coordination across all plans and regions of the state. The state’s many communication channels with MCPs and other stakeholders appears to work well in terms of sharing Medi-Cal policies with different levels and types of MCP personnel. Stakeholders cited the well-organized implementation of Medi-Cal’s palliative care benefit, which involves extensive provider education and outreach, as an example of a successful DHCS initiative.

### Challenges

The size, scope, and complexity of the Medi-Cal managed care program also presents unique challenges. DHCS directly oversees 22 MCPs through six different models, and covered services differ across the MCPs.<sup>1</sup> For these reasons, some managed care monitoring approaches that work well in smaller states may not be feasible in California or may only work in certain regions of the state.

While DHCS could consider employing additional tools used by other California public purchasers, such as Covered California and CalPERS, some approaches used by these purchasers might require explicit federal approval and others might not be possible or recommended for Medi-Cal. For instance, DHCS must comply with federal Medicaid managed care rules related to cost-sharing limitations for enrollees, provider incentive arrangements, alternative payment models (APMs), provider-directed payments, and annual actuarial soundness of MCP rates, which may make it more difficult for Medi-Cal to innovate in these areas. In addition, DHCS is specifically required to comply with federal waiver terms and conditions as well as certain state laws and regulations that apply only to Medicaid managed care plans,<sup>2</sup> or that apply differently to Medicaid plans, such as those related to annual audits and assessing network adequacy of MCPs.

### Opportunities for Improvement

The Newsom administration has already identified a number of ways in which it plans to improve the MCP monitoring and oversight process, including expanding oversight of plan performance to include every adult and child Healthcare Effectiveness Data and Information Set (HEDIS)<sup>3</sup> measure, and requiring that plans achieve the National Committee for Quality Assurance (NCQA) 50th national performance percentile for these measures. The authors applaud the administration for taking quick action to show it is committed to continuing to improve the quality of care provided to Medi-Cal beneficiaries.

In developing recommendations for Medi-Cal, Bailit Health considered limitations in purchasing options for Medi-Cal due to federal and state restrictions applicable specifically to Medicaid managed care programs and contracts, and the feasibility of options based on the size of the Medi-Cal program. The authors also focused on prioritizing activities and tools, or modifications of tools, expected to result in better value from MCPs participating in Medi-Cal.

Bailit Health recommends that DHCS consider adopting the following specific purchasing and contracting tools and approaches to strengthen Medi-Cal's monitoring and contracting with MCPs, including some which build upon initiatives already underway.

## Priority Recommendations

In the short term, the authors recommend that DHCS focus on the following priority recommendations:

**Articulate a strategic vision for managed care and translate to policy requirements within the MCP contract.** The upcoming, anticipated procurement process for certain Medi-Cal contracts provides DHCS with an important opportunity to review its vision of the Medi-Cal managed care program. While not all MCPs will be reprocured, DHCS can leverage the procurement activity to make clear its aligned vision for all managed care plan models and to renegotiate updated MCP contracts, regardless of plan type. DHCS should use this opportunity to clearly define and broadly communicate its goals and priorities for Medi-Cal managed care over the next five years (coinciding with the term of the upcoming MCP contracts). Building off the 2017 DHCS Strategy for Quality Improvement in Health Care, the department should articulate a clear and aligned vision specifically for Medi-Cal managed care plan oversight, shifting the focus from minimal MCP contract compliance to one of excellence and ongoing performance improvement. Massachusetts's recent procurement provides an excellent example of a clear strategic vision and accompanying goals.<sup>4</sup>

**Strengthen oversight of MCPs that delegate risk to another entity.** As part of the forthcoming commercial plan reprocurement and related County Organized Health System (COHS) and local initiative revised boilerplate contracts, DHCS should consider new requirements for MCPs. Specifically, the authors encourage DHCS to consider:

- ▶ Enhancing oversight requirements for MCPs that delegate services and/or risk to subcontractors, similar to the new Florida Medicaid MCP contracts.
- ▶ Adding new MCP oversight approaches in coordination with the Department of Managed Health Care (DMHC) related to delegated entities' financial solvency, impact on overall MCP network adequacy, and on an individual beneficiary's ability to access care.
- ▶ Requiring MCPs to report on their use of risk-based alternative payment models with provider entities, the impact of these APMs on encounter data, and MCP and provider performance on quality and efficiency measures.

Florida's acute care managed care organization (MCO) contract provides example language regarding additional requirements and oversight of delegated entities and reporting on APM arrangements.<sup>5</sup>

**Enhance the current focus on quality measurement and reporting.** The authors recommend that DHCS take the following steps to enhance the focus of MCP performance on quality metrics, and specifically performance improvement:

- ▶ Involve MCP representatives, consumer advocates, and other stakeholders in the selection of MCP External Accountability Set (EAS) measures and specifically consider aligning EAS measures with MCP measures used by other purchasers in the marketplace, including Covered California and CalPERS, as appropriate.
- ▶ Regularly and consistently use data on plan performance to prioritize MCP oversight activities, and compare MCP performance on all prioritized measures to state, and where available, regional or national benchmarks.
- ▶ Ensure that contracted MCPs achieve objective, measurable improvements in performance, above current performance and above the currently set Minimum Performance Level of the NCQA 25th percentile for national Medicaid performance. Governor Newsom has indicated that his administration will require MCPs to meet the NCQA 50th percentile. It may be difficult for MCPs to make that big of a leap initially. One approach toward moving to that 50th percentile may be, consistent with the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) approach, to expect MCPs to seek and over time obtain a 10% gap closure between the difference of current performance and the 50th percentile, or as required within PRIME, the 75th or 90th percentile for NCQA Medicaid MCO performance. It is recommended that DHCS phase in the 50th percentile requirement and look to see whether it is realistic for MCPs to meet that standard for every measure or if there should be individualized benchmarks for certain measures. When phasing in the increased performance standard, DHCS could focus on improvement over time and that the Minimum Performance Level for a given measure be based on current Medi-Cal MCP quality scores rather than adoption of a single benchmark (e.g., 50th percentile for every measure).

- ▶ Require more granular population data collection and analysis and the development of a plan to address identified disparities, similar to DHCS efforts in the PRIME program.<sup>6</sup>
- ▶ Where appropriate, seek alignment with Covered California, CalPERS, and the Integrated Healthcare Association on performance measure reporting and improvement expectations.
- ▶ Make quality, and specifically MCP performance on quality metrics, an integral part of ongoing MCP contract management and a focus of discussion between MCPs and senior DHCS leaders, beyond the chief medical officers and the quality improvement staff.

**Use a combination of financial and nonfinancial incentives to improve performance.** The authors recommend that DHCS follow the lead of many other state Medicaid purchasers and its sister public programs, Covered California and CalPERS, to create meaningful consequences for MCP performance and follow through using a combination of financial and nonfinancial incentives for contracted plans that fail, meet, or exceed DHCS performance expectations.

DHCS creating and using a meaningful combination of financial and nonfinancial incentives makes a business case for MCPs to invest in improved performance on behalf of Medi-Cal beneficiaries. In terms of nonfinancial incentives for plans to improve performance, the authors encourage DHCS to:

- ▶ Continue to use performance-based auto-assignment.
- ▶ Continue to develop and update its MCP performance dashboard.
- ▶ At least annually develop and share MCP-specific performance data on its website and as part of its MCP and workgroup meetings, including with consumer advocates.

Similarly, the authors encourage DHCS to develop and use a menu of financial incentives linked to MCP performance, including:

- ▶ Financial penalties on MCPs performing below state-defined minimum benchmarks.

- ▶ Positive financial incentives for MCPs that are high performing and/or those that demonstrate significant improvement over time.

DHCS should consider a range of positive financial incentives commensurate with the effort required by MCPs to meet the performance goals, the availability of funds to support positive financial incentives for MCP performance, and the potential impact of the Medicaid managed care rule.

**Establish regular meetings between DHCS and MCP leadership.** DHCS conducts a significant number of audits of its MCPs and receives a large amount of information on a regular basis from its plans to allow it to oversee MCP performance. These formal audits are largely paper reviews focused on compliance and minimum contractual expectations for MCP performance. To promote higher performance, quality improvement, and joint problem solving, regularly scheduled in-person leadership meetings with senior executives of DHCS and the individual MCPs may be more effective and meaningful for improving performance than lengthy audits and Corrective Action Plans. In the authors' experience, this type of senior-level engagement helps to build a culture of collaboration and partnership between states and MCPs similar to what has reportedly occurred in some smaller DHCS-led workgroups on specific issues. Most states reviewed do conduct in-person meetings with MCP leadership individually at least annually.

Given the size of the Medi-Cal program and the number of MCPs across the state, the authors recognize that it is difficult for senior DHCS leadership to meet regularly with individual MCPs. However, the authors believe that one-on-one meetings with MCPs — particularly those serving large numbers of Medi-Cal beneficiaries — are an essential tool for DHCS to use in partnering with its MCPs to implement its vision, goals, and objectives. Ideally, the authors recommend annual management meetings led by senior DHCS staff with each MCP. The agenda should include a review of plan performance on a variety of metrics aligned with DHCS priorities, such as HEDIS measures, member satisfaction results, member services telephone response times, and network adequacy issues.

## Longer-Term Recommendations

Over the next two years, the authors recommend that DHCS:

**Continue to improve operational simplification and coordination of MCP oversight.** It is recommended that DHCS simplify and improve Medi-Cal MCP oversight through continued coordination with other agencies to use resources more efficiently and to reduce duplication related to oversight of the managed care plans, particularly with DMHC. Since all Medi-Cal plans except COHS are required to be licensed under the Knox-Keene Act, DHCS shares responsibility for the oversight of many of its MCPs with DMHC.

The authors understand that DHCS and DMHC do make an effort to coordinate MCP audits when they overlap to reduce the burden on the MCPs. However, it is believed that greater efficiencies are possible by reducing duplication in DHCS and DMHC oversight, particularly related to managed care network adequacy, basic financial standards, the scheduling of audits, and the alignment of audit tools and scope. In doing so, the authors recognize that there are differences in state and federal requirements for Medi-Cal and other Knox-Keene plans. However, the recent surprise collapse of a provider organization raises the question to stakeholders of how DHCS and DMHC are coordinating and overseeing health plans that subdelegate certain functions to other provider organizations, including the financial strength of provider entities that have taken on a meaningful level of financial risk. The authors also recommend that the legislature consider allowing DHCS to reduce its auditing of MCPs based on meeting certain performance standards. For example, if a MCP is also licensed under Knox-Keene and has clean audits for a certain number of years, the legislature could provide DHCS with discretion to skip or narrow audit oversight.

The authors also recommend that, similar to CalPERS, DHCS require MCPs to timely submit to DHCS a copy of any financial audit report and any public quality-of-care study or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., The Joint Commission, NCOA, or the Utilization Review Accreditation Commission [URAC]).

**Pursue greater alignment with other large purchasers in California.** The authors recommend that DHCS align select Medi-Cal MCP policy, performance, transparency, and/or incentive approaches with other DHCS initiatives and with large purchasers in the California marketplace where feasible and appropriate.

As the largest purchaser of health care in California, the state has incredible leverage to influence health policy and purchasing decisions. Within the Medi-Cal program there are a number of different initiatives to improve health care access and quality while containing costs. In many instances, these efforts occur outside of or parallel to the MCPs. If reform initiatives, such as Delivery System Reform Incentive Payments (DSRIP) funding, were more closely aligned with the managed care program, then the initiatives may be more effective in the short term, and more sustainable in the long term, provided they are shown to be cost-effective.

Where Medi-Cal aligns with CalPERS and Covered California, it allows the state to further move the needle on improved health care access and quality, as well as on activities to contain costs. Although Medi-Cal sometimes works with other state health purchasers to pursue specific activities, ongoing attention to alignment of policies and approaches across purchasers has been limited. Opportunities for improved alignment include the development of a common quality measure set across public programs in California, similar financial incentive (and penalty) approaches for MCPs meeting specific quality benchmarks, and more consistent and frequent transparency of MCP performance compared to peers, statewide benchmarks, and national standards. Tennessee is one example of a state that has embraced alignment across its public and private sector to improve population health.

**Build upon recent efforts to improve access to care and MCP network adequacy.** The authors recognize that DHCS has invested significant time and effort in new MCP network adequacy standards and health plan reviews and that it is no easy or small task. It is recommended that DHCS:

- ▶ Continue to improve, routinely use, and synthesize different types of access reporting and monitoring to better identify access issues. Beyond provider miles and minute analyses, secret shopper appointment availability, member satisfaction data, emergency

department utilization, and out-of-network volume all help to assess network adequacy within plans and across regions.

- ▶ Consider modifying MCP reporting requirements and create performance incentives specific to access to care as part of the upcoming reprocurement and contract revisions.
- ▶ Expand its capabilities to assess primary care provider (and ideally other provider) participation across plans.
- ▶ Work with MCPs to explore why so many alternative access arrangements are necessary, particularly for specialty care. Continue to monitor this situation to improve access and reduce the need for alternative arrangements, and require MCPs to create short-term and longer-term interventions to address and, where feasible, resolve network deficiencies over time.

**Implement a calendar of activities to reflect goals and priorities.** A calendar of activities is a simple tool that can improve communication with plans and increase the predictability of DHCS activities. DHCS already posts a calendar of events on its website that stakeholders can review by month.<sup>7</sup> The authors recommend that DHCS implement an enhanced calendar of activities, specifically focused on activities and an improvement cycle related to the Medicaid managed care program and MCP performance. This type of performance-driven calendar can also become a part of specified DHCS responsibilities that are delineated within the MCP contract. Key elements that could be included in such a calendar for both internal DHCS and MCP use are as follows:

- ▶ Timing of reports on managed care performance (including clinical, administrative, financial, and consumer satisfaction metrics).
- ▶ Planned updates to MCP performance metrics and related meetings and deadlines.
- ▶ Periodic meetings with MCP CEOs, chief financial officers (CFOs), and chief medical officers (CMOs).
- ▶ All Plan Letters under development, with anticipated publication dates.
- ▶ Contract amendment timelines.
- ▶ Medi-Cal budget and contract rate development timelines.

This level of transparency would serve multiple purposes. Most simply, it would provide staff at both DHCS and the plans with a more comprehensive view of interactions between the state and the MCPs related to plan performance and quality improvement. In addition, such a calendar can help with identifying competing priorities and draw attention to the interaction between different oversight and management activities.

**Continue to invest in staff.** For several years, DHCS has used the DHCS Academy to train potential leaders on cross-agency functions. The DHCS Academy appears to be a best practice among Medicaid agencies that often struggle to hire and retain staff and to support long-term skill and leadership development.

In addition to training through the DHCS Academy, the authors recommend that DHCS provide management training to all staff that liaise with managed care staff and/or who have responsibility for MCP contract management. Such training will provide staff with the necessary tools and skills to most effectively provide consistent oversight and support to MCPs. Specifically, the managed care program staff would benefit from training focused on the issues unique to managed care oversight, including an introduction to the contract and the extensive supporting materials; education about key managed care issues like network adequacy, customer service standards, and quality metrics; and a primer on how DHCS divisions work with one another and in concert with DMHC. Texas's ongoing training and teaming model for staff may provide some additional insight for DHCS.

## Conclusion and Next Steps

California has taken numerous steps over the past decade to improve timely access to high-quality care for Medi-Cal enrollees. Despite these efforts, quality of care for Medi-Cal managed care enrollees varies widely and lags behind that of many other states. If California is to fulfill the promise of Medi-Cal managed care, it will need to take bold action. The Newsom administration has taken promising early steps to increase monitoring of performance measures and raise the MCP performance standards. The authors recommend that DHCS continue this effort by actively defining and promoting its vision and expectations for MCP performance improvement across a variety of metrics and by offering plans positive and negative incentives to achieve improved performance.

The upcoming Medi-Cal reprocurement offers a unique opportunity to broaden and solidify DHCS's Medi-Cal managed care orientation from a focus on compliance to more of a value-based purchasing, performance improvement perspective. However, as this report makes clear, the procurement is only one of several tools available to DHCS to improve performance among contracted MCPs. If it adopted the recommendations in this report, DHCS would use its enormous purchasing power more effectively and improve health outcomes for nearly 11 million Californians who rely on Medi-Cal managed care for their care.



# I. Introduction, Purpose, and Methodology

The California Health Care Foundation (CHCF) engaged Bailit Health to research and recommend purchasing strategies and approaches that the Department of Health Care Services (DHCS) could adopt to further improve the effectiveness and efficiency of its oversight of Medi-Cal managed care plans (MCPs), to improve the quality and value of health care services provided to Medi-Cal beneficiaries. The primary purpose of this project is to provide state policymakers and Medi-Cal stakeholders with a clear understanding of how DHCS currently contracts for and oversees Medicaid managed care and to offer DHCS and state lawmakers recommendations regarding additional tools and approaches that the state could use to improve its MCP monitoring and performance.

This report details findings regarding the current processes and practices of DHCS and other public purchasers — Covered California, the California Public Employees’ Retirement System (CalPERS), and other state Medicaid programs — for monitoring MCPs across a range of dimensions, including:

- ▶ The state’s management approach with plans
- ▶ MCP contract requirements
- ▶ Procurement strategies
- ▶ Use of All Plan Letters (APLs)
- ▶ Performance expectations for plans
- ▶ Use of MCP performance incentives

This research was not designed to assess the performance of Medi-Cal MCPs, but rather the MCP monitoring and oversight processes and tools. Consequently, no inferences from this report should be made as to the access to, or quality of, care provided to Medi-Cal beneficiaries by MCPs. The report provides recommendations aimed at helping DHCS to more fully leverage its purchasing power as one of the largest health care purchasers in the nation, public or private, to improve health plan performance and health outcomes of Medi-Cal managed care enrollees.

Bailit Health used a multipronged research approach for this project including:

- ▶ Identifying potential types of purchasing tools and approaches.
- ▶ Reviewing managed health plan contracts and other related documents of select public purchasers in California and elsewhere.
- ▶ Interviewing public purchasers and stakeholders in California as well as senior Medicaid managed care staff in select other states.

The accompanying appendices include additional detail on the methodology used for this report (Appendix A) and summaries of the contracts reviewed from California, including the health plan contracts of Medi-Cal and Covered California, and the strategic plan and appendices to the CalPERS contract (Appendix B). The authors also worked with CHCF to identify key organizations to interview in the state including DHCS, Covered California, and CalPERS, several Medi-Cal health plans, and consumer representatives. A summary of interview findings is included in Section IV below.

Appendix C includes a summary of the authors’ review of Medicaid managed care contracts in five states (Florida, Massachusetts, Tennessee, Texas, and Washington) and interviews with senior Medicaid staff from four of these states. The authors also conducted a targeted review and interview with Oregon relative to its MCP subdelegation oversight and related requirements. These states were selected based on the authors’ knowledge of these purchasers, relevance to Medi-Cal, and recommendations from CHCF. Throughout this report, the authors reference strategies used by these public purchasers.<sup>8</sup>

## Value-Based Purchasing

Bailit Health approached this work using a value-based purchasing<sup>9</sup> framework and layered onto this foundation knowledge of other states' Medicaid managed care contracts, prior experience as state Medicaid managed care staff, consulting experience with many Medicaid agencies, and knowledge of other state and private purchaser's use of tools with contracted health plans. As depicted in Figure 1, value-based purchasing is an ongoing process that begins with the purchaser defining a procurement approach and vision, then continually monitoring, measuring, and modifying the approach in collaboration with health plans to improve quality and outcomes. At its core, value-based purchasing requires a purchaser to become much more active in its management and oversight of health plans than is typical in a traditional Medicaid managed care environment. By developing a collaborative, strategic partnership with plans, the Medicaid agency can more successfully promote and achieve a vision for better program outcomes.

Sections II, III, and IV below provide a brief overview of the Medi-Cal program and the federal Medicaid managed care rule, and findings from stakeholder interviews. In Sections V, VI, and VII the authors present opportunities for DHCS to manage and oversee

its relationship with MCPs in a value-based purchasing environment. Section V presents strategies that DHCS can use in its procurement and contracting process. Section VI presents tools that can be used to strengthen managed care plan accountability throughout the cycle, while Section VII discusses approaches to enhance contract management and oversight across the term of the contract.

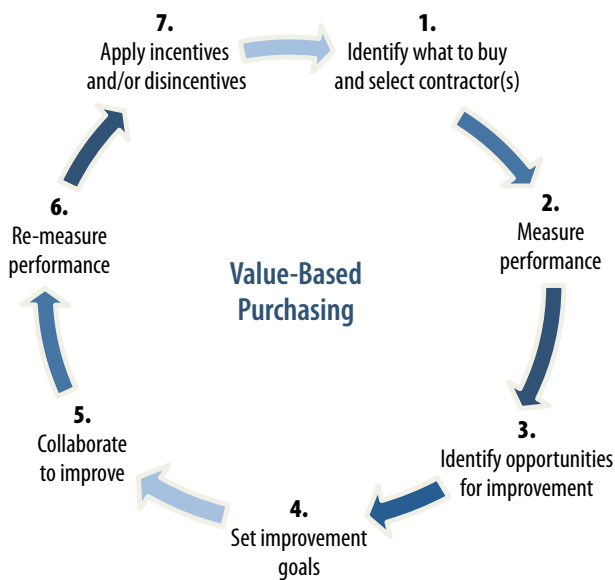
## II. An Overview of Medi-Cal Managed Care

As the designated single state Medicaid agency and largest health care payer in California, DHCS is a powerful purchaser. As in most other states, today the predominant delivery system for serving Medicaid beneficiaries in California is managed care. California's Medicaid managed care program is larger than the entire state budget of 47 of the 49 other states. DHCS purchases care on behalf of far more Medicaid enrollees than any other state (about 80% more than the next largest state, New York), and many of the MCPs it oversees are significantly larger than and provide services to more beneficiaries than participate in entire Medicaid programs in other states.

The Medi-Cal managed care program has a long history and a unique structure designed in part to account for geographically diverse counties across the state, differences in population size and density, and differences in local and regional health care delivery and financing systems. DHCS has increased the reach of its managed care program through the successful expansion of Medicaid, changes in the administration of the Children's Health Insurance Program, and significant increases in Medicaid managed care to more rural areas of the state. Medi-Cal's enrollment has grown significantly in the past five years and currently includes approximately one-third of California's population, with about 82% of Medi-Cal beneficiaries enrolled in a managed care plan.

In California, the historical role of counties in the financing and delivery of health services to poor and medically indigent residents contributed to the development of different types of Medicaid managed care models.<sup>10</sup> MCPs participate in Medi-Cal's managed care program through six main managed care models, as described in

Figure 1. Value-Based Purchasing Cycle



Source: Bailit Health Purchasing.

Table 1 below (listed by size of total Medi-Cal enrollment) and shown in the county map included as Figure 2.<sup>11</sup> In all regions where the Two-Plan model operates, the noncompetitively procured local initiative plans have a significantly larger total enrollment than the competitively procured commercial plans (CPs).

The planned upcoming competitive procurement for new contracts effective July 2021 with CPs within the GMC and Two-Plan models provides DHCS with an important opportunity to review and refine its vision of Medi-Cal managed care and to offer detailed objectives and goals to be accomplished through MCPs.<sup>12</sup> While COHS and local initiative plans that provide coverage in Two-Plan counties are not selected through a competitive procurement process, the current boilerplate contracts and oversight for these plans appears to be nearly identical to all other MCP contracts.

**Figure 2. Medi-Cal Managed Care Models, by County**



Source: California Department of Health Care Services.

**Table 1. Medi-Cal Managed Care Models**

	DESCRIPTION	PLANS	COUNTIES	ENROLLEES
<b>Two-Plan</b>	Two plans compete for enrollees in the county. One plan is a publicly run entity known as a local initiative, and the other is a competitively procured commercial plan (CP).	12	14	6.8 million
<b>County Organized Health System (COHS)</b>	A health plan created and administered by a county board of supervisors; all enrollees in the county are in the same plan.	6	22	2.1 million
<b>Geographic Managed Care (GMC)</b>	DHCS contracts with a mix of commercial and nonprofit plans that compete to serve beneficiaries in San Diego (7 plans) and Sacramento (5 plans).	12	2	1.1 million
<b>Regional Model</b>	DHCS contracts with a two to three competing CPs.	3	18	294,000
<b>Imperial</b>	DHCS contracts with two competing CPs.	2	1	76,000
<b>San Benito</b>	DHCS contracts with one CP.	1	1	8,000

Source: California Department of Health Care Services, "Medi-Cal Managed Care Enrollment Report, December 2018," [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).

### III. Federal Medicaid Managed Care Rule and Other Medi-Cal Limitations

The Medi-Cal program is jointly funded by the federal and state government, and as such, there are specific statutes and regulations that DHCS must follow to maintain compliance with federal Medicaid requirements. These create unique constraints that apply to the Medi-Cal managed care program that do not apply to insurers in the commercial market, health care exchange programs such as Covered California, or to state employee health benefit programs such as CalPERS. For example, all Medicaid managed care plans must comply with federal requirements related to freedom of choice of providers and access to care that limit the ability of the state and plans to use narrow networks or differential cost sharing for beneficiaries.

The federal Medicaid managed care (MMC) rule was completely overhauled in 2016. This rule includes several new and many modified requirements designed to increase state and federal oversight of MCPs as well as to increase MCP accountability.<sup>13</sup> For example, MCP contracts must now include more-specific language related to continuity of care, network adequacy standards, the MCP's Quality Assessment and Performance Improvement program, and reporting and payment of provider-preventable conditions. The revised MMC rule also restricts state flexibility in developing MCP capitation rates and certain types of financial incentives for providers,<sup>14</sup> codifies prior state guidance related to managed care for long-term services and supports, and modifies federal guidance related to requirements for each state's comprehensive Medicaid managed care quality strategy.<sup>15</sup>

California codified its implementation of new federal MMC provisions in state statute (AB 205), which both directs and somewhat restricts DHCS's flexibility in the development and oversight of MMC contracts. Like most MMC contracts, to meet federal and state requirements as well as program objectives, the Medi-Cal MCP contracts are prescriptive across many domains, including but not limited to covered services, network adequacy, and grievances and appeals.

To some extent, DHCS is both directed and restrained by existing state law regarding certain approaches for oversight of Medi-Cal plans, such as state laws requiring DHCS to audit MCPs annually in certain areas of performance. Since these audits require substantial resources, it may impact DHCS's ability to dedicate resources to pursuing additional MCP oversight and management strategies.

### IV. Summary of Findings from Interviews with California Managed Care Stakeholders

In the fall of 2018, Bailit Health interviewed a selection of MCPs and consumer representatives to better understand their perspectives on DHCS oversight (see sidebar). This section describes the themes of these interviews. The MCP interviewees were senior executives at the plans, often including CEOs and/or chief medical officers, and the interviews with consumer advocates were with staff who are responsible for their organizations' activities related to Medi-Cal.

#### Stakeholder Interviewees

##### Health Plans

- ▶ Alameda Alliance for Health
- ▶ Health Plan of San Joaquin
- ▶ HealthNet
- ▶ Inland Empire Health Plan
- ▶ L.A. Care
- ▶ Partnership PHP

##### Consumer Representatives

- ▶ California Pan Ethnic Health Forum
- ▶ Children's Partnership
- ▶ Health Access
- ▶ National Health Law Program
- ▶ Western Center on Law and Poverty

## DHCS Engagement in Plan Oversight

Generally speaking, interviewed MCPs reported that DHCS was an engaged partner on operational issues, was available for discussion of issues raised by the plans, and open to adding agenda items requested by MCPs to various meetings. However, one interviewee noted, and others implied, that topics often aren't brought to closure even after discussion.

DHCS managed care leadership was generally praised for its content knowledge and responsiveness. Multiple plan interviewees mentioned Jennifer Kent, Mari Cantwell, Sarah Brooks, and their teams, as being very responsive. As one interviewee described it, "When issues pop up, we resolve them pretty quick based on many willing people who are willing to engage, take time to clarify. It's all about relationships."

However, some plans also noted that other DHCS staff, including MCP liaisons, often did not have sufficient managed care content expertise or training. A few plans reported that the experience with plan liaisons on day-to-day issues was inconsistent because the liaisons often lacked the content expertise or managed care experience necessary for a high-quality partnership. Additional management oversight of the DHCS staff and specific training or collaboration opportunities may improve the two-way engagement at this level.

Some plans mentioned that similar inconsistency applied to their on-site auditing team (which were sometimes state contractors). One interviewee noted that it is a challenge for DHCS to recruit and retain staff with knowledge of the managed care system they oversee. "There is a chasm between policy and operations sometimes." An interviewee of another plan noted a "lack of state staff understanding of what managed care is and what we do. Very few DHCS staff have ever worked in a health plan — they don't understand the complexity of health plan operations (systems, encounter data, provider network, moving needle on quality). They don't understand the reality of the requirements and expectations." In addition, one interviewee indicated that a required MCP report might go to one DHCS analyst who requests it in a different format or requires clarification, while another analyst might say it's fine. The interviewee noted that this lack of consistency within DHCS happens on the contract interpretation side as well. One plan noted that they

struggle with the operations division at Medi-Cal being responsive and timely, "They have their own operational issues, so they don't always know how to face plan-specific issues."

A number of interviewees mentioned that the focus of DHCS is on operational issues. A couple of MCP interviewees noted that DHCS has limited staff and has been primarily focused on implementation issues related to the federal managed care rule, California's AB 205 codifying the state's approach to compliance with the federal rule, and the implementation of Medicaid expansion statewide and Medicaid managed care expansion in new counties. One interviewee noted that DHCS's focus on implementation of these many and complex Medicaid managed care changes could be viewed as the state's priority.

Consumer representatives are engaged with the program in numerous ways and believe their role is important in ensuring the plans are accountable to the population they serve and to taxpayers. One interviewee noted that their "sense of concern was heightened," as the state has expanded managed care to more vulnerable populations including seniors and persons with disabilities. Consumer representatives acknowledged that there are some strong consumer protections in place, including for most plans, licensing under DMHC. They also remarked that DHCS includes consumer advocates in its advisory groups and overall planning efforts and that there are some opportunities to have their voices heard. Interviewees remarked, however, that the decisionmaking process felt somewhat opaque at times, and that they are frustrated by what they perceive as DHCS's lack of a vision for its overall program management. Moreover, they believe that there are opportunities for DHCS to play a more active role in its oversight responsibilities of plans.

## DHCS Strategic Priorities

In terms of DHCS strategic policies, the MCPs that were interviewed generally reported little or no awareness of DHCS strategic priorities. Plans reported that, despite their familiarity with the DHCS quality plan, they did not understand DHCS's performance priorities specific to MCPs. However, one interviewee noted that the department has "morphed over time" and is now more focused and targeted in its setting and communication of objectives, and this respondent believed that DHCS currently was more formal and organized in its oversight.

Multiple MCP interviewees noted the limited time that DHCS allows plans to respond to draft policies (days in some cases), and a few indicated that DHCS often did not change its policies based on the input solicited and received. Some plans and one consumer interviewee also suggested that DHCS should collaborate more in developing or finalizing All Plan Letters (APLs) and be more responsive to MCP feedback on APLs. These interviewees also suggested that DHCS provide guidance that is more detailed. One MCP suggested more time for implementation prior to changes in new policies were needed, and added, “DHCS needs to be more thoughtful about operational challenges — get more guidance.” One plan interviewee summarized a negative policy implementation as follows: “Everyone is looking for the specifics. What I’ve seen is that the details aren’t provided as often as everyone would like. Example: last year’s transportation implementation. Nonemergency medical transportation is much more complicated than emergency medical transportation. We had days to respond and operationalize instead of months.”

Multiple health plan interviewees generally described DHCS’s policy development approach as not very collaborative and largely done through All Plan Letters. As one interviewee noted, “The contract is 200 pages long and hasn’t been updated in about seven years, so most of the policy guidance comes from APLs.” Some interviewees noted that DHCS implemented new policies through APLs and did not engage plans in the policy development in a meaningful way. One plan noted that the running set of APLs had in large part superseded the contract as the source of expectations about plan operations. However, another plan noted that DHCS overall provides MCPs with “good, clear, specific expectations,” and they noted that Medi-Cal has a very specific set of expectations around performance that is set out by contract and APLs.

A few interviewed plans raised concerns about specific DHCS policies, including the implementation of potentially preventable admissions policy, geographic risk averaging, and the alignment of network adequacy and access standards between DHCS and DMHC.

When asked for positive examples of how DHCS helps MCPs improve, one plan noted the palliative care benefit rollout. This interviewee was impressed by DHCS’s inclusion of stakeholders and use of extensive provider education and learning collaboratives to clarify how

the Medicaid palliative care benefit was being defined. Another plan interviewee believes “the PIPs [performance improvement projects] have been helpful,” noting that the “collaborative nature of getting plans to work together” was “more likely to be able to move the needle.” Another plan interviewee noted that smaller workgroups convened by DHCS for county-level plans were particularly helpful in working through policy issues. This MCP believes that the quarterly CEO meetings held by DHCS are too large to have any meaningful dialogue and are more of a list of announcements or updates by DHCS. Alternatively, the smaller meetings, which were held before the larger CEO and CFO meetings, provide a safe environment for health plan representatives to voice concerns about new and emerging issues.

Consumer representatives viewed DHCS as mostly reactionary when it comes to policymaking. This, they believe, is evidenced by the fact that DHCS conducts a lot of its policymaking via APLs to respond to issues that arise during a contract year. Interviewees were unclear of DHCS’s priorities and wondered whether priorities were communicated with plans. If a vision and priorities exist, they recommend that DHCS communicate that vision more clearly and widely, and include strategies for achieving its priorities more proactively. One consumer representative noted that the state’s size and the scope of the program means that DHCS staff will understandably “spend most of their time just making the program work. They have their hands full keeping the wheels turning. Because those [operational demands] are so big, priorities like ‘Are we driving towards a better health care system?’ get lost.” Consumer representative interviewees suggested that DHCS should have proactive goals and prioritize prevention, access, quality of care, and improving health disparities for its MCP beneficiaries.

## Performance Incentives

Interviewed health plans reported that DHCS had few performance incentives for MCPs. Plans were focused on the External Accountability Set measures and reported that DHCS enforcement of the Minimum Performance Level (MPL) standard for individual HEDIS measures with Corrective Action Plans (CAPs) was predictable and reasonably effective. The prospect of having to do a CAP seemed to be an effective incentive for some plans to improve their performance on targeted HEDIS measures. One plan interviewed, however, indicated that it has been engaged in a number of CAPs and has successfully

completed all the required CAP activities, yet its performance is still not above the MPL. This plan questioned the applicability of national HEDIS benchmarks to certain regions/counties in California, given the limited providers and resources in the area combined with the relatively low Medi-Cal rates from the plan's perspective.

A few plans mentioned the DHCS Performance Dashboard as an incentive — specifically not wanting to be shown at the bottom of plan comparisons. Some interviewees noted the Aggregated Quality Factor Score (AQFS), the composite score that accounts for plan performance on all DHCS-selected HEDIS measures, was important to them. One plan mentioned that the Minimum Performance Level on the AQFS is 40%, and if a plan goes below that threshold, a CAP is triggered. Interviewees expressed different levels of understanding of, and confidence in, how the AQFS composite score was developed. One interviewee believes that plans are only evaluated against their own performance in prior years.

In general, interviewed health plans thought that the Medi-Cal auto-assignment incentive was not significant due to the relatively high percentages of people selecting health plans and the ability of members to transfer out of an assigned plan. One plan indicated that the auto-assignment is complicated by local initiative plans being paid more than commercial plans and therefore having more money to put into provider incentives and rates, which also puts local initiatives at advantage for improved HEDIS scores, in this plan's perspective. A few plans noted that the specific measures in auto-assignment are what plans focus on to lift those HEDIS measure scores, but this creates a perverse incentive to ignore other measures, some of which may be more important.

Consumer representatives that were interviewed believed that DHCS could more actively manage the plans around performance. They believe that DHCS could push the plans much harder than it does. For example, requiring plans to meet only a 25th percentile on HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) was viewed by the interviewees as a low bar. They suggested that perhaps adjusting plan performance expectations by patient characteristics might be fairer to plans in some cases and would allow for a higher bar. In addition, DHCS does not currently include financial incentives for better performance. While auto-assignment motivates some plans, it may not work in all

counties, and DHCS should consider additional positive financial incentives for improved performance.

Consumer representatives urge DHCS to implement CAHPS surveys more frequently than every three years to measure consumer satisfaction. However, they are also somewhat dissatisfied with the focus on HEDIS and CAHPS measures, which they believe do not truly assess what consumers care about: timely access to patient-centered care. One interviewee noted that plans should not be allowed to select the measures they are being graded on and that DHCS must take a more proactive role in setting quality priorities. That interviewee offered that DHCS could “develop the measures list in a collaborative, transparent way with advocates, providers, plans, and DHCS.” In addition, one consumer representative suggested that DHCS should consider a child-specific set of performance indicators that it monitors regularly. This interviewee noted that “the Child CMS [Centers for Medicare & Medicaid Services] core indicators for California are below the nationwide median pretty much consistently.”

There was concern noted by consumer representatives regarding access standards and network adequacy, especially as they relate to specialty care and in certain geographic regions. The shift in the population enrolled in managed care has made timely access to specialists even more important. Although the contracts specify certain standards, DHCS often approves exemptions to some of the standards. Several consumer representatives noted that eight MCPs are on CAPs for failing to meet network adequacy standards. Consumer representatives voiced concern about access and suggested that the state needs deeper enforcement of these standards.

## Coordination Between DHCS and DMHC

Most interviewed plans thought more could be done to coordinate between DHCS and DMHC both in day-to-day responsibilities and with respect to the scope and execution of their audits. All plans noted the resource intensity of the various audits. One MCP interviewee noted that the state wants to be “deliberate and specific” and has a workgroup with plan compliance staff, which has narrowed the scope of audits. In terms of the usefulness of the audits, as one plan summarized it, “Sometimes findings are warranted and follow-up is good, sometimes kind of picky and not as helpful. Item-by-item issue.”

Another plan found that auditor experience and familiarity with managed care seemed to drive focus more than any overarching DHCS priority or approach.

## Alignment Across California Purchasers

While the plan representatives the authors spoke to did not mention coordination across California purchasers as an important issue to them, most consumer advocates mentioned the desire for more coordination. One consumer representative interviewee did note that there was alignment in the maternal child health area across DMHC, DHCS, and Covered California. Consumer representatives frequently noted that Covered California was more proactive with its plan oversight, noting that it sets priority areas and holds plans accountable for meeting high standards. One interviewee noted that Covered California requires MCP performance to improve year over year and offered that DHCS should have the same expectation. Consumer representatives recognize that Covered California is a much smaller and newer purchaser and began its role more recently, whereas “active purchasing” is more the norm. Still, consumer representatives desire greater coordination across the purchasers on their “quality, cost, and equity agenda.” One representative suggested that they would like to see more consistency in consumer-facing services as well as including expectations about customer service and provider networks, and another suggested that engagement with consumer advocates could also be more consistent across agencies.

## Data and Reporting

For the most part, MCPs did not single out particular reporting as useful or burdensome, although one plan was frustrated with encounter data requirements, including lack of coordination with CMS. Another interviewed plan indicated that the Medi-Cal encounter data policy encourages plans to use fee-for-service (FFS) with providers and said that DHCS holds plans to different encounter data standards. Some plans commented on the burden and usefulness of multiple network filings, including time doing geo-mapping, without DHCS providing feedback or assistance for improving network access where there are no physicians or where providers won’t participate in Medi-Cal.

One plan noted that DHCS is clear on deadlines — and that it is obvious that DHCS opens and reviews the MCP reports, which has not always been the case. This interviewee noted that the reporting requirements work best when DHCS “is clear on contents of the report too. The reports or formats are not always completely defined. It can involve a lot of back and forth.” One MCP noted that it documented its conversations with state staff regarding the nonemergency transportation benefit implementation and shared its assumptions with auditors when that benefit was added to the audit schedule to ensure that the auditor understood why certain implementation decisions were made.

At least one plan noted that data reporting could be more granular — at the subregion level. It noted that there may be specific challenges in rural areas regarding access or outcomes that are not obvious if the data are reported at a higher level. One plan also noted that it supports the state’s goal of improving and using encounter data for comparing MCP and overall managed care program performance but indicated there are opportunities for improvement and that the encounter data standards are harder for plans in markets with a lot of delegation at the provider level.

There also is some confusion among MCPs regarding how the data are being used. One MCP interviewee indicated that DHCS is “using encounter data in many different ways and publishing Q-Med data set with a graph over 24 months and upper/lower limit of where DHCS wants you to be.” It was unclear to this interviewee how DHCS sets the upper and lower benchmarks or where the data for this analysis comes from. This interviewee thought that greater transparency about where data come from and how benchmarks are calculated may be helpful, as well as how DHCS will use the data that plans are reporting to them.

Interviewees from consumer representatives provided a number of suggestions regarding data monitoring. In general, they believed that the data collected and reported by DHCS were too high-level and too old to be relevant. They want to see data analyzed by plan, and by various sociodemographic characteristics including region, race/ethnicity, language, and disability status. They acknowledged that such an effort would require additional resources but firmly believe that aggregate-level data do not provide enough granularity to assess quality and access, and averages can be very misleading.



## Rates and Rate Setting

Not surprisingly, some interviewees raised the issue of low Medi-Cal rates and the lack of sufficient transparency in setting the rates. Some interviewees noted the impact of the low rates on the plans' ability to perform and innovate, and their ability to contract with providers and motivate providers to improve their performance on quality metrics. As one plan noted, "The reality of the Medi-Cal space: It is the lowest payer in the market with highest expectations and highest admin burden," which makes it difficult to perform at the level expected by the state. A few interviewees noted that local initiative plans are paid higher rates than the commercial plans in the same region. One health plan noted that they have little incentive to reduce costs of care because they are penalized for it in future years' rate-setting processes.

## V. Using Procurement and Contracting to Support Value-Based Purchasing

A comprehensive approach to value-based purchasing begins by executing a well-defined approach to procurement and contracting. This section describes the best practices for establishing a solid foundation for managed care oversight and performance improvement. It is organized by the following objectives:

- ▶ Establish a clear vision for the managed care program
- ▶ Use procurement as a tool to reinforce policy goals and oversight
- ▶ Put the contract in the center of the MCP management strategy
- ▶ Align state purchasing when consistent with the program's priorities

## Establish a Clear Vision for the Managed Care Program

Value-based purchasing works best when a clear vision for contractors is articulated up front, and subsequent policies tie back to that vision. The purchaser needs to develop accompanying goals and objectives to measure against and clearly and consistently communicate to its contractors. The policy window for articulating a new vision naturally occurs when there is a change in administration, during a new contract procurement, or when the state or federal government makes substantial changes to the program.

Since DHCS has not recently reprocured its MCPs, DHCS has not had the opportunity to describe its vision for the managed care program. Governor Newsom has signaled that health care will be a key part of his agenda, and that he is interested in alignment in state purchasing, based on his early announcements regarding improved access and statewide negotiations for prescription drugs.<sup>16</sup> Having the focus of the governor may provide the Medi-Cal program with the needed support to articulate a new and broader vision for health.

As noted above, the MCPs the authors interviewed generally reported little or no awareness of DHCS strategic priorities. Plans reported that, despite their familiarity with the DHCS quality plan, they did not understand DHCS's performance priorities specific to MCPs. Consumer representatives viewed DHCS as mostly reactionary when it comes to policymaking. Interviewees were unclear of DHCS's priorities and wondered whether priorities were communicated with plans. If a vision and priorities exist, they recommend that DHCS communicate that vision more clearly and widely, and include strategies for achieving its priorities more proactively. One consumer representative acknowledged that the state's size and the scope of the program mean that DHCS staff will understandably focus their time on making the program work.

There are a number of recent examples of states laying out clear visions for their Medicaid managed care programs within the procurement process. In Massachusetts's most recent procurement,<sup>17</sup> the state presented its broad reform efforts and included the following vision statement: "These reforms aim to integrate care across silos, to incorporate social determinants into Members' care, to balance the needs of large health systems with those of small community providers, and to support a shift

in the delivery system to appropriate higher value and lower intensity settings.”

Massachusetts also articulated specific goals within its procurement, as provided in Table 2.

To ensure that stakeholders were aware of this new managed care strategy, Massachusetts conducted a widespread outreach campaign prior to the release of the procurement to share its new vision. Other states, including Florida, conduct an additional series of educational outreach sessions once new vendors and contracts are finalized. Such meetings can help to reinforce with contractors the new strategy and also provide additional detail on performance objectives.

During the upcoming procurement, DHCS could establish a clear vision for managed care aligned with its overall vision for the Medicaid program. DHCS should consider using a formal stakeholder process, including MCPs, providers, and consumer representatives in developing this vision. DHCS could build off its successful experience in developing and updating the DHCS Strategy for Quality Improvement in Health Care,<sup>18</sup> which includes clear and specific linked goals and priorities to drive improvements in population health and care delivery, as outlined in Table 3.

**Table 2. Massachusetts’ MCP Procurement Goals**

- ▶ Improving the experience of enrollee care.
- ▶ Increasing integration and coordination among providers, including in particular integration across the physical health, behavioral health, and LTSS (long-term services and supports) delivery systems.
- ▶ Increasing the clinical quality of enrollee care.
- ▶ Increasing the cost efficiency of enrollee care, including reducing the rate of growth in enrollees’ total costs of care.
- ▶ Achieving value for the commonwealth through increasing the cost efficiency of administrative services.
- ▶ Ensuring enrollees’ access to care and choice among providers.
- ▶ Increasing the cultural and linguistic appropriateness of enrollee care, and increasing access to accessible medical and diagnostic equipment for enrollees with disabilities.
- ▶ Contracting with managed care organizations (MCOs) who demonstrate capacity to operate and support members and programming statewide or in a larger number of regions.
- ▶ Achieving alignment with overall MassHealth pricing strategy.
- ▶ Supporting the uptake of alternative payment models in the MassHealth Managed Care Program, including MCO-administered accountable care organizations (ACOs).
- ▶ Contracting with MCOs who are best qualified to meet the commonwealth’s goals and create value for the commonwealth.

Source: Massachusetts Request for Response for Managed Care Organizations, 2016.

**Table 3. DHCS Quality Improvement Goals and Priorities**

DHCS QUALITY IMPROVEMENT GOALS	PRIORITIES OF THE DHCS QUALITY STRATEGY
<ul style="list-style-type: none"> <li>▶ Improve the health of all Californians.</li> <li>▶ Enhance quality, including the patient care experience, in all DHCS programs.</li> <li>▶ Reduce the department’s per capita health care spending.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Improve patient safety.</li> <li>▶ Deliver effective, efficient, affordable care.</li> <li>▶ Engage persons and families in their health.</li> <li>▶ Enhance communication and coordination of care.</li> <li>▶ Advance prevention.</li> <li>▶ Foster healthy communities.</li> <li>▶ Eliminate health disparities.</li> </ul>

Source: DHCS Quality Strategy, 2017.

By using the goals and priorities in the 2017 DHCS quality improvement strategy as a roadmap for its managed care vision, DHCS can specifically articulate how this quality improvement vision applies to Medi-Cal managed care, which can help shift DHCS's and plans' expectations from minimum compliance to higher levels of performance and ongoing performance improvement. Its vision statement could be accompanied by a strategic plan or roadmap for how the vision will be met through measurable goals and objectives that are reflected in revised contract requirements for all Medi-Cal plans. Ideally, decisions about the managed care procurement would be developed with deliberate reference to the agency's overarching priorities and specific managed care goals.

DHCS can also look for opportunities to clearly communicate its vision and roadmap with all staff, other state agencies, MCPs, providers, Medi-Cal beneficiaries and their consumer representatives, and other key stakeholders. Moreover, the vision and roadmap could be used to unify and align the entire managed care strategy including the procurement, changes to COHS and local initiative contracts, and the quality strategy.

### Best Practice

Establish a clear vision accompanied by measurable goals and objectives for the managed care program and communicate it broadly.

### Why This Is Important

A clear and well-communicated vision statement sets the direction and focus for the program for the next three to five years. The vision's measurable goals and objectives should be focused on continuous improvement, as well as reflect any changes in the health care market, state priorities, and beneficiary needs.

## Use Periodic Procurement as a Tool to Reinforce Policy Goals and Oversight

The groundwork for an effective contract begins in the procurement process. In developing procurements, state Medicaid programs should discuss and seek consensus on specific value objectives that will establish clear direction for the request for proposal (RFP), including the scope of work, questions to which MCPs must respond, and evaluation criteria.<sup>19</sup>

The procurement process is an important opportunity for a state to reiterate its vision and priorities and secure commitments from bidding plans that help further those priorities. For example, reprourement of health plans, and to a lesser extent, substantive annual contract amendments, enable state purchasers to:

- ▶ Rebase performance measures.
- ▶ Negotiate higher minimum and target benchmarks for plan performance.
- ▶ Negotiate higher service level agreements.
- ▶ Negotiate stronger provider networks and access standards.
- ▶ Focus quality measures on key Medicaid goals.
- ▶ Update oversight strategies.

Ideally, reprourements should occur every five years. This time frame is long enough for the MCPs to create a baseline, implement performance initiatives over at least two years, and for the MCPs and the state Medicaid agency to assess results. This five-year time frame also allows for plans to engage with providers and consumers, to develop and invest in quality and/or cost-effective interventions for the covered populations, and to potentially achieve a return on investment.

The procurement process also uniquely offers states the ability to raise the bar by requiring MCPs interested in obtaining or retaining their business to commit to new and improved state standards and contract terms.

California does not currently have a reprourement schedule for its MCPs. Although California's situation is somewhat different from other states in that a number of its MCPs are not reprocured per se — the nonprocured

plans do abide by similar, if not the same, contract requirements. It is the authors' understanding that DHCS makes key updates to its model contract — it uses this updated language with all types of MCPs — to provide further direction and requirements related to specific policies and initiatives. It therefore remains important for DHCS to consider reprourement a periodic and important opportunity for resetting priorities and engaging with MCPs around its strategic vision.

Many states, including Florida and Massachusetts, contract with MCPs every five years. Typically, and among the purchasers that were reviewed, the longest MCP contracts are for no more than eight years. In a number of states, the maximum length of a Medicaid managed care contract is stipulated by state law or procurement rules. Some states have shorter MCP contract terms (three to four years), with options for a limited number of one- or two-year renewals. An optional renewal period provides the state with some flexibility for more time between procurements in cases where the Medicaid agency is not ready to reestablish a vision or does not have appropriate resources to commit to a reprourement at that time due to competing demands. CalPERS and Covered California aim to reprocur within this five-year time frame, as do Florida, Massachusetts, Tennessee, Texas, and Washington.

DHCS could consider establishing a schedule for MCP reprourement that aligns with the five-year average the authors have seen in other states. Any substantive changes made to the model contract at that time should be similar, if not identical, to the contracts operating in COHS and local initiative plans.

#### **Best Practice**

Reprocure competitive MCPs at least every five years and conduct a major rewrite of model contracts.

#### **Why This Is Important**

A regular procurement process offers states the ability to raise the bar by requiring MCPs interested in obtaining or retaining their business to commit to new and improved state standards and contract terms.

## **Put the Contract in the Center of the MCP Management Strategy**

Putting the contract at the center of the MCP management strategy is the heart of effective management and oversight. The contract should clearly outline the suite of management strategies that the state will use and can include other terms that facilitate ongoing oversight and management. At a minimum, the contract should include a detailed table of contents referencing both major sections and specific topics. Supporting documentation, including APLs, quality materials (specifications, reports, measure lists), reporting requirements and templates, and explanatory guidance can explicitly refer to the contract sections for consistent reference. State and MCP staff, as well as other stakeholders, use these supporting documents regularly. If states explicitly connect these documents to the contract, all parties will have better access to the current state of policy, operations, and guidance. An initial step could be to create an online index of these materials based on the contract's sections. However, a best practice is to consolidate these supplemental operational materials into an operations manual that is organized in parallel to the contract and regularly updated.

The DHCS managed care contract itself is organized into a series of attachments, each of which covers a separate topic. The boilerplate contracts available on the DHCS website do not include a table of contents, which makes it somewhat difficult to navigate the 257-page document. Other than on the managed care website, DHCS does not maintain a specific policy manual for managed care; implementation details such as reporting expectations and templates are handled ad hoc or through APLs. DHCS also uses APLs to communicate changes in policy to its MCPs. The APLs are organized by date of release, which makes it difficult to access the latest guidance on a particular topic or section of the contract.

Most state MCP contracts include a detailed table of contents, including those that the authors reviewed from Florida, Massachusetts, Tennessee, Texas, and Washington. Florida includes a comprehensive reporting manual that it pairs with the state's version of APLs to provide more detailed operational and policy guidance outside of the MCP contract. Texas publishes an online "Uniform Managed Care Manual" that provides a single source for MCPs to access everything related to the program including member publications, standard forms, reports, contract instructions, and guidance.<sup>20</sup>

Some state purchasers also include their own commitments in the body of the contract. Articulating specific roles and responsibilities of the agency increases transparency, sets clear expectations, and serves as a common point of reference for state and plan staff alike. For instance, one commitment might be to publish an annual update to quality metrics and targets on a regular schedule so that MCPs can plan their operational calendars accordingly. In Massachusetts, the state's contract with MCPs includes a section that delineates clear responsibilities for the state during the contract period, describing how the state will manage the contract, including who the contract liaison is and what their responsibilities are under the contract; how the state will evaluate the performance of the MCP; how the state will coordinate with the MCP on operational issues including enrollment and coordination of benefits; and when and how the state will implement sanctions on the MCP. Covered California goes a step further and sets specific performance targets for itself around operational issues like phone metrics and complaint resolution, and if it falls short, the MCP receives credits that offset penalties the MCP might otherwise earn.

While developing a consolidated Medicaid managed care policy manual would be a significant amount of work for DHCS, the state could consider a staged approach. For example, a first step could include leveraging Medi-Cal's APLs to create a manual by organizing the APLs by topic and mirroring contract numbering. This strategy could provide an organized single source of guidance for MCPs, state staff, and other stakeholders as they work toward a more comprehensive manual.

#### **Best Practice**

Develop a consolidated Medicaid managed care policy manual that provides a single source of guidance for MCPs, state staff, and other stakeholders.

#### **Why This Is Important**

Creating a strong organizational approach allows state and plan staff and other stakeholders to quickly and clearly understand the history and current guidance in areas where policy has changed since the contract was initiated.

## **Align State Purchasing**

As the largest purchaser of health care in the country and in many states, Medicaid programs have incredible leverage to influence health policy and purchasing decisions. If states align their purchasing goals and strategies across other state purchasers, they can increase their purchasing power even more and potentially influence overall population health. Opportunities for improved alignment include the development of a single or aligned quality measure set across the programs, implementation of similar value-based payment requirements, or strategic focus on specific health or public health outcomes. To more effectively advance value, Medicaid agencies can encourage or require health plan participation in multi-payer initiatives. In addition, state purchasers can create alignment by engaging in common contracting tools as well as using common performance metrics and reporting strategies as other large purchasers in their marketplace. Importantly, alignment does not have to occur across all dimensions of a value-based initiative to be successful.

While a state Medicaid program tends to be one of the largest, if not the largest purchaser in a state, it is not the only one. Providers interact with many different payers. The maximum leverage for delivery system improvement likely will come from coordinating efforts around common multipurchaser priorities. Alignment with other purchasers could take two forms. Given its size, Medicaid can lead efforts to align purchasers around key initiatives. However, in other areas, Medicaid can join existing initiatives to take advantage of the experience and momentum of other purchasers.

DHCS's existing efforts to align contract terms across its managed care models as well as its effort to coordinate audits with DMHC provide evidence of its willingness to coordinate efforts to maximize efficiencies. Smart Care California is an example of an alignment effort in California that brings together Medi-Cal, Covered California, and CalPERS plans to focus on strategic health care goals, including reducing the use of c-sections for low-risk, first time pregnancies; reducing opioid prescribing; and increasing the use of evidence-based care for low back pain.

However, within the Medi-Cal program there are several initiatives to improve health care access and quality while containing costs that are not fully incorporated into the managed care program. For example, reform initiatives,

such as DSRIP funding — in particular the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, which requires hospitals to participate in alternative payment models — could be more closely aligned with the managed care program. Such alignment could increase the effectiveness of these efforts in the short term, and potentially make them more sustainable in the long term.

While the plan representatives the authors spoke to did not mention the lack of coordination across California public purchasers as an important issue to them, most consumer representatives mentioned the desire for more coordination regarding the state’s quality, cost, and equity agenda. One representative would like to see more consistency on consumer-facing services as well as documented expectations about customer service and provider networks, and another suggested that engagement with consumer representatives also could be more consistent across agencies.

A number of states have made significant strides to align their public purchasers around certain key priorities. Washington State provides one example where alignment across public purchasers has been ambitious. There, a single agency — the Washington Health Care Authority — was created to aid coordination of key initiatives across Medicaid, the Affordable Care Act (ACA) marketplace, and state employee and retiree health benefits. Tennessee also has an aspiring agenda for transforming its health care delivery system and broadly coordinates payment reform strategies across its public purchasers, while other states have implemented aligned approaches for measuring quality and implementing value-based payment (VBP) requirements.

Where Medi-Cal aligns with CalPERS and Covered California, it may allow the state to further move the needle on improved health care access and quality, as well as activities to contain costs. While Medi-Cal works with other state health purchasers to pursue specific initiatives, such as Smart Care California, ongoing attention to alignment of policies and approaches across purchasers has been fairly limited. In part, this is likely because of the ongoing regulatory and oversight requirements placed on DHCS, as well as on Covered California and CalPERS. Where those requirements overlap and approaches to health care system reform are similar, despite the differences in population, it will make sense for these agencies to work more closely on policy approaches.

### Best Practice

Maximize opportunities for alignment across state purchasers including marketplace and state employee programs.

### Why This Is Important

Creating an aligned purchasing strategy around specific common goals, such as quality measurement and value-based purchasing, could strengthen a state’s ability to improve care delivery, increase efficiency, and reduce costs.

## VI. Contract Tools to Increase Managed Care Plan Accountability

In looking at particular oversight and management tools, it is essential to consider the context within which Medi-Cal operates. To that end, the authors considered six key questions to assess the applicability of approaches for DHCS:

- ▶ Does the tool help measure health plan accountability for **defined goals**?
- ▶ Is the tool **feasible** for DHCS given regulatory and resource constraints? Is it administratively feasible for plans and/or providers?
- ▶ Is there an **example** DHCS can build from (i.e., doesn’t require building from scratch)?
- ▶ Is it an **efficient** way to meet DHCS goals (i.e., doesn’t require significant new spending or other resources)?
- ▶ Is it **flexible and appropriate** across the different Medi-Cal contracting environments? Can it be used statewide or regionally?
- ▶ Does it **leverage** or align with multipayer opportunities, where applicable (e.g., Smart Care California)?

All oversight and management activities come with some administrative cost. When considering contract requirements on MCPs, it is important to keep in mind the capacity and strengths of staff at both DHCS and at the

MCPs, as well as the capabilities of various technological tools (e.g., data analysis, project management, and information display tools). Oversight strategies with high administrative burden should be reserved for the highest priorities and goals, and DHCS should systematically seek ways of reducing the burden before implementing new processes.

There are a variety of contractual tools that can enhance MCP oversight. The tools described below are divided into four separate areas:

- ▶ Financial Tools
- ▶ Performance Measurement and Nonfinancial Incentives
- ▶ Reporting and Transparency
- ▶ Specific Contractual Requirements

Which tools a state selects will depend in large part on the state’s goals and priorities for its Medicaid managed care program. Table 4 lists the potential tools included in this report and considerations for each tool.

**Table 4 Summary of Specific Contractual and Oversight Tools**

TOOL	CONSIDERATION
Performance Measures Incentives	Can provide incentive for exceeding performance target or improvement, and may also provide penalty for missing target.
Bonus Payment Funded by Withhold	Appropriate for objective metrics or milestones that can be standardized and measured.
Shared Savings (profit or gain sharing)	Requires careful definition of metrics and may or may not relate to medical loss ratio standards. The incentive is only effective if plans anticipate profits.
Liquidated Damages (or other explicit penalties)	Damages are “downside only” and appropriate for objective metrics or milestones that can be standardized and measured.
State-Funded Bonus Payments	Payments are “upside only” — the amount of payment should be scaled to resources required to achieve certain outcomes.
Capitation Rate Adjustment	Amount of payment scales with enrollment.
Nonfinancial Incentives	Where states do not have ability to provide financial incentives, or in addition to financial incentives, can provide encouragement to improve performance and/or meet specific contractual requirements.
Reporting and Transparency	The act of reporting and providing transparent information on plan performance may in and of itself encourage plan improvement on reportable measures.
Requirement for Accreditation	Accreditation requirements should be offset by reduced auditing and reporting of overlapping policy areas.
Minimum Requirements for Alternative Payment Models with Providers	May look at number of contracts, number of providers, or number of covered members.
Specific Requirements for Performance Improvement Plans	Useful for areas where improvement is desired but data are insufficient.
Required MCP Participation in Multipayer Initiatives	Important to assess how initiatives align with priorities and resources of the managed care program.
Enhanced Delegation Requirements	Depends on which obligations are delegated.
Auditing	Focus on compliance and meeting process requirements.
Corrective Action Plans (CAPs)	Where plans are not meeting contractual requirements, CAPs can be an important tool to provide plans with an opportunity to improve performance and receive technical assistance from the state.

## Financial Tools

Purchasers can attach financial incentives to a variety of contract areas in order to motivate behavior change, and they can implement these financial tools in myriad ways. Considerations include the availability of additional funding, the impact of these tools on actuarial soundness of rates, the size of the financial impact, and the timing of the payments or penalties.<sup>21</sup> CHCF recently published a review of financial tools that states use to hold Medicaid managed care plans accountable for quality performance,<sup>22</sup> including:

- ▶ Bonus payment funded by withhold
- ▶ Shared savings (profit or gain sharing)
- ▶ Liquidated damages or other explicit penalties
- ▶ State-funded bonus payments
- ▶ Capitation rate adjustment

Below are brief descriptions of each approach and state-specific best-practice examples from the contracts reviewed for this report.

DHCS does not use extensive financial incentives to improve performance, as discussed below. DHCS does require CAPs,<sup>23</sup> and when CAPs do not remedy the infraction, DHCS can apply financial penalties to the MCPs but these sanctions have been used sporadically. Consumer representatives the authors spoke with believe that DHCS could more actively manage the MCPs around performance and should consider financial incentives.

### Bonus Payment Funded by Withhold

Withholding a percentage of the monthly capitation payment is the most common approach states have taken to implement a performance-based incentive program. Twenty-nine states reported having withhold arrangements in the 2017 annual state budget survey of the National Association of Medicaid Directors, with withhold amounts ranging from 1% to 5%.<sup>24</sup> Under a withhold arrangement, MCPs can gain or lose the entire amount withheld based on performance. An advantage to this approach is that a MCP knows in advance the maximum amount of its financial exposure. Additionally, the state has the option to retain the withhold or to redistribute unearned dollars to top performers.

A promising MCP withhold practice from Tennessee includes a withholding provision from the state's capitation rates that changes over time based on the performance of the MCP. Initially, the maximum withhold is up to 10% of MCP capitation for noncompliance with TennCare contractual performance requirements.<sup>25</sup> If MCPs have no deficiencies for six months, Tennessee immediately reduces the withheld amount to 5% and then again to 2.5% of the capitation after another six months without any deficiencies. If a MCP is cited for any deficiency, the withhold goes back to 10%.

The MCP withhold that Texas implemented recently is more similar to capitation withhold approaches used in other states. In the revised Texas Pay-for-Quality Program, the state consistently withholds up to 3% of the capitation rate, which can be earned back by MCPs based on annual performance on quality measures.<sup>26</sup> When determining whether a plan will earn back the full 3% capitation withheld annually, Texas will assess MCPs both on performance against benchmarks and performance against themselves in the prior year.

### Shared Savings (profit or gain sharing)

In this model, a MCP shares with the state a portion of the savings the MCP generates. There are different ways to implement a shared savings model. One option is for states to set a cap on plan profit (margin) and then permit MCPs to retain a percentage of profits above the set cap should the MCP meet specific state-defined performance targets on specified quality measures. Another method might require the MCP to achieve a certain percentage of savings before additional savings are shared with the MCP. In addition, a state could vary the proportion of savings shared with the MCP based on the strength of the MCP's performance on the identified quality measures.

Some states that were reviewed, including Florida and Texas, have implemented profit-sharing provisions in their managed care contracts. In Florida, in addition to profit-sharing options, a high-performing MCP is eligible to retain up to an additional 1% of its total revenue if it achieves performance measure rates at or above the 75th percentile for 5 of the 10 performance measures identified by the state, and with none of the MCP's rates below the 50th percentile. Other states, like Washington, have shared savings provisions for plans that achieve certain total cost of care benchmarks. In Washington's



gain-sharing program the MCP keeps the first 3% of gain, and shares gain between 3% and 5% on a 50/50 basis with the state. The state receives all funds in excess of 5% gain.

### Liquidated Damages or Other Explicit Penalties

Under this approach, a state imposes a financial penalty for poor performance. This is a downside-only arrangement for MCPs, and the state does not have any financial exposure. Performance metrics for which a state applies a penalty are typically operational indicators (e.g., timely submission of encounter data).<sup>27</sup> Penalties may be assessed for persistent low performance, noncompliance with contract terms, or serious violations. In addition to potentially generating revenue for the state, this approach has the virtue of being a predictable, immediate consequence in areas where plans may fall out of compliance but more significant consequences (like Corrective Action Plans) may not be appropriate.

Of the states the authors reviewed, Florida, Tennessee, and Texas have provisions within their contracts that allow for the extensive use of liquidated damages, setting predetermined penalty amounts for a catalog of contract infractions. Similarly, Covered California imposes penalties on plans that do not meet minimum operational and quality metrics. CalPERS recently added a provision allowing it to impose liquidated damages but only in very limited circumstances.

### State-Funded Bonus Payments

A performance-based bonus payment provides an opportunity for MCPs to receive additional revenue on top of their base payment. This is an upside-only incentive arrangement for MCPs, but the amount of the incentive payment needs to be significant enough for a MCP to invest in changing its way of doing business. A Medicaid program's priorities may differ strategically from that of a MCP and without an incentive that is large enough to motivate action, success in state-targeted areas could be limited. This approach also would require additional funding from the state.

New York uses a Quality Incentive Program, under which MCPs are eligible for bonus payments for performance on select quality, patient satisfaction, and prevention measures. In Texas, after MCPs are assessed on

performance against the capitation withhold provisions, if there are additional funds remaining from associated MCP recoupments, Texas MCPs can obtain bonus funds based on their performance regarding the state-defined bonus pool measures and MCO size.<sup>28</sup>

### Capitation Rate Adjustment

States may adjust the base capitation rate for MCPs based on quality performance. Rate adjustment has the drawback of reducing budget predictability for the state, as membership growth will also change the amount of the bonus or penalty. This approach may be implemented so the rate adjustment is built into future-year MCP rates and could be adjusted upward and downward based on performance, making it both an upside and downside arrangement for MCPs. (Rules governing actuarial soundness of rates limit downside risk). This approach may require additional state funding.

Oregon includes a performance factor in its rate development whereby a portion of the rate varies based on the managed care plan's performance on cost and quality indicators.

DHCS may want to consider adding one or more financial incentives to ensure that MCPs have the right incentives to improve care delivery for the Medicaid beneficiaries they serve.

#### Best Practice

Consider the full range of financial incentives available and use multiple financial tools to encourage improved performance.

#### Why This Is Important

Financial tools can be strong motivators for contracted MCPs to meet or exceed performance expectations. Most states reviewed have implemented a combination of financial tools and incentives to ensure overall plan compliance and improved performance. Financial incentives applied to state-defined metrics make a stronger business case for MCPs to invest in improved performance on behalf of members.

## Performance Measurement and Nonfinancial Incentives

Best practice in performance measurement is to align measurement and incentives across programs to reflect state priorities, then regularly use data on plan performance to (1) set performance expectations, (2) prioritize Medicaid health plan oversight activities, and (3) compare MCP performance to state, regional, and where available, national benchmarks.

In many large Medicaid managed care programs, contracted plans are expected to improve their clinical quality performance year over year and meet specific performance expectations tied to national, state, or regional benchmarks. Medicaid agencies use a combination of performance benchmark approaches depending on the measure and the availability of applicable statewide or external benchmarks. This type of approach can be used alone or in combination with a comparison of plan performance to an absolute standard. States often look to national benchmarks such as the NCOA Medicaid HEDIS or CAHPS to establish performance expectations based on the 50th or 75th or even 90th percentile performance on the same measure in the immediately preceding year. Other options include comparing plan performance to a statewide weighted average or other state-determined performance target.

Selecting, clearly defining, and using benchmarks for performance measurement enables state purchasers to:

- ▶ Draw the attention and efforts of MCPs to focus on certain areas of importance.
- ▶ Target clear and valid measures of performance to hold MCPs accountable.
- ▶ Focus MCP efforts on demonstrated statewide, regional, or plan-specific opportunities for improvement.
- ▶ Provide timely feedback to MCPs related to performance, including comparison to peers and benchmarks.
- ▶ Establish clear performance benchmarks in advance to clarify the state's expectations for contracted MCPs and providers.

The Medi-Cal program undertakes several activities to further the quality of its managed care program today. DHCS has developed a quality strategy for its Medicaid managed care program as required by the MMC rule, a Managed Care Performance Dashboard that summarizes the performance of MCPs on an aggregate and individual basis, and an External Accountability Set through which it assesses MCP performance on 30 measures.

In addition, Medi-Cal rewards certain plans using an auto-assignment policy based on performance on specific quality measures. In place since 2005, the auto-assignment algorithm rewards competing plans in the same region with automatic enrollment of Medi-Cal beneficiaries based on performance on eight quality measures (six HEDIS measures and two measures of participation of safety-net providers in their contracted networks) as well as encounter data quality.<sup>29</sup> The program rewards better-performing plans (with a bonus for plans that improve year-to-year) in the GMC and Two-Plan regions. The auto-assignment policy is more effective in some areas of California than in others. For example, Kaiser has opted out of receiving assigned enrollees altogether while in Contra Costa County, one plan gets up to 87% of beneficiaries who are automatically assigned to a MCP. Moreover, the auto-assignment policy does not apply to all areas or plans in California. It does not apply to all COHS plans, as they automatically serve all Medi-Cal managed care beneficiaries in their designated regions.

While DHCS has implemented the quality strategies noted above, it sets a fairly low MCP performance expectation at the 25th percentile as a Minimum Performance Level for assessing MCP performance for each measure, without differentiation based on current plan performance or practice in California. Each year, there are MCPs that are not meeting the 25th percentile for certain measures in the state's External Accountability Set. Where that is the case, DHCS typically requires the MCP to implement a Corrective Action Plan, particularly if the performance has not improved for a second year in a row. Ultimately, DHCS has the authority to also impose financial penalties or other consequences for MCPs failing to meet the 25th percentile, but based on the authors' interviews, that does not typically occur.

Of the other state Medicaid purchasers the authors reviewed, all required MCP performance at or above the 50th percentile. Florida, for example, has financial penalties for MCPs performing below the 50th percentile on

groups of HEDIS metrics identified by the state. Florida does allow for a one-year transition period for their new MCP contracts before these penalties are triggered. Other states, like Texas, have financial rewards for plans performing above the 75th percentile. While states typically do not expect their plans to perform at the 90th percentile, some states with consistently high regional NCQA performance do benchmark MCP performance using a variety of NCQA Medicaid percentiles, including the 90th percentile.

Other public purchasers within California use performance measurement and incentives to improve quality of care. Covered California uses specific target performance levels for metrics related to its operational goals. Some of the metrics are HEDIS or CAHPS quality measures, while others include benchmarks in specific areas of policy interest (see Appendix B). Each metric is associated with a maximum possible penalty, and excellent performance on certain metrics can offset poor performance in other areas. Likewise, CalPERS holds its plans accountable through financial penalties for approximately 20 metrics that ultimately impact the plans' administrative fee (see Appendix B). Both programs also require their plans to demonstrate year over year improvements in quality performance and meet specific benchmarks tied to national, regional, or statewide average performance.

While Medi-Cal's current approach to performance measurement appears to be reasonably effective at ensuring compliance with their relatively low minimum MCP expectations, there are few incentives for plans to seek excellent performance, or any improvement, on quality measures. Moreover, quality improvement in Medi-Cal managed care appears to be modest over the past decade, with many plans scoring below the 50th percentile among Medicaid plans nationally on several quality measures. This may be because the only benefits to MCPs of high performance include the potential for somewhat higher enrollment through additional auto-assignments for some non-COHS plans, and some limited public recognition. In contrast, effective value-based purchasing would establish strong incentives for both improving performance over time (at both the MCP and program level) as well as achieving exemplary levels of performance. This would shift the expectation away from minimal compliance and toward the pursuit of excellence, continuous improvement over time, or both.

Consumer representatives the authors spoke with believe that DHCS could more actively manage the plans around performance. They believe that DHCS could push the plans much harder than they do and that requiring plans to meet only a 25th percentile on HEDIS and CAHPS is a missed opportunity. One consumer representative suggested that perhaps adjusting plan performance expectations by patient characteristics might be fairer to plans in some cases and would allow for a higher bar. A few interviewed MCPs participating in the Two-Plan and/or GMC models felt that the Medi-Cal auto-assignment incentive is not a significant incentive for better performance due to the relatively high percentage of people who actively select a health plan in their regions and the ability of members to transfer out of an assigned plan. A number of interviewed plans noted that they focus on getting potential members to affirmatively choose their MCP rather than focus on the plan's performance on auto-assignment measures. COHS plans noted that the auto-assignment logic does not apply in their regions.

DHCS should consider raising its MCP minimum performance expectations above the NCQA 25th percentile and encourage objective, measurable improvements in performance. For example, similar to the PRIME approach, DHCS could require MCPs to obtain a 10% gap closure between the difference in current MCP performance and the 75th percentile for NCQA Medicaid MCO performance (or other applicable high-performance standard) for core MCP metrics in order for the MCP to earn financial incentives and/or avoid financial penalties.

#### **Best Practice**

Set high but attainable performance expectations for MCPs tied to national, state, or regional benchmarks and include year-to-year improvement.

#### **Why This Is Important**

Setting high but attainable performance expectations for MCPs focuses health plan efforts on working toward and achieving excellence and not just meeting minimum standards.

## Reporting and Transparency

Reporting is a key complement to any oversight tool. Effective reporting is (1) well-tailored to the oversight goal, (2) easily understood by the reporting entity, (3) updated with appropriate frequency, and (4) acted on in a timely and predictable manner. In recent years, there has been a significant trend among states toward increased transparency of reporting, as discussed in the “Contract Management and Oversight” section below. It can be challenging for states to prioritize and limit reports to those that are the most actionable, but doing so can significantly reduce administrative burden on MCPs in producing the reports and on states in reviewing them.

Public reporting can be a powerful tool for motivating plan performance if information is presented on a plan-specific basis. Public, plan-specific accountability dashboards should report operational and quality metrics in a way that state staff, plan staff, and the public can evaluate and compare plan performance. State staff can use these dashboards as a point of reference for one-on-one MCP meetings to discuss trends, challenges, and opportunities with senior MCP staff outside of the constraints of specific performance improvement projects (PIPs), CAPs, or audits.

DHCS has developed a robust reporting infrastructure, including a recent investment in automated reporting and a public Managed Care Performance Dashboard. The development of the dashboard is an important effort, but there is limited plan-specific information available to the public. The only plan-specific information currently published is the Aggregated Quality Factor Score. Individual quality scores for plans are not easily accessible or comparable across plans. In addition, while the most recent Medi-Cal External Quality Review Organization (EQRO) annual report includes data in plan-specific appendices, these appendices are no longer highlighted separately on the DHCS website.

Tennessee and Texas, among other states, present plan-specific Medicaid HEDIS performance data. In addition to their MCP dashboards, the Texas HealthCare Learning Collaborative is a best practice in terms of publicly sharing detailed Medicaid MCP performance on a variety of state, regional service area, and national benchmarks,

as well as showing plan performance for the three most recent years.<sup>30</sup> In California, CalPERS reports plan-specific performance data, while Covered California includes a large number of reporting requirements within its plan contracts, and then reviews those reports as part of the plans’ annual recertification process. Covered California also requires its plans to describe their “planned approach to providing healthcare shopping cost and quality information” in significant detail.

While commercial plans and states have moved in the direction of increased transparency of provider quality and price information, price transparency has not been emphasized for Medicaid plans because Medicaid beneficiaries are generally not price sensitive due to low or zero cost-sharing amounts. However, DHCS could require plans to review and potentially publish quality metrics for hospitals and large practice groups or health systems to better inform member (and referring provider) decisionmaking. DHCS could encourage and recognize MCP participation in regional or statewide initiatives to analyze and share performance data at the provider level (e.g., the Integrated Healthcare Association’s Cost & Quality Atlas) as meeting these types of provider performance requirements.

### Best Practice

Use plan-specific public reporting of MCP performance wherever possible.

### Why This Is Important

Public reporting is a powerful tool for motivating plan performance. It can assist state staff in engaging with MCP staff by highlighting plan performance differences and can facilitate discussions around challenges and opportunities for meeting specific performance requirements.

## Specific Contractual Requirements

The contract is an important tool for states to use in requiring or encouraging MCPs to further specific policy objectives of the state. The following discussion includes specific contractual requirements that states have included to enhance managed care plan accountability.

### Requirement for Accreditation

One potential consideration in the procurement process is to require MCPs to be accredited by the National Committee on Quality Assurance (NCQA).<sup>31</sup> By requiring NCQA accreditation, a state brings itself and its constituents some assurance that the plan has appropriate processes and procedures in place to serve its beneficiaries. Moreover, there may be additional efficiencies gained by requiring such accreditation, including fewer or less extensive audits. The new MMC rule includes a mandate that state contracts with MCPs require the plan to inform the state as to whether it has been accredited by a private independent accrediting entity, and authorize the accrediting entity to provide the state a copy of its most recent accreditation review. The accreditation review includes accreditation status, survey type, and level (as applicable); recommended actions or improvements, Corrective Action Plans and summaries of findings; and the expiration date of the accreditation.<sup>32</sup> This additional reporting requirement by CMS suggests, at a minimum, that there is some benefit to states of this additional external oversight.

DHCS does not currently require its MCPs to be accredited by NCQA but as of 2018, 12 Medi-Cal MCPs have been accredited by NCQA.

Increasing numbers of Medicaid programs, including several of the ones reviewed — Florida, Massachusetts, and Tennessee — require MCPs to have or seek accreditation in order to participate in the managed care program.

While DHCS could include a requirement for accreditation for its competitively procured MCPs, it is unlikely that the same requirement could be extended to non-competitively procured COHS and local initiative plans. However, DHCS could explore creating incentives for MCPs to become NCQA accredited, and for MCPs to be Knox-Keene licensed, even if not required to do so. For example, plans maintaining a certain level of NCQA accreditation could have fewer or less frequent reporting

requirements in certain areas, and MCPs that are Knox-Keene licensed could similarly benefit from reduced DHCS oversight requirements that may be duplicative of the DMHC Knox-Keene requirements.

### Minimum Requirements for Alternative Payment Models with Providers

In the past several years there has been a movement away from FFS payment and toward alternative payment models within the Medicare and commercial marketplaces. State Medicaid purchasers have thus far taken the following approaches to requiring MCPs to implement alternative payment methodologies with network providers, including:

- ▶ Requiring bidders in procurements to demonstrate experience with APM arrangements and requiring contractors to develop VBP strategic plans.
- ▶ Requiring health plan reporting to establish APM baselines and track changes in APM arrangements over time.
- ▶ Creating minimum APM requirements for health plans and/or minimum rates of increases in VBP arrangements with contracted providers over time.
- ▶ Requiring health plans to implement and/or increase their use of certain types of VBP arrangements, such as patient-centered medical homes, shared savings arrangements, accountable care organizations, episodes of care, and primary care capitation arrangements with a link to quality.

Given the health care marketplace in California and the prevalence of independent practice associations (IPAs) that have participated in risk-sharing arrangements, DHCS has traditionally taken a hands-off approach to requiring APMs in its MCP contracts. Through the PRIME waiver, however, Medi-Cal safety-net hospitals have specific reporting requirements and have increased their use of APMs to improve their performance on quality metrics. In addition, Covered California recently required its plans to make at least 6% of their hospital payments “at risk” based on hospital quality metrics.

Medicaid programs, including those reviewed in Massachusetts, Texas, and Washington, are increasingly focused on MCP use of APM approaches with their network providers. They are particularly interested in aligning

financial incentives at the provider and health plan level to improve quality of care and efficiency of care as well as providing a funding stream to support delivery system reform. However, there also are states like Florida that are not encouraging MCPs to increase APM participation but are including specific MCP contractual requirements when a plan elects to enter into risk-based contracts with delegated subcontractors.

Minnesota and Tennessee require MCPs to implement specific APM models based on the state's defined parameters. However, many states provide their MCPs with a menu of potential APM strategies from which to choose. Texas and Washington have created financial incentives and penalties for plans to increase certain types of VBP arrangements and meet specified thresholds that are typically based on the percentage of expenditures associated with VBP. Alternatively, a threshold could be measured by the number of physicians who participate in a VBP arrangement (as is the case in Massachusetts) or by the number of beneficiaries that are served by a provider who receives a VBP. For example, Tennessee's contract requires that by 2020, 35% of its beneficiaries be served by a primary care provider that is a patient-centered medical home. These financial incentives are generally linked to both health plan premium withholds and to improving plan and program performance on specific quality metrics of interest to the state Medicaid agencies.

Consistent with the PRIME and Covered California approach, DHCS could require MCPs to report on their use of APMs with hospitals and IPAs. In addition, DHCS could participate in joint meetings with safety-net hospitals and Covered California to help shape financial incentives that reflect joint priorities for performance improvement. In its next procurement cycle, DHCS may want to consider requiring some level of MCP tracking of APMs, and monitoring if the payment arrangements are improving health outcomes, and potentially requiring an increase in such arrangements with hospitals.

### Best Practice

Require NCOA accreditation of MCPs within a certain period of time within the contract term, or provide incentives to plans to become accredited.

### Why This Is Important

An accreditation requirement provides the state with assurance that contracted plans have met minimum process standards as defined by NCOA. This can provide states with more flexibility to focus on key aspects of the contract to monitor and manage.

## Specific Requirements for Performance Improvement Plans

While federal rules are prescriptive on PIP protocols and the need for at least two PIPs per plan, states can elect to require plans to engage in specific PIPs and require plans and the EQRO to conduct and review more than two PIPs. This is one way for the state to link MCP contract requirements with the state's comprehensive quality strategy and address more challenging issues such as those relating to disparities and health equity.

In 2017–18, California MCPs were required to conduct two PIPs, one focused on a statistically significant health disparity and the other on childhood immunization or another specified Medi-Cal focus area (hypertension, diabetes, or prenatal and postpartum care) where the MCP is performing below the MPL or is "in need of improvement."<sup>33</sup> Notably, these PIP priority areas seem to be only partially aligned with the priorities outlined in DHCS's Medi-Cal Quality Strategy.

Some of the states reviewed use PIPs strategically as follows. In Tennessee, MCPs are required to submit and conduct at least two clinical PIPs and three nonclinical PIPs. Tennessee prescribes that one clinical PIP must be related to behavioral health services, and one nonclinical PIP must be related to long-term services and supports, which are required to be covered by all the state's managed care plans. Washington State requires MCPs to complete two clinical and one nonclinical PIP. One clinical PIP must be an evidenced-based project focused on a mental health intervention, while another is determined

in partnership with the state and focused on well-child visit rates.

In developing the scope of MCP and EQRO activities, it is important to recognize that PIPs are focused efforts by their nature and tend to capture a narrow slice of care delivered to Medicaid managed care subpopulations. Therefore, while they are an important piece of a state's quality strategy, they should only be seen as one piece of a broader overall strategy.

DHCS could align its annual PIP requirements so that they reinforce the objectives laid out in the Medi-Cal Quality Strategy. It could also consider additional clinical or non-clinical PIPs, especially in areas where performance has been substandard.

#### **Best Practice**

Use PIPs to target key areas for plan-specific performance improvement. Use state power as a convener to support collaborative PIPs and share lessons learned across managed care entities.

#### **Why This Is Important**

PIPs provide a key focus for plans to improve an aspect of their quality and overall performance. Where the PIP is tied to specific state goals, data driven, and based on local, regional, or state opportunities for improvement, the state and the EQRO can help plans to collaborate and create more meaningful and rapid improvement.

### **Enhanced Delegation Requirements**

State contracts typically identify specific requirements for material subcontractors and/or delegated entities to ensure that there is sufficient protection for beneficiaries where the MCP subcontracts functions to other entities. These delegated entities may be vendors or providers.

In general, DHCS focuses on the plan, and provides less direct oversight of delegated entities and subcontractors. However, DHCS staff reported that they can get involved during the audit process, and cited their involvement in recent cases.<sup>34</sup> DHCS is reviewing monitoring processes

for subdelegates and anticipates adding a component to the audit scope in this area.

The most recent Florida MCP contract includes new requirements for MCPs and risk-bearing subcontractors regarding submission of the subcontractors' financial statements to the MCP for review and the requirement for the subcontractor to maintain an insolvency account equal to 2% of the annual contract value. In addition, if a MCP in Florida delegates claims processing and payment, the subcontractor must maintain a surplus account to meet its obligations. If the MCP or the subcontractor fails to comply with any delegation requirements, including notices to the Medicaid agency of potential issues, the MCP may be subject to sanctions or liquidated damages as specified in the contract.

DHCS could consider enhancing oversight requirements for MCPs that delegate services and/or risk, including limiting MCPs ability to delegate appeals and grievances and the ability to pass through any financial penalties to subcontracted entities. DHCS could add specific language requiring the MCP to consider the impact of delegated entities on their overall network adequacy and on an individual beneficiary's ability to access care, particularly care that is likely to require referral to a specialty provider.

#### **Best Practice**

Include specific contract language requiring strong oversight of delegated entities.

#### **Why This Is Important**

Delegated entities often are responsible for key services or administrative aspects of the contract. Ensuring that these contractual requirements are met is key to the overall success of the MCP.

## VII. Contract Management and Oversight

Once the contract is in place, states face the important challenge of effective management and oversight throughout the contract term. States can choose from a variety of approaches for contract management and oversight. Historically, states have focused on compliance, minimum standards, and auditing, but recently the authors have seen a movement toward states adopting a value-based purchasing approach. The latter approach requires moving from a culture of enforcing minimum requirements to one of setting high-performance expectations. Once the high-performance expectations are set, active purchasers partner with their MCPs to identify opportunities for improvement, to establish shared goals, and to track progress. This section describes some of the management tools that are crucial for making this shift, and highlights states that have effectively used these strategies. The strategies include:

- ▶ Communication with MCPs to Build Relationships
- ▶ Audits
- ▶ Corrective Action Plans
- ▶ Use and Engagement of the EQRO
- ▶ Efforts to Improve Access and MCP Network Adequacy
- ▶ Investment in Staff
- ▶ Stakeholder Communication

### Communication with MCPs to Build Relationships

Operational and communication approaches can help Medicaid staff identify trends in compliance across various issues within a single plan or across multiple plans and present a unified approach to communicating feedback and policies with MCPs. More effective communication can strengthen the relationships between the state and the plans. Strong relationships are an underappreciated tool for contract oversight. Relationships at multiple levels, from contract liaisons to managers, directors, and executives, help to reinforce program goals, identify challenges early on, and allocate resources efficiently. Because relationships happen between people,

not between organizations, activities such as in-person meetings and one-on-one calls can be particularly valuable. These touch points lend themselves to soliciting feedback and strengthening the relationship. It is important that the purchaser act deliberately in considering the feedback and in closing the loop with the plan on issues that arise.

Due to the size and complexity of the managed care program, DHCS relies on a large number of staff from several operating divisions to provide oversight and management of the MCPs. The contracting team alone will include many people with different responsibilities, backgrounds, and priorities across DHCS. Seen from the plan perspective, the sheer number of individuals, organizational entities, and interests represented can lead to a feeling that DHCS priorities are fragmented.

DHCS managed care leadership was generally praised for its content knowledge and responsiveness. As one interviewee described it, “When issues pop up, we resolve them pretty quick based on many willing people who are willing to engage, take time to clarify. It’s all about relationships.”

However, some plans also noted that other DHCS staff, including MCP liaisons, often did not have sufficient managed care content expertise or training. A few plans reported that the experience with plan liaisons on day-to-day issues was inconsistent because the liaisons often lacked the content expertise or managed care experience necessary for a high-quality partnership. Multiple MCP interviewees noted the limited time that DHCS allows plans to respond to draft policies (days in some cases), and a few indicated that DHCS often did not change its policies based on the input solicited and received. Some plans also suggested that DHCS should collaborate more in developing or finalizing APLs and be more responsive to MCP feedback on APLs. These interviewees also suggested that DHCS provide guidance that is more detailed. One MCP suggested more time for implementation prior to changes in new policies were needed, and added, “DHCS needs to be more thoughtful about operational challenges — get more guidance.” One plan interviewee summarized a negative policy implementation as follows: “Everyone is looking for the specifics. What I’ve seen is that the details aren’t provided as often as everyone would like. Example: last year’s transportation implementation. Nonemergency



medical transportation is much more complicated than emergency medical transportation. We had days to respond and operationalize instead of months.”

In Washington, the Health Care Authority has established an interdisciplinary TEAMonitor Group that is charged with oversight activities. In Texas, the Medicaid agency has four teams of contract managers dedicated to monitoring MCPs, each with some more senior and experienced team members. The MCPs are assigned to teams based on risk and size of the plans. Texas rebalances the contract management teams about once per year so that staff are exposed to different perspectives and are not so familiar with plans that they lose objectivity.

In Texas and Tennessee, all functional areas within Medicaid also have a MCP monitoring and oversight role. In Texas, for example, if there is an issue of MCP noncompliance in any area (e.g., quality, financial), the involved subject matter experts report the issue to the MCP contract managers and recommend the corrective action or more severe contract remedy. In addition, Texas conducts a monthly managed care oversight meeting for a specified Medicaid product to discuss general plan performance, review MCP performance dashboards, and create opportunities for functional areas to report on issues. These meetings include the Medicaid director as well as the entire managed care leadership team.

DHCS could make high-quality internal and external communication a priority. To provide coordinated oversight of plans, DHCS would need to focus on scheduled internal communication, training, and collaboration within and across different parts of the Medi-Cal program. Based on interviews with the plans and DHCS, there are significant one-on-one conversations between the state and its MCPs that should be continued, and to the extent practical, expanded upon.

### Calendar of Activities

Another effective approach to communicating with MCPs is to create and use a calendar of activities. Oversight should be predictable, allowing both the state and the MCPs to plan thoughtfully for short-, medium-, and long-term goals. A calendar of activities can increase predictability of state activities and the likelihood of positive MCP response, and also can be a specified state responsibility delineated within the MCP contract.

The calendar of activities as a MCP monitoring tool is focused on annual activities and an improvement cycle related to the Medicaid managed care program and MCP performance. Some of the key elements that could be included on such a calendar are:

- ▶ Timing of reports on managed care performance (including clinical, administrative, financial, and consumer satisfaction metrics).
- ▶ Planned updates to MCP performance metrics and related meetings and deadlines.
- ▶ Periodic meetings with MCP CEOs, CFOs, and CMOs.
- ▶ APLs under development, with anticipated publication dates.
- ▶ Contract amendment timelines.
- ▶ Budget and contract rate development timelines.

The managed care calendar need not be a literal listing of dates. Instead it can list ongoing and upcoming activities, with anticipated milestones and estimated completion timeframes. This kind of calendar gives plans (and others, such as consumer advocates) better insight into current state activities and can enhance the quality of stakeholder participation in managed care policy development.

The same calendar approach could also be used to detail plan-specific information such as audit schedules, active Corrective Action Plans, performance improvement projects, EQRO activities, and other scheduled interactions between the state and the plan (such as on-site visits). This transparency allows staff to better see the complete set of interactions between the state and the MCP. It can also be a tool to identify and discuss competing priorities and to draw attention to the interaction between different oversight and management activities. This type of calendar tool could be particularly valuable in a state with a large number of plans and broad scope of activities underway at any given time.

While DHCS does maintain a calendar of activities, it is not focused on annual activities or an improvement cycle related to MCP performance.

## Annual Review of Goals and Priorities

Committing to a planned, periodic review of the managed care program's goals and priorities helps states and their MCPs to stay focused despite the inevitable day-to-day pressures of program management. As noted earlier, one way to commit to the planned visits is by detailing the reviews within the contract either as a MCP or a state commitment. An annual review can also serve as a Medicaid staff training and engagement technique by helping leadership, management, and individual contributors to identify and discuss key goals and priorities, and to ensure that resources are dedicated to efforts aligned with what is important and not just what is urgent. Ideally, an annual review would consider overall managed care program performance, as well as assess performance in specific regions and among specific kinds of plans (e.g., local initiative plans). Questions that might be asked in a review include:

- ▶ What have we accomplished in the past year? What important areas have we neglected?
- ▶ In what priority areas are MCPs performing furthest from best practice or defined desired performance?
- ▶ Are there plan- or region-specific opportunities for improvement?
- ▶ How can the state focus its efforts toward improving plan performance in targeted areas?

DHCS conducts a significant number of audits of its MCPs and receives a large amount of information on a regular basis from its plans to allow it to oversee MCP performance. These paper reviews are focused on compliance and minimum expectations. DHCS also hosts regular all-plan phone calls including separate calls for CEOs, CFOs, and CMOs. Plan-specific communication, however, tends to be operational, including monthly standing meetings with the contract manager and team members, as well as daily contact regarding ongoing issues. While plans reported positive experience with ad hoc executive-level communication, DHCS does not have a process for regular or systematic plan-specific strategic or executive-level communication. For example, DHCS does not review plan performance annually with each MCP in order to discuss DHCS priorities and plan-specific challenges and opportunities.

Massachusetts holds a quarterly plan meeting with each of its MCPs. Tennessee uses a similar collaborative approach to plan management with its MCPs, facilitating combined MCP meetings quarterly and conducting a specific annual performance review, meeting separately with each of its three contracted MCPs and senior state Medicaid officials. Each year, 90 days before the anniversary date of the contract, Covered California evaluates each plan's fulfillment of obligations; this evaluation and subsequent action or inaction taken by the plan can lead to recertification or decertification.

To promote high performance and improvement, the authors believe that in-person leadership meetings with the MCPs is an effective and meaningful strategy in the long run, and may help to build a culture of collaboration and partnership. Given the size of the Medi-Cal program and the number of MCPs across the state, it may be difficult for senior DHCS leadership to meet regularly with MCPs. However, the authors believe that one-on-one meetings with MCPs — particularly those serving significant numbers of Medi-Cal beneficiaries — are an essential tool for DHCS to use in partnering with its MCPs to implement its vision, goals, and objectives. Ideally, DHCS could hold annual management meetings with each MCP that are led by DHCS staff. The agenda could include a review of plan performance on a variety of metrics aligned with DHCS priorities, such as HEDIS measures, member satisfaction results, member services response times, and network adequacy issues. If that is not possible, DHCS could identify the top 5 to 10 plans to meet with each year, and rotate annual meetings with other plans.

### Best Practice

Build strong relationships and facilitate ongoing communication with plans, including holding regular in-person meetings to review strategic goals and MCP performance.

### Why This Is Important

Strong relationships and communication facilitate open discussions about strategic goals, plan performance, and challenges faced in meeting expectations. In-person conversations allow for focused review and technical support.

## Audits

An efficient and effective auditing program will operate on a predictable schedule, have a well-defined scope that reinforces the specific goals of the managed care program, and be staffed by well-trained auditors who are familiar with the managed care program. States using best practices also include predictable follow-up on audit findings to ensure that the audits support ongoing improvement. Auditing requires significant resources from both the state and the MCP, both for the initial review and for any needed follow-up. Frequent audits are a signal of a state's focus on administrative compliance but may draw resources away from more proactive oversight and engagement opportunities.

Based on legislative requirements, DHCS has a very comprehensive auditing program and coordinates with DMHC to make an effort when they overlap (every three years) to ask for similar questions and information to reduce the burden on the MCPs. DHCS utilizes a CAP process to allow MCPs to demonstrate progress in areas where deficiencies in performance are found. Most interviewed plans believe the state could achieve additional coordination between DHCS and DMHC with respect to the scope and execution of their audits. All plans noted the resource intensity of the various audits. One MCP interviewee believes that the state wants to be "deliberate and specific" and has established a workgroup with plan compliance staff, which has narrowed the scope of audits. In terms of the usefulness of the audits, as one plan summarized it, "Sometimes findings are warranted and follow-up is good, sometimes kind of picky and not as helpful." Another plan found that auditor experience and familiarity with managed care seemed to drive the focus of an audit more than any overarching DHCS priority or approach. Consumer representatives also highlighted some of the differences in plan requirements and monitoring by plans regulated by DMHC versus those managed by DHCS. While respondents believe that the agencies do try to coordinate efforts, they noted that there exist separate processes that are not well aligned, and some improvements and perhaps even efficiencies could be realized.

DMHC also conducts audits of Covered California and CalPERS plans, all of which must be licensed under the Knox-Keene Act. Covered California and CalPERS do not have the same legislatively mandated audits as DHCS.

Instead, these programs primarily rely on DMHC to perform oversight and monitoring of their plans, which frees up staff at Covered California and CalPERS to spend time and resources on monitoring progress in key policy areas. If the legislature were to reduce mandated audits by the Department of Health and Human Services (DHHS), it may provide both Med-Cal staff and MCPs more ability to focus on other issues, which would improve the program for beneficiaries. For example, the legislature could allow MCPs to be excused from participating in overlapping DHHS audits where the MCPs are Knox-Keene licensed and have regularly met certain performance standards, such as having clean audits for a certain number of years.

Several other states have similar MCP audits required by legislation. As a partial substitute for and/or a supplement to legislatively mandated MCP audits, some states require NCQA accreditation of their MCPs. These states note that NCQA accreditation takes some of the pressure off of conducting broad, resource-intensive compliance audits, allowing the state to instead focus its audits and resources more strategically. For example, Tennessee requires NCQA accreditation and has targeted audits of its MCPs, such as its annual audits concerning member access to transportation. Whether or not NCQA accreditation is required, DHCS could set up its oversight approach to enable accredited plans with a commendable rating from NCQA to position themselves for more-streamlined state compliance review. The Medicaid Managed Care Final Rule's nonduplication provision specifically allows states to accept information obtained from a nationally recognized accreditor in lieu of a review by the state or its External Quality Review Organization.

There is likely additional work that can be done to further improve DHCS coordination with DMHC for Knox-Keene plans, to use resources more efficiently and reduce duplication in oversight of managed care network adequacy and basic financial standards, including but not limited to the scheduling of audits. In addition, the recent surprise collapse of a provider organization raises the question of how DHCS and DMHC are overseeing health plans that subdelegate certain functions to other provider organizations, including the strength of the provider entity, which has taken on a meaningful level of financial risk.

### Best Practice

Facilitate a balanced approach to oversight activities including regular focused auditing to ensure compliance with certain contractual requirements.

### Why This Is Important

Audits typically focus on compliance with minimum standards and can use significant state resources. States will likely see the best performance from MCPs where there is a combination of auditing and other oversight mechanisms to allow for a focus on strategic priorities.

## Corrective Action Plans

Corrective Action Plans (CAPs) can be an important and effective tool for contract oversight. As discussed previously, California and other states use CAPs to correct a deficiency in performance or noncompliance. CMS defines a CAP as a step-by-step plan that MCPs are required to develop and implement to achieve targeted outcomes for resolution of identified errors found during audit or other compliance activities. However, used alone, they may not provide significant incentive for MCPs to address identified problems, or to address the problem quickly.

Based on an identified deficiency in quality or operations, Medi-Cal's MCPs can be required to implement CAPs as a roadmap to improved performance.<sup>35</sup> As implemented by Medi-Cal today, the CAPs appear to be comprehensive and completed within a specified time period. The state reviews and approves MCP activities completed under CAPs, or requires further action, where appropriate. Plans reported that the threat of CAPs was an effective motivator, and that CAPs were generally taken seriously. However, consumer representatives commented that DHCS has relatively low clinical quality performance standards to begin with, few tools for plan compliance with contract standards, and relies too heavily on CAPs for poorly performing plans, especially when used for noncompliance with provider access standards.

All states that were reviewed require CAPs for identified MCP deficiencies and most, like California, also have the authority to implement financial penalties for noncompliance. However, the extent to which states use CAPs, alone or in combination with other remedies, varies. While DHCS has a contractual provision to apply financial sanctions on MCPs that do not implement successful CAPs, interviewees indicated that financial sanctions are rarely used. Most states reviewed use CAPs as one part of a menu of state remedies, including liquidated damages and sanctions. Which remedy occurs first depends on the particular performance issue. For example, Tennessee uses a CAP approach, followed by liquidated damages if needed, and/or increasing withhold amounts for nonperforming MCPs. The CAP does not need to be the first remedy used by the state. For example, Florida noted that it finds it more effective to have relatively small but immediate and automatic liquidated damages for certain instances of noncompliance rather than a CAP. In addition, with nonperforming MCPs, Florida uses sanctions, which can be monetary or nonmonetary, including enrollment freezes. DHCS should continue its use of CAPs but consider utilizing additional tools for MCP compliance in strategic areas, such as sanctions and/or small, automatic liquidated damages for certain types of MCP deficiencies.

### Best Practice

Use CAPs in combination with other financial and nonfinancial sanctions to enforce contract requirements and regularly follow up with plans to ensure ongoing compliance.

### Why This Is Important

The use of CAPs provides MCPs with the opportunity to develop strategies for improvement when the MCP fails to meet a contract requirement. When aligned with other enforcement mechanisms and incentives, CAPs can reinforce the importance of meeting key contract requirements.

## Use and Engagement of the EQRO

External Quality Review Organization activities are an important component to assist states in monitoring MCP performance. CMS requires states to use their EQRO for the following four activities:

- ▶ PIP validation
- ▶ Performance measurement validation
- ▶ Review of MCP compliance with federal standards within the previous three-year period relating to access; care coordination; amount, duration, and scope of covered services; and other plan standards
- ▶ Network adequacy validation, which is a new responsibility added as part of the Medicaid managed care rule<sup>36</sup>

State Medicaid agencies should take a hands-on approach with their EQRO, such as by attending meetings held with contracted plans where feasible. The EQRO annual report can and should be more than a report completed to meet CMS requirements and posted on the state website. States should be familiar with the EQRO tasks and findings throughout the annual review process and should use this information to identify and prioritize statewide, regional, and plan-specific opportunities for improvement.

States can leverage enhanced federal matching for EQRO activities, as well as use EQRO data and recommendations to help select MCP performance measures and identify opportunities for improvement on administrative, clinical, consumer perspectives, and network measures relative to national, regional, or local benchmarks. States should consider how best to use EQRO resources to more quickly and comprehensively compile and act on broader assessments of health plan performance, include consumer and potential provider surveys.

California and most states reviewed are using their EQROs to complement other MCP performance monitoring activities, such as EQRO secret shopper activities related to assessing network adequacy. DHCS could explore increasing both its use of, and collaboration with, its EQRO to improve MCP monitoring and oversight. In Tennessee, for example, the EQRO facilitates collaborative workgroups with MCPs around quality improvement activities, conducts analysis of annual CAHPS data, and

facilitates an annual quality awards meeting. Many states, including Massachusetts and Texas, use their EQRO to conduct or review annual, or in some cases biennial, CAHPS surveys for adults and children enrolled in MCPs. DHCS could consider using their EQRO to conduct more frequent CAHPS surveys (e.g., annual) of some or all MCPs and managed care populations. In addition, the Texas EQRO plays a key role in developing and maintaining the state's portal for sharing detailed Medicaid MCP performance.<sup>37</sup>

### Best Practice

Maximize the potential of the EQRO to assist in a variety of activities to support the state's quality agenda, including quality improvement among MCPs and transparency of plan performance data shared with stakeholders. CAHPS surveys occur annually.

### Why This Is Important

The EQRO's technical expertise and resources can be a key component of moving from compliance-based MCP monitoring to a value-based performance improvement focus. EQRO data and analysis can support development of valid financial and nonfinancial MCP performance incentives. The EQRO can help keep MCPs focused on priority quality initiatives. States receive 75% federal matching funds for EQRO assistance in allowable activities.

## Efforts to Improve Access and MCP Network Adequacy

Assessing MCP network adequacy is challenging for state Medicaid programs in part due to validity issues with network provider data, provider participation in multiple plans and lines of business, and providers' choices as to which and how many MCPs, if any, in which to participate. As part of reprocurement and contract revisions, states often modify access specifications, reporting requirements, and performance incentives. For example, in Florida, MCPs are required to track and annually report emergency department (ED) visits for members who have not recently had a primary care physician (PCP) visit.<sup>38</sup> In addition, as part of Florida's recent reprocurement, MCPs

agreed to meet new access standards, which have financial implications and may vary by region, such as:

- ▶ MCP agrees that at least 40% to 50% of required participating PCPs, by region, offer after-hours appointment availability to Medicaid enrollees.
- ▶ MCP agrees that no more than 5% to 10% of enrollee hospital admissions, by region, shall occur in nonparticipating facilities, excluding continuity-of-care periods.
- ▶ MCP agrees that no more than 8% to 10% of enrollee specialty care (physician specialist) utilization, by region, shall occur with nonparticipating providers, excluding continuity-of-care periods.<sup>39</sup>

DHCS has invested significant time and effort in new MCP network adequacy standards and health plan reviews. In 2019, similar to the DHCS 2018 network review, a number of MCPs were granted approval for a variety of alternative access arrangements. DHCS posts all approved alternative access standards on its website and will update the posting at least semiannually.<sup>40</sup> DHCS notes that “a large number of [alternative access standards] requests are due to geographically remote regions. Additionally, the trends show that there is a lack of specialists, specifically pediatric specialists, in both rural and urban counties within time and distance standards.”<sup>41</sup>

DHCS efforts to create a centralized process for enrolling managed care providers and improving MCP directories should improve the validity and usefulness of MCP provider data as well as help to inform and address ongoing needs for alternative access arrangements. DHCS should continue to work with MCPs to explore why these alternative access arrangements were necessary and continue to monitor this situation to identify ways to improve access and reduce the need for alternative arrangements. In addition, DHCS should continue to use its EQRO to validate primary and specialty care appointment accessibility through secret shopper or similar approaches to monitor access and require its MCPs to address issues of provider and network noncompliance with state standards. Where feasible, DHCS could require MCPs to resolve network gaps as part of the contractual requirement for a network development plan. In Florida, a MCP’s annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including short- and long-term interventions for resolving network gaps.

Furthermore, the health plan network adequacy approaches used by Covered California, DMHC, and/or CalPERS may be useful for DHCS to explore in order to identify opportunities for collaboration and improvement in MCP network adequacy over time. For example, CalPERS conducts an annual Health Plan Member Survey, a modified version of CAHPS, which asks members to report their accessibility to health care including ED and after-hours care.<sup>42</sup> In addition, CalPERS plans must maintain a minimum of a two-star rating for “Getting Care Easily” in the “Member Ratings” section from the Office of the Patient Advocate’s Health Care Quality Report Card.

### Best Practice

Include specific access requirements in MCP contracts and use different types of access reporting and monitoring to identify potential compliance issues, including appointment availability, certain ED utilization, and out-of-network volume to assess network adequacy. Improve the validity of MCP provider listings and maintain a database that shows PCP participation (at a minimum) across plans. Require MCPs to create short-term and longer-term interventions to address and, where feasible, resolve network deficiencies over time.

### Why This Is Important

The ultimate goal of MCP network adequacy requirements is to ensure timely access to care commensurate with the urgency of Medicaid beneficiaries’ needs. History has shown that without state oversight, Medicaid managed care plans may not provide adequate access to care. In addition, the federal Medicaid managed care rule requires that states attest that their contracted plans meet the state’s access standards.

## Investment in Staff

Effective oversight of MCP contracts requires staff with a high level of knowledge about the specific managed care program, managed care generally, the managed care contract, and the specific MCPs. Ongoing training and other learning opportunities for staff can help develop high-quality liaisons and managers and encourage consistency in approach across plans in different parts of the state and in different managed care models.

For several years, DHCS has trained potential leaders on cross-agency functions through the DHCS Academy. The DHCS Academy is a best practice among Medicaid agencies across the country that often struggle to hire and maintain staff and to support long-term skill and leadership development. However, in the authors' interviews with plans, some interviewees noted that some DHCS staff, including MCP liaisons, often did not have sufficient managed care content expertise or training. A few plans reported that the experience with plan liaisons on day-to-day issues was inconsistent because the liaisons often lacked the content expertise or managed care experience necessary for a high-quality partnership. One interviewee noted that it is a challenge for DHCS to recruit and retain staff with knowledge of the managed care system they oversee.

DHCS's Academy is a best-practice approach. Other states, including Texas, also have invested in its MCP staff. For oversight of state contracts over \$10 million, Texas requires specific contract management classes to be taken; applicable Health and Human Services Commission staff need to be certified by the Office of Comptroller. In addition, as noted above, Texas and Washington both use team approaches to monitor plan performance, allowing for ongoing training of managed care staff.

Similar to the activities in Texas and Washington, DHCS may want to consider providing management training to all staff who liaise with managed care staff and who have any responsibility for contract management, to give them the appropriate tools and skills to most effectively provide consistent oversight and support to MCPs. Managed care program staff could benefit from a program focused on the issues unique to managed care oversight, including an introduction to the contract and the extensive supporting materials; education about key managed care issues like network adequacy, customer

service standards, and quality metrics; and a description of how DHCS divisions work with one another and in concert with DMHC.

### Best Practice

DHCS's Academy appears to be a best practice among Medicaid agencies to promote retention of strong staff. Providing a similar academy focused on training in managing and partnering with MCPs would enhance the skills of the managed care team.

### Why This Is Important

Knowledgeable staff interacting with MCPs ensure that together, they can achieve the highest possible performance. If the state staff are not experienced or well trained in managed care or contract management, they may not be able to effectively manage or support MCPs.

## Stakeholder Communication

Stakeholder engagement is an important element to public program management. Where states do provide stakeholders the opportunity to be heard and provide context for policy approaches and feedback on why certain concerns have or have not been addressed, the culture of collaboration between the consumer representatives and the state can often improve. There also is empirical evidence that stakeholders can help program management by "mobilizing local knowledge, identifying opportunities for innovation or improvement that otherwise may have been missed, and identifying potential adverse effects and conflicting interests early on."<sup>43</sup>

DHCS includes consumer representatives in its advisory groups and overall planning efforts, and there are some opportunities to have their voices heard. Consumer representatives the authors spoke with are engaged with the program in numerous ways and believe their role is important in ensuring the MCPs are accountable to the population they serve and to taxpayers. One interviewee's "sense of concern was heightened" as the state expanded managed care to more vulnerable populations, including seniors and persons with disabilities.

Consumer representatives noted that sometimes decisionmaking seemed somewhat opaque and that DHCS often did not close the loop with stakeholders regarding issues that were brought up at meetings. As described by some interviewees, many meetings feel like a reporting of decisions rather than a discussion with stakeholders about potential options.

Covered California’s approach with stakeholder engagement may be a best-practice approach within California. Consumer representatives thought that MCPs and consumers were in the same meetings advocating for similar goals. They also noted that Covered California staff are more transparent in their decisionmaking. One consumer representative acknowledged that there are barriers for DHCS regarding meaningfully engaging with stakeholders due its large size and scope. However, DHCS’s approach also may be indicative of a culture within the agency, particularly where there is a history of stakeholders using the legislative process to place requirements on DHCS.

There appears to be opportunity for DHCS to better use in-person meetings with stakeholders to seek meaningful input. This may occur by presenting potential approaches earlier in the process and by allowing for more interactive discussions and substantive feedback to the state on policy issues.

#### **Best Practice**

Provide ample opportunities for stakeholder voices to be heard and be transparent regarding whether stakeholder feedback was or was not incorporated into final policy decisions.

#### **Why This Is Important**

Empirical evidence demonstrates that including stakeholder input can improve program policies and save program costs in the long run. In addition, involving stakeholders in the process creates a sense of partnership across the state and stakeholders, providing for a more collaborative and less adversarial approach.

## **VIII. Key Recommendations and Next Steps**

It is important to recognize DHCS for its success in managing the Medi-Cal program as a whole and the Medicaid managed care program in particular. DHCS’s recent success implementing a significant expansion of Medi-Cal and several innovative pilots through a series of groundbreaking Section 1115 waivers speaks to the strength of the Medi-Cal managed care program upon which these achievements were built. Similarly, the agency’s recent implementation of significantly increased oversight of MCPs related to the 2016 revisions to the federal Medicaid managed care rule (AB 205) demonstrates DHCS’s capability to develop, coordinate, and execute large-scale change in its monitoring and oversight approach.

Given the size and scope of the Medi-Cal managed care program, the state’s ability to “keep the trains running” during these multiple changes was an enormous accomplishment that the leadership and staff should be proud of. Implementation of any changes, including modifications to Medi-Cal benefits, involves coordination across all plans and regions of the state. The state’s many communication channels with MCPs and other stakeholders appear to work well in sharing Medi-Cal policies with different levels and types of MCP personnel. Stakeholders also cited the well-organized implementation of Medi-Cal’s new palliative care benefit involving extensive provider education and outreach as one recent example of a successful DHCS initiative.

With any program the size of the Medi-Cal, there is always opportunity to strengthen the program. The Newsom administration has quickly identified some key areas to focus on. Given the breadth of state and federal requirements placed on the program, there is a limit to what DHCS can prioritize to work on outside of those parameters to improve Medi-Cal. Understanding these limitations, the authors have identified priority and longer-term recommendations for DHCS to consider as it embarks upon its reprocurement with the ultimate goal of obtaining better value from contracted MCPs.



## Priority Recommendations

In the short term, the authors recommend that DHCS:

**Articulate a strategic vision for managed care and translate to policy requirements within the MCP contract.** The upcoming, anticipated procurement process for certain Medi-Cal contracts provides DHCS with an important opportunity to review its vision of the Medi-Cal managed care program and to detail the vision, objectives, and goals of the managed care program. The vision should include broad themes and articulate a clear and aligned vision specifically for Medi-Cal managed care plan oversight, shifting the focus from minimal MCP contract compliance to one of excellence and ongoing performance improvement.

DHCS's vision for the next phase of Medi-Cal managed care should be accompanied by a roadmap for how that vision will be met through specific objectives and goals that are reflected in revised contract requirements for Medi-Cal plans that reflect new expectations. While not all MCPs will be reprocured through the competitive procurement, DHCS can still leverage the procurement activity to make clear its aligned vision for managed care and to renegotiate updated contracts, regardless of plan type.

As part of articulating its strategic vision through the managed care reprocurement, DHCS should also clearly share its vision with all staff, other state agencies, providers, Medi-Cal beneficiaries and their consumer representatives, and other key stakeholders. DHCS should use this opportunity to clearly define and communicate its goals and priorities for Medi-Cal managed care over the next three to five years (coinciding with the term of the upcoming MCP contracts).

**Strengthen oversight of MCPs that delegate risk to another entity.** As part of the reprocurement process, it is anticipated that DHCS will make key updates to its model contracts with its MCPs to provide further direction and requirements related to specific policies and initiatives. The authors recommend that as part of these contractual revisions, DHCS consider:

- ▶ Enhancing oversight requirements for MCPs that delegate services and/or risk to subcontractors, similar to Florida's recently released MCP contracts.
- ▶ Adding new MCP oversight approaches in coordination with DMHC related to delegated entities'

financial solvency, impact on overall MCP network adequacy, and on an individual beneficiary's ability to access care.

- ▶ Requiring MCPs to report on their use of risk-based alternative payment models with provider entities, the impact of these APMs on encounter data, and MCP and provider performance on quality and efficiency measures.

**Enhance the current focus on quality measurement and reporting.** The Medi-Cal program undertakes several activities to further the quality of its managed care program today. For example, DHCS has developed a quality strategy for its Medicaid managed care program as required by the MMC rule, a Managed Care Performance Dashboard that summarizes the performance of MCPs on an aggregate and individual plan basis to a limited extent, and an external accountability measure set through which it assesses MCP performance on 30 measures. However, these strategies are not as aligned as they could be and do not always go as far as they could in motivating MCPs to improve performance or in rewarding improved performance. The Newsom administration has taken steps to signal an increased focus on monitoring performance and increasing performance standards. The authors recommend that DHCS take the following steps to further enhance the focus on MCP performance on quality metrics, and specifically performance improvement.

- ▶ Involve MCP representatives, consumer advocates, and other stakeholders in the selection of MCP External Accountability Set (EAS) measures and specifically consider aligning EAS measures with MCP measures used by other purchasers in the marketplace, including Covered California and CalPERS, as appropriate. To assist in the measure selection process, DHCS could consider utilizing the free Buying Value Measure Selection Tool and consider the recommendations from an upcoming CHCF advisory group project. Governor Newsom has signaled an interest in the MCPs expanding reporting beyond the current EAS measures to all measures within both the adult and children's HEDIS measurement set.
- ▶ Regularly use data on plan performance to prioritize MCP oversight activities, and compare MCP performance to state, regional, and where available, national benchmarks.

- ▶ Ensure that contracted MCPs achieve objective, measurable improvements in performance, above current performance and above the currently set Minimum Performance Level of the NCQA 25th percentile for national Medicaid performance. Governor Newsom has indicated that his administration will require MCPs to meet the NCQA 50th percentile. It may be difficult for MCPs to make that big of a leap initially. One approach toward moving to that 50th percentile may be, consistent with the PRIME approach, to expect MCPs to seek and over time obtain a 10% gap closure between the difference of current performance and the 50th percentile, or as required within PRIME, the 75th or 90th percentile for NCQA Medicaid MCO performance. It is recommended that DHCS phase in the 50th percentile requirement and look at whether it is realistic for MCPs to meet that standard for every measure or if there should be individualized benchmarks for certain measures. When phasing in the increased performance standard, DHCS could focus on improvement over time and that the Minimum Performance Level for a given measure be based on current Medi-Cal MCP quality scores rather than adoption of a single benchmark (e.g., 50th percentile for every measure).
- ▶ Require more granular population data collection and analysis and the development of a plan to address identified disparities, similar to DHCS efforts in the PRIME program.<sup>44</sup>
- ▶ Where appropriate, seek alignment with Covered California, CalPERS, and the Integrated Healthcare Association on performance measure reporting and improvement expectations.
- ▶ Make quality, and specifically MCP performance on quality metrics, an integral part of ongoing MCP contract management and a focus of discussion between MCPs and senior DHCS leaders, beyond the chief medical officers and the quality improvement staff.

**Use a combination of financial and nonfinancial incentives to improve performance.** It is recommended that DHCS follow the lead of many other state Medicaid purchasers and its sister public programs, Covered California and CalPERS, to create meaningful consequences for MCP performance and follow through using a combination of financial and nonfinancial incentives for contracted plans that fail, meet, or exceed DHCS performance

expectations. In terms of nonfinancial incentives, the authors encourage DHCS to continue to:

- ▶ Use performance-based auto-assignment in regions where there is a choice of MCPs.
- ▶ Recognize higher-performing plans and plans as part of their annual MCP quality awards.
- ▶ Develop and update its Managed Care Performance Dashboard as a nonfinancial incentive for plans to improve performance, and to separately post the MCP-specific appendices of the annual External Quality Review on its website as it has in the past to make it easier for stakeholders to review individual plan performance.

In terms of new nonfinancial incentives, Bailit Health recommends that DHCS:

- ▶ At least annually, develop and share MCP-specific performance data on its website and as part of its MCP and workgroup meetings, including with consumer advocates.
- ▶ Ask MCPs to present their performance in person annually at regional meetings with DHCS and in the presence of stakeholders.
- ▶ Require that the MCP-specific data shared online and in person include MCP performance on HEDIS and CAHPS measures over time and compared to other California MCPs (statewide, regionally, and/or by plan type). Each MCP's performance should be easily compared with the Minimum Performance Level as well as national benchmarks where available — such as the 50th, 75th, and/or 90th HEDIS and CAHPS percentiles.

For financial incentives, the authors encourage DHCS to consider:

- ▶ Assessing financial penalties on MCPs whose performance on targeted HEDIS and CAHPS measures continue to be below a Minimum Performance Level or other state benchmark even after Corrective Action Plans have been implemented. Some Medicaid agencies have found it better to use a smaller, automatic penalty rather than allow for state discretion in applying MCP penalties, which can end up in prolonged consideration of extenuating circumstances or just buried under competing state priorities.

- ▶ Developing positive financial incentives for MCPs that are high performing and/or those that demonstrate significant improvement over time. These financial incentives can take a variety of forms (e.g., quality awards, pay-for-performance bonuses, gain-sharing opportunities, etc.). DHCS should consider a range of positive financial incentives commensurate with the effort required by MCPs to meet the performance goals, the availability of funds to support positive financial incentives for MCP performance, and the potential impact of the Medicaid managed care rule related to value-based payments to MCPs. The important step is to make more of a business case for MCPs to invest in improved performance on behalf of Medi-Cal beneficiaries through a meaningful combination of financial and nonfinancial incentives.

#### **Establish regular meetings between DHCS and MCP leadership.**

- ▶ DHCS conducts a significant number of audits of its MCPs and receives a large amount of information on a regular basis from its plans to allow it to oversee MCP performance. These paper reviews are focused on compliance and minimum expectations. To promote high performance and improvement, the authors believe that in-person leadership meetings with the MCPs may be more effective and meaningful in the long run and may help to build a culture of collaboration and partnership.
- ▶ Given the size of the Medi-Cal program and the number of MCPs across the state, the authors recognize that it is difficult for senior DHCS leadership to meet regularly with MCPs. However, the authors believe that one-on-one meetings with MCPs — particularly those serving significant numbers of Medi-Cal beneficiaries, are an essential tool for DHCS to use in partnering with its MCPs to implement its vision, goals, and objectives. Ideally, it is recommended that annual management meetings with each MCP are led by senior DHCS staff. The agenda should include a review of plan performance on a variety of metrics aligned with DHCS priorities, such as HEDIS measures, member satisfaction results, member services telephone response times, and network adequacy issues.

## **Longer-Term Recommendations**

In the longer term (over the next two-plus years), the authors recommend that DHCS:

**Continue to improve operational simplification and coordination of MCP oversight.** DHCS shares responsibility for the oversight of most of its MCPs with DMHC and has mandated audit requirements based on state legislation. While DHCS and DMHC make an effort to coordinate audits when they overlap (every three years) to ask for similar questions and information to reduce the burden on the MCPs, there is likely more work that can be done to further improve DHCS coordination with DMHC for Knox-Keene plans. Doing so would use resources more efficiently and reduce duplication related to oversight of managed care network adequacy and basic financial standards, including but not limited the scheduling of audits and the alignment of audit tools and scope. In addition, DHCS and DMHC could together consider how to improve their oversight of plans that subdelegate certain functions to other provider organizations, including the strength of the provider entity, which has taken on a meaningful level of financial risk. The authors also recommend that the legislature consider allowing DHCS to reduce its auditing of MCPs that are Knox-Keene licensed based on meeting certain performance standards, such as receiving clean audits for a certain number of years.

The authors also recommend, similar to CalPERS, that DHCS require MCPs to timely submit to DHCS a copy of any financial audit report and any public quality-of-care or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., the Joint Commission, NCQA, or URAC).

**Pursue greater alignment with other large purchasers in California.** As the largest purchaser of health care in California, the state has incredible leverage to influence health policy and purchasing decisions. The authors recommend that DHCS align select Medi-Cal MCP policy, performance, transparency, and/or incentive approaches with other DHCS initiatives and with other large purchasers in the California marketplace where feasible and appropriate.

Within the Medi-Cal program there are a number of different initiatives to improve health care access and quality while containing costs. In many instances, these efforts occur outside of or parallel to the MCPs. If reform

initiatives, such as DSRIP funding, were more closely aligned with the managed care program, then the initiatives may be more effective in the short term, and more sustainable in the long term through MCPs, provided they are shown to be cost-effective.

Where Medi-Cal aligns with CalPERS and Covered California, it allows the state to further move the needle on improved health care access and quality, as well as activities to contain costs. While Medi-Cal sometimes works with other state health purchasers to pursue specific activities, ongoing attention to alignment of policies and approaches across purchasers has been fairly limited. Opportunities for improved alignment include the development of a common quality measure set across public programs in California, similar financial incentive (and penalty) approaches for MCPs meeting (or not meeting) specific quality benchmarks, and more consistent and frequent transparency of MCP performance compared to peers, statewide benchmarks, and national standards. Tennessee is one example of a state that has embraced alignment across its public and private sector to improve population health.

**Build upon recent efforts to improve access to care and MCP network adequacy.** The authors recognize that DHCS has invested significant time and effort in new MCP network adequacy standards and health plan reviews, and that it is no easy or small task. It is recommended that DHCS:

- ▶ Continue to improve, routinely utilize, and synthesize different types of access reporting and monitoring to better identify access issues. Beyond provider miles and minute analyses, techniques such as secret shopper appointment availability, member satisfaction data, ED utilization, and out-of-network volume all help to assess network adequacy within plans and across regions.
- ▶ Consider modifying MCP reporting requirements and creating performance incentives specific to access to care, as part the upcoming procurement and contract revisions.
- ▶ Expand its capabilities to assess primary care provider (and ideally, other provider) participation across plans.

- ▶ Work with MCPs to explore why so many alternative access arrangements are necessary, particularly for specialty care, and continue to monitor this situation to improve access and reduce the need for alternative arrangements.
- ▶ Require MCPs to create short-term and longer-term interventions to address and, where feasible, resolve network deficiencies over time.

**Implement a calendar of activities to reflect goals and priorities.** A calendar of activities is a simple tool that can improve communication with plans and increase the predictability of DHCS activities. DHCS already posts a calendar of events on its website that stakeholders can page through by month. It is recommended that DHCS create a new calendar of activities focused on activities and an improvement cycle related to the Medicaid managed care program and MCP performance. This type of performance-driven calendar can also become a part of DHCS responsibilities specified in the MCP contract. Key elements that could be included in such a calendar for both internal DHCS and MCP use are as follows:

- ▶ Timing of DHCS reports on managed care performance (including clinical, administrative, financial, and consumer satisfaction metrics)
- ▶ Planned updates to MCP quality metrics and related meetings and deadlines
- ▶ Periodic meetings with DHCS and MCP CEOs, CFOs, and CMOs
- ▶ All Plan Letters under development, with anticipated publication dates
- ▶ Contract amendment timelines
- ▶ Medi-Cal budget and contract rate development timelines

This level of transparency would serve multiple purposes. Most simply, it would provide staff both at DHCS and at the plans with a more comprehensive view of interactions between the state and the MCPs related to plan performance and quality improvement. In addition, such a calendar can help with identifying competing priorities and draw attention to the interaction between different oversight and management activities. The calendar need not be a literal listing of dates. Instead, it can list ongoing and upcoming activities, with anticipated milestones and

estimated completion time frames. This product will give plans and stakeholders better insight into the current activities at DHCS, which will also enhance the quality of their participation in managed care policy development.

Additionally, the authors recommend that DHCS consider the same calendar approach to detail plan-specific information such as audit schedules, active Corrective Action Plans, EQRO activities, and other planned interactions between the state and a specific MCP (such as on-site visits).

**Continue to invest in staff.** For several years, DHCS has used the DHCS Academy to train potential leaders on cross-agency functions. The DHCS Academy is a best practice among Medicaid agencies across the country that often struggle to hire and maintain staff and to support long-term skill and leadership development. In addition to training through DHCS Academy, the authors further recommend that DHCS provide management training to all staff that liaise with managed care staff and who have any responsibility for contract management, to give them the appropriate tools and skills to most effectively provide consistent oversight and support to MCPs. Specifically, the managed care program would benefit from a similar program focused on the issues unique to managed care oversight, including an introduction to the contract and the extensive supporting materials; education about key managed care issues like network adequacy, customer service standards, and quality metrics; and a description of how DHCS divisions work with one another and in concert with DMHC.

## IX. Conclusion and Next Steps

Achieving positive change in a state's health care market, particularly for vulnerable populations, is no small task. Many state Medicaid agencies, DHCS included, often spend much of their time and energy focused on MCP compliance with detailed federal and state requirements. While effective oversight of MCPs is essential to ensure compliance, it's easy to end up spending most resources setting the floor for minimally acceptable MCP performance and lose track of the potential.

Improving access to quality care, reducing cost growth, and improving consumer satisfaction has been an overarching goal of Medicaid managed care programs for years, including Medi-Cal. More recently, states and DHCS have articulated visions for Medicaid managed care related to whole person care and population health. To better attain the promise of Medi-Cal managed care, the authors recommend that DHCS actively define and promote its vision and expectations for MCP performance improvement across a variety of metrics, and offer plans incentives — positive and negative — to achieve that improved performance.

The upcoming Medi-Cal repurchase offers a unique opportunity to broaden and solidify DHCS's Medi-Cal managed care orientation from compliance to more of a value-based, performance improvement perspective. However, the procurement is not the only tool available to DHCS to improve performance among contracted MCPs. The authors recommend that DHCS consider how it can best leverage the enormous purchasing power of Medi-Cal to partner with other public purchasers and to identify and work with willing MCPs to produce more meaningful achievements for Medi-Cal beneficiaries.

## Appendix A. Additional Information on Methodology

Bailit Health used a multipronged research approach that included the following four components.

### 1. Identifying Potential Types of Purchasing Tools

As a first step, Bailit Health considered how best to identify different types of monitoring tools and approaches that DHCS could include in its contracts and use with Medi-Cal plans to improve performance and accountability. The authors focused on specific aspects of plan accountability and performance that CHCF and DHCS might seek to improve, such as:

- ▶ Clinical quality of care
- ▶ Population health
- ▶ Administrative performance
- ▶ Member access to care
- ▶ Member satisfaction with care
- ▶ Health of the safety net
- ▶ Total cost of care for Medicaid managed care beneficiaries

Bailit Health next cataloged potential purchasing and monitoring tools and approaches that the authors knew to be in use by leading public purchasers in California and other states. This cataloguing — as informed by subsequent research — forms the basis for the recommendations. The identified purchasing tools and approaches are not mutually exclusive, can be designed and implemented in different ways, and include:

- ▶ Competitive procurement process
- ▶ Health plan contracting requirements
- ▶ Financial and nonfinancial incentives focused on improving results
- ▶ Contract compliance tools and strategies
- ▶ Performance on quality, cost, and process measures
- ▶ Public reporting and dashboards
- ▶ Stakeholder engagement/presentations

- ▶ Prioritization/time management
- ▶ Collaboration with other state agencies

### 2. Reviewing Managed Health Plan Contracts of Selected Public Purchasers

Bailit Health identified public purchasers in California and five other states to include in the review. The authors selected the other purchasers based on knowledge of these purchasers, relevance to Medi-Cal, and recommendations from CHCF. Specifically, the authors obtained and reviewed current health plan contracts from Medi-Cal, Covered California, and CalPERS, as well as current Medicaid managed care contracts in Florida, Massachusetts, Tennessee, Texas, and Washington. In addition, the authors conducted targeted reviews of the New York and Oregon Medicaid managed care contracts relative to subdelegation oversight and requirements. As part of the authors' contractual reviews, Bailit Health searched for other relevant information and tools from these public purchasers that may not be detailed directly in the health plan contracts but rather in related, non-contractual policies or strategies.

### 3. Interviewing California Stakeholders and Medicaid Managed Care Staff in Other States

Bailit Health worked with CHCF to identify key organizations to interview, including DHCS, Covered California and CalPERS, several Medi-Cal health plans, and consumer representatives, and also interviewed senior Medicaid staff from other states. Bailit Health completed interviews with six Medi-Cal health plans and six consumer advocate organizations in California. These interviews are summarized in Appendix B. In addition, the authors conducted two calls with California purchasers — one with multiple DHCS staff and one with CalPERS staff. Bailit also interviewed Medicaid MCP staff from Florida, Texas, Massachusetts, and Tennessee and conducted a brief interview regarding provider delegation with staff from Oregon. The results of the California purchaser and other state interviews are both woven into the body of the report as well as summarized in the purchaser tables found in Appendix C.

A semistructured interview guide was tailored to each person the authors interviewed. These interviews helped both to fill gaps in understanding after review of the contract documents and to receive meaningful input regarding DHCS activities related to contract management and oversight of MCPs.

#### 4. Development of Priority and Longer-Term Recommendations

Based on the authors' current knowledge as well as the first three components of this methodology, Bailit Health considered recommendations aimed at helping DHCS to fully leverage its purchasing power to improve health plan performance and health outcomes of Medi-Cal managed care enrollees. The authors applied criteria that were developed using a value-based purchasing perspective to prioritize activities and tools, or modifications of tools, expected to result in better value from MCPs participating in Medi-Cal.

## Appendix B. Summary of Contracts for California Purchasers

### Medi-Cal

#### Overview

California's Medicaid program, Medi-Cal, is administered by the Department for Health Care Services (DHCS). Approximately 80% of Medi-Cal beneficiaries are enrolled in managed care, a significant expansion in managed care over the last several years. Medi-Cal managed care plan (MCP) capitation payments totaled approximately \$49 billion in state fiscal year 2017–18. California also has a separate dental managed care system, a Drug Medi-Cal Organized Delivery System, and county mental health plans. There are more than 30 MCPs that participate in Medi-Cal's managed care program through six main managed care models: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito.<sup>45</sup> The Two-Plan model is the largest by far, followed by COHS enrollment and the GMC model plans.

- ▶ Approximately 7 million beneficiaries (65%) in 14 counties are enrolled in a MCP participating in the Two-Plan model, which typically includes a choice between a local initiative (LI) plan and a commercial plan (CP) operating within a county.
- ▶ Another 2.2 million beneficiaries (20%) are enrolled in six COHS plans. Each COHS is created by a county board of supervisors and governed by an independent commission. In the 22 COHS counties, a single plan serves all beneficiaries who are enrolled in managed care.
- ▶ GMC plans operate in two counties (Sacramento and San Diego) and account for another 1.2 million beneficiaries (11%).
- ▶ The remaining three models are newer and much smaller in terms of enrollment. In the Regional and Imperial models, beneficiaries in these less populated counties have the choice of two CPs. In the San Benito model, beneficiaries have the option of enrolling in one CP or remaining in Medicaid fee-for-service.

MCPs are responsible for the majority of medical benefits for Medi-Cal beneficiaries, including primary and specialty care, as well as nonspecialty mental health services for beneficiaries with mild-to-moderate functional

impairments. MCP coverage of long-term care skilled nursing services varies depending on the county. MCPs do not cover specialty mental health, substance use disorder, or dental benefits.<sup>46</sup>

#### Performance Goals

DHCS reported that its first priority is timely access to good quality care. Beyond this, they described three additional priorities for plan performance: encounter data, network adequacy, and beneficiary rights. DHCS also noted that plans should be familiar with the goals described in the managed care quality strategy.<sup>47</sup> The quality strategy goals and objectives are maternal and child health (postpartum care and immunization), chronic disease (diabetes and hypertension), tobacco cessation, reducing health disparities, and reducing opioid misuse and overuse. DHCS reported that in the future it hopes to incorporate the concept of "whole person care" (one of the PRIME components) into its managed care program.

In interviews, plans had a difficult time articulating DHCS performance goals beyond the latest All Plan Letter or ongoing expectations for improved encounter data submissions.

#### Procurement Approach

DHCS has reprocured the competitive managed care contracts infrequently in recent years; the latest contract boilerplate is from 2014, and the last procurement was several years before that. DHCS has indicated that it intends to release Requests for Proposals (RFP)/Requests for Applications (RFAs) for most of the commercial plans in the Two-Plan and GMC regions in late 2019 and early 2020.

DHCS does not competitively reprocure the contracts for the County Organized Health Systems model plans, or for the local initiative plans in the Two-Plan model counties. Together, these nonprocured plans cover 70% of the Medi-Cal managed care population. In these COHS and LI contracts, it appears as though DHCS makes program changes through contract amendment exclusively. Despite these differences in procurement approach, the boilerplate MCP contract language is very similar across different plan types.

Between major contract updates or reprocurement, DHCS has implemented new policies through contract



amendments (although the process for finalizing amendments, which requires CMS approval, is quite lengthy and has been significantly delayed in recent years) and All Plan Letters (which are used for a variety of reasons, including providing implementation guidance, communicating new policies or requirements, providing clarification on existing standards, etc.).

### Contract Structure

Overall, the model contract language is similar in structure to many other states' Medicaid managed care contracts. The contract requires MCPs to meet a variety of specific policy and operational standards across many domains, including but not limited to covered services, network adequacy, and grievances and appeals. In general, the contract is focused on requirements and minimum standards, and does not include meaningful incentives for high performance.

DHCS has additional expectations for plans that are not reflected directly in the contract. These include certain DHCS policies (such as the Auto-Assignment Incentive Program, see below), the approach to audits (which is set, to some extent, by state law), and policies implemented through All Plan Letter.

DHCS publishes a wealth of material about the managed care contracts on its website.<sup>48</sup> Some materials (e.g., those related to quality strategy and measurement) are well organized and easy to navigate. Notably, however, All Plan Letters are posted by date, which makes it difficult to find material on a specific topic or to determine how the content relates to contract provisions.

The managed care contract itself is organized into a series of attachments, each of which covers a separate topic. The boilerplate contracts available on the DHCS website do not include a table of contents, which makes it somewhat difficult to navigate the 257-page document. Other than the managed care website (see above), DHCS does not maintain a specific policy manual for managed care; implementation details such as reporting expectations and templates are handled through All Plan Letters or on an ad hoc basis.

The contract contains a liquidated damages clause, although DHCS rarely uses this authority in practice.

### Contract Management and Oversight

DHCS hosts regular all-plan phone calls, including separate CEO, CFO, and CMO calls. Plan-specific communication tends to be operational, including monthly standing meetings with the contract manager and team members, as well as daily contact on ongoing issues. While plans reported positive experiences with ad hoc executive-level communication, DHCS does not have a process for regular or systematic plan-specific strategic or executive-level communication. For instance, DHCS does not review plan performance annually with each MCP in order to discuss DHCS priorities and plan-specific opportunities.

Plan audits are a prominent feature of DHCS's relationship with the MCPs. The Medi-Cal boilerplate MCP contract also describes a variety of audits and direct oversight activities, including annual medical compliance audits that review elements such as utilization management practices and provider training protocols. Since 2015, state law has required annual audits for MCPs. DHCS's Audits and Investigations (A&I) unit currently conducts on-site medical audits of each MCP annually, alternating between reduced-scope and comprehensive full-scope audits. Additionally, A&I conducts annual follow-up on the previous year's CAP, where applicable. A&I medical audits cover utilization management, case management and coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity.

In California, the Department of Managed Health Care has a partially overlapping audit responsibility for the managed care plans under its purview. DHCS coordinates with DMHC on the medical audits every three years. These surveys cover the following review categories: utilization management, continuity of care, availability and accessibility, member rights, and quality management. DMHC and DHCS also both review timely access to care, but the DHCS staff described their approaches as "different by design" in that DMHC is looking at past performance, while DHCS is looking prospectively and has recently revised its process. Both departments have authority to sanction health plans and generally coordinate before doing so.

In general, DHCS focuses on the plan and provides less direct oversight of delegated entities and subcontractors. However, DHCS staff reported that they can get involved

during the audit process and cited their involvement in recent cases.<sup>49</sup> DHCS is reviewing monitoring processes for subdelegates and anticipates adding a component to the audit scope in this area.

The Medi-Cal contract contains a number of standard managed care reporting requirements, including encounter data, certain operational information, and data about the provider network and subcontractors.<sup>50</sup> Some of these data are used to populate a public Managed Care Performance Monitoring Dashboard, although the

public version of the dashboard reflects only statewide data, with the exception of plan-specific aggregate HEDIS scores.<sup>51</sup> DHCS indicates that it has made, and continues to make, changes to automate and digitize its collection and review of MCP reports. For instance, DHCS implemented an automated provider file and other enhancements to pull data from MCP reports and assess certain compliance aspects more quickly. DHCS is testing additional automated functions related to MCP reported data within one unit before rolling these enhancements out department-wide.

KEY TOPICS	REVIEW OF MEDI-CAL MCP MODEL CONTRACT
Link to contract	The “boilerplate” contracts for all plan six managed care models can be found at: <a href="http://www.dhcs.ca.gov">www.dhcs.ca.gov</a> .
Contract term	Posted boilerplate contract is dated 2014.
Background	There are six models of managed care, although contractual requirements are broadly consistent between the models. Most beneficiaries are enrolled in the Two-Plan model or a County Organized Health System.
Number of MCP members and plans	Thirty-eight plans, including six County Organized Health Systems serving 10.8 million Medicaid managed care enrollees statewide.
NCQA accreditation	NCQA accreditation is not required and is considered only in limited cases (e.g., with respect to credentialing).
Member access	DMHC and DHCS both review timely access to care, but the DHCS staff described their approaches as “different by design” in that DMHC is looking at past performance, while DHCS is looking prospectively, and has recently revised its process.
Clinical quality	<p>The Medi-Cal MCP Quality Improvement System includes two basic tools: (1) the External Quality Review (EQR) conducted by the External Quality Review Organization (EQRO) with whom the state contracts, and (2) performance improvement projects (PIPs).</p> <p>The EQR includes:</p> <ul style="list-style-type: none"> <li>▶ An assessment of each MCP’s strengths and weaknesses for the quality and timeliness of, and access to, health care services furnished to Medi-Cal beneficiaries</li> <li>▶ Recommendations for improving the quality of health care services furnished by each MCP</li> <li>▶ Methodologically appropriate, comparative information about all MCPs</li> <li>▶ An assessment of the degree to which each MCP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year</li> </ul> <p>DHCS posts the full annual <i>Medi-Cal Managed Care External Quality Review Technical Report</i> that it receives from the EQRO. The annual report includes program-wide and plan-specific performance on the Medi-Cal performance measures.</p> <p>As part of the EQR, Medi-Cal MCPs are held accountable for being at or above a Minimum Performance Level (MPL) for 21 specific quality measures in their External Accountability Set. These are primarily HEDIS measures (15 of 17). The MPL is set at the 25th percentile of national Medicaid performance for each measure. MCPs that fail to meet the MPL must engage in a Corrective Action Plan (CAP) and may be subject to financial penalties for failure to comply with the requirements or CAP. MCPs generally reported that the CAP process was sufficient to raise performance above the MPL. The state also defines a High Performance Level (HPL). While there are no financial incentives tied to achieving HPL, DHCS recognizes these plans with quality awards annually based on plan size, improvement, and innovation. The quality awards are given publicly in years where DHCS holds its public quality conference. MCPs can publicize these awards in marketing materials. The aggregate HEDIS score for each MCP is reported publicly on the DHCS Medi-Cal Managed Care Performance Monitoring Dashboard.</p>

## KEY TOPICS

## REVIEW OF MEDI-CAL MCP MODEL CONTRACT

Clinical quality, <i>continued</i>	Since 2005, DHCS has used an auto-assignment algorithm to reward competing plans in the same region with automatic enrollment of Medi-Cal beneficiaries based on performance on eight quality measures (six HEDIS measures and two measures regarding support of safety-net providers in their contracted networks) as well as encounter data quality. <sup>52</sup> The program rewards better-performing plans in the GMC and Two-Plan regions with a greater percentage of enrollees who are assigned to a MCP because they do not choose a MCP within the allotted time frame.
Member satisfaction	The contract calls for the EQRO to conduct member satisfaction surveys every three years. The MCP is required to submit a quarterly call center report and grievance log and report.
Safety net health	DHCS also administers California's 1115 DSRIP waiver: Medi-Cal 2020. Medi-Cal 2020 runs from 2016 to 2020 and includes four main components: Public Hospital Redesign and Incentives in Medi-Cal (PRIME), Dental Transformation Initiative, Whole Person Care, and Global Payment Program. The DSRIP waiver was established after the most recent MCP reprocurement; waiver elements are not reflected in the managed care contract, although some have been addressed through All Plan Letters. PRIME in particular has an impact on the managed care program. PRIME also has significant financial incentives for achievement on specific outpatient delivery system transformation and quality metrics; public hospitals are focused on these measures, which may reduce attention given to plan-specific performance measurement and incentives.
Addressing disparities	The managed care quality strategy includes reducing health disparities as one of six focus areas. DHCS has directed plans to do data analysis on disparities and to implement a Performance Improvement Plan related to disparities.
Population health	California's Section 1115 demonstration waiver introduces funding for Whole Person Care pilots, and the DHCS staff indicated an interest in using the managed care program to further these goals.
Value-based payment	There are no value-based payment requirements in the MCP contracts. However, DHCS does require VBP as part of the PRIME program for public hospitals. One goal of the PRIME program is to move 60% of Medi-Cal managed care beneficiaries assigned to designated public hospitals to APM arrangements by the end of the demonstration.
Utilization	DHCS uses encounter data to track utilization (e.g., ED visits, inpatient admissions, and prescriptions) and reports aggregate data publicly on the Managed Care Performance Monitoring Dashboard.
Administrative performance	DHCS has focused on encounter data submission quality, and uses encounter data for a variety of purposes, including public reporting through the California Regional Health Care Cost & Quality Atlas.
Other (PIPs)	The Medi-Cal model contract also requires that the MCPs undertake two PIPs as required by CMS. <sup>53</sup> In 2017–18, California MCPs were required to focus one PIP on a statistically significant health disparity and were directed to focus the other PIP on childhood immunization or another specified Medi-Cal focus area (hypertension, diabetes, or prenatal and postpartum care) where the MCP is performing below the MPL or is "in need of improvement." <sup>54</sup> Notably, these PIP priority areas seem to be only partially aligned with the priorities outlined in DHCS's overall Medi-Cal Quality Strategy. In addition to the PIPs, DHCS also holds quarterly discussions with the MCPs on their performance on priority areas.

## Covered California

### Overview

Covered California is the state exchange established under the ACA to provide subsidized and unsubsidized health insurance coverage to Californians and California businesses without access to other means of affordable health insurance. Eleven health insurance carriers (issuers) offer health insurance products (qualified health plans, or QHPs) through Covered California on the individual and family marketplace. Six of the carriers also offer group coverage to small businesses.

There are 19 pricing regions in California. Health insurance company plan offerings and prices vary by region. Three or more health insurance companies are available to at least 82% of all Californians, and there are at least two carrier options for everyone.

### Procurement Approach

Covered California aims to reprocure its issuers every three years; however, contract extensions are allowed. According to a recent board meeting, the current contract, which runs from 2017 to 2019, will be rolled over for an additional year to allow for (1) better engagement and alignment with other large purchasers, (2) time to gather additional data and conduct analyses, and (3) time to summarize and share results with external stakeholders and to solicit input to incorporate into future contracts.

### State Vision and Contracting Principles

The Covered California contract clearly discusses its vision for contracting with QHPs: “The Exchange’s ‘triple aim’ framework seeks to improve the patient care experience, including quality and satisfaction, improve the health of the population, and reduce the per capita costs of Covered Services.”

The contract language also includes a general quality framework for the agency and its issuers. This framework requires QHPs to “work with the Exchange to develop or participate in initiatives to promote models of care that: (1) target excessive costs, (2) minimize unpredictable quality, (3) reduce inefficiencies of the current system, and (4) promote a culture of continuous quality and value improvement, health promotion, and the reduction of health disparities to the benefit of all Enrollees and, to the extent feasible, other health care consumers.”

The contract language includes requirements for QHPs to move providers toward payments models that support quality performance.

### Contract Structure

The contract is organized with a main body and attachments. Some of the attachments are adapted each year to reflect changes. Attachments 7 and 14 are particularly useful regarding contract management and oversight. The attachments are (1) “Contractor’s Qualified Health Plan List,” (2) the current year’s standard benefit plan designs, (3) “Silver 70 Off-Exchange Plan, Nonmirrored Silver Level Plan Design,” (4) “Service Area Listing,” (5) “Health Carrier Evaluation Rubric,” (6) “Reserved for future use,” (7) “Quality, Network Management, Delivery System Standards and Improvement Strategy,” (8) “2017 Rates – Individual Exchange,” (9) “Updated Rates – Individual Exchange,” (10–12) “Reserved for future use,” (13) “List of Required Reports,” and (14) “Performance Measurement Standards.”

### Contract Management and Oversight

Covered California relies on DMHC to perform oversight and monitoring of its plans, all of whom must be licensed under the Knox-Keene Act, which leaves time and resources to focus on key priority areas. Each year, 90 days before the anniversary date of the contract, the exchange evaluates the QHP’s fulfillment of obligations. This evaluation and subsequent action or inaction taken by the QHP can lead to recertification or decertification.

Note: Performance Standards Penalty: The maximum penalty is 0.4% of gross premium for QHPs. The amount of the penalty can increase based on low performance on a wide variety of measures, can decrease based on high performance on some measures, and can also decrease (up to 15%) if Covered California fails to meet certain performance standards (call center performance, appeals processing, enrollee complaint resolution). For 2019, the penalty is based on customer service performance standards (15%); operational performance standards (35%); and quality, network management, and delivery system standards (45%).

KEY TOPICS	COVERED CALIFORNIA ISSUER CONTRACT
Link to contract	The current contract can be found at: <a href="http://hbex.coveredca.com">hbex.coveredca.com</a> (PDF).
Contract term	2017–19 (probably extending for one additional year to 2020).
Number of MCP members	Open enrollment for this year ended on January 15, 2019. As of May 2018, there were 1.4 million beneficiaries.
Number of plans	Eleven health insurance carriers are available in the individual and family marketplace. Six of the carriers are offered for group coverage to small businesses.
NCQA accreditation	QHPs are required to maintain a current accreditation throughout the term of the agreement from one of the following accrediting bodies: (1) Utilization Review Accreditation Commission (URAC), (2) National Committee on Quality Assurance (NCQA), (3) Accreditation Association for Ambulatory Health Care. A CAP is required if the MCP receives a score other than fully accredited.
Member access	<p>Performance standards (which contain a financial penalty) include a requirement that QHP produces an access map to demonstrate that low-income, medically underserved enrollees have access to health care services.</p> <p>QHPs must:</p> <ul style="list-style-type: none"> <li>▶ Report how they are using telehealth and other technologies to improve access to quality care.</li> <li>▶ Support at-risk enrollees as they transition insurance coverage, including identification of in-network providers, clear communication processes, advance notice of out-of-network provider status, and information about formulary.</li> </ul>
Clinical quality	<p>Issuers must consider quality metrics in network design.</p> <p>Performance standards (which contain a financial penalty) include a requirement for QHPs to design networks based on quality criteria.</p> <p>QHPs must:</p> <ul style="list-style-type: none"> <li>▶ Collect and annually report to the exchange, for each QHP product type, its HEDIS and CAHPS data.</li> <li>▶ Include their planned approach to providing health care shopping cost and quality information to members.</li> <li>▶ Develop an ACA-mandated Quality Improvement Strategy aligned with Covered California goals.</li> <li>▶ Participate in Improvement Collaboratives (Smart Care California and others).</li> <li>▶ Participate in a statewide initiative to reduce inappropriate c-sections.</li> <li>▶ Develop a strategy to improve safety in network hospitals focusing on requiring each hospital to meet performance standards rather than managing to a network average. The initial focus will be on the following hospital-acquired conditions: catheter-associated urinary tract infection, central line-associated blood stream infection, surgical site infection, MRSA, and C. diff infections.</li> </ul>
Member satisfaction	<p>Performance standards (which contain a financial penalty) include call center metrics, appeals decisions, grievance resolutions, emails and written inquiries, ID card processing time, etc.</p> <p>Enrollee Survey Summary Rating; star level determines performance penalty or credit.</p>
Safety net health	Performance standards (which contain a financial penalty) require the QHPs to maintain a network that includes a sufficient geographic distribution of care, including essential community providers and other providers, to provide reasonable and timely access to covered services for low-income (<200% federal poverty level), vulnerable, or medically underserved populations in regions served by the QHP, and must demonstrate provider agreements with at least 15% of 340B nonhospital providers in each applicable rating region.
Addressing disparities	<p>Performance standards (which contain a financial penalty) include a requirement for QHPs to collect self-reported race and ethnic identity data and to report required quality metrics for certain conditions (for 2017 these include diabetes, hypertension, asthma, and depression) by race, ethnicity, and gender.</p> <p>Requirements for “narrowing disparities.”</p>

Population health	<p>Performance standards (which contain a financial penalty) include a requirement for QHPs to:</p> <ul style="list-style-type: none"> <li>▶ Assign a PCP within 60 days of enrollment.</li> <li>▶ Use a payment strategy that “creates a business case for PCPs to adopt accessible, data-driven, team based care in Application for certification for 2019.”</li> <li>▶ Use integrated health care models or ACOs.</li> </ul> <p>QHPs must:</p> <ul style="list-style-type: none"> <li>▶ Report on their work to integrate physical and behavioral health.</li> <li>▶ Facilitate the sharing of data so providers can coordinate care and manage total cost of care.</li> <li>▶ Report on preventive services used by members including wellness benefits, tobacco cessation, and obesity management.</li> <li>▶ Report on partnerships with community organizations that it supports to promote wellness and better community health for enrollees.</li> <li>▶ Demonstrate capacity to assess risk and changes in risk among its enrollees and agree to proactively manage health conditions.</li> <li>▶ Offer diabetes prevention program to eligible enrollees age 18+.</li> </ul>
Value-based payment	<p>Performance standards (which contain a financial penalty) include requiring:</p> <ul style="list-style-type: none"> <li>▶ Payment reform strategies for hospital care for appropriate use of c-sections, use of patient-centered medical home and integrated healthcare models (ACOs), and hospital patient safety.</li> <li>▶ QHPs to use payment reform strategies for hospital care, putting at least 2% of payment “at risk” in 2019 for quality performance and 6% by 2023. Issuers may select the measures used for this purpose, but if a readmissions measure is included it cannot stand alone.</li> </ul>
Cost/Utilization	<p>If QHP uses a centers of excellence approach, it must report on how methods are used to determine the center(s) of excellence.</p> <p>If QHP uses a Reward-Based Consumer Incentive Program, it must report participation rates and outcomes to the exchange.</p> <p>QHPs must:</p> <ul style="list-style-type: none"> <li>▶ Consider cost in network design and report on cost variation.</li> <li>▶ Provide cost and quality information and tools for shared decisionmaking to enrollees to improve patient engagement.</li> <li>▶ Participate in a statewide workgroup through Choosing Wisely to reduce overuse of c-sections, opioid prescribing, and imaging for lower back pain.</li> <li>▶ Report its use of telehealth, centers of excellence, reference pricing, and cost transparency to consumers.</li> <li>▶ Report pharmacy value strategy.</li> </ul>
Administrative performance	<p>QHPs are subjected to liquidated damages for failure to submit data as required.</p> <p>QHPs are required to submit extensive data reporting around administration of plan including information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, rating practices, cost sharing, payments for out-of-network coverage, and enrollee rights.</p> <p>The exchange may impose penalties in the event that the QHP fails to comply or otherwise act in accordance with the performance measures. The exchange shall also administer and calculate credits that may offset or reduce the amount of any performance penalties, but in no event shall such credits exceed the total amount of the penalty levied.</p>

Note: The maximum performance standards penalty is 0.4% of gross premium for QHPs. The amount of the penalty can increase based on low performance on a wide variety of measures, can decrease based on high performance on some measures, and can also decrease (up to 15%) if Covered California fails to meet certain performance standards (call center performance, appeals processing, enrollee complaint resolution). For 2019, the penalty is based on customer service performance standards (15%); operational performance standards (35%); and quality, network management, and delivery system standards (45%).

## CalPERS

### Overview

The California Public Employees' Retirement System (CalPERS) is California's largest purchaser of health benefits in California and the second largest in the nation behind the federal government, covering nearly 1.45 million employees, retirees, and their families. CalPERS contracts with nine carriers to offer various health maintenance organization (HMO) plans that are regulated by the Department of Managed Care (DMHC) with standardized benefits across all MCPs. CalPERS also offers three preferred provider organization (PPO) plans, which have comparable benefit designs but are self-funded and regulated under federal law. The majority of CalPERS members have access to both HMO and PPO options; however, members in some rural counties only have access to CalPERS PPO plans. Approximately 71% of CalPERS non-Medicare enrollees are enrolled in an HMO plan.

### Procurement Approach

MCPs are typically reprocured every five years. The CalPERS board has the authority to add new plans during the procurement period, and CalPERS has the ability to close plans mid-contract. CalPERS amends some aspects of the contract each year; for example, performance measures. Performance measures are reviewed annually with the MCPs, and CalPERS ensures that current important outcomes are being measured.

### State Vision and Contracting Principles

In April of 2018, CalPERS developed a set of six "health beliefs" that were developed with input from various stakeholders and adopted by the board. These health beliefs provide a foundation for the strategic management of the program. The beliefs are health program sustainability, high-quality care, affordability, comprehensive care, competitive plan choice, and quality program administration. In 2019, CalPERS began offering a value-based insurance design option that provides members with a lower-cost option and encourages members to be more engaged in health care.

### Contract Management and Oversight

In addition to its standard terms and conditions, CalPERS contracts with its MCPs include the following attachments:

- ▶ Attachment A: Services
- ▶ Attachment B: Account support from the plan

- ▶ Attachment C: Compensation
- ▶ Attachment D: Performance Measures

CalPERS recently evaluated its performance measurement oversight approach and has taken steps to move away from operational measures as part of its performance measures and toward outcomes measures. Previously, the plans were required to report on 80 separate operational statistics; this reporting is still required but not the focus of oversight activities. Bailit Health reviewed Attachment D from the CalPERS contract as part of this research. CalPERS plans are held accountable through financial penalties for approximately 20 specific metrics that impact their administrative fee. These metrics cover the following topics:<sup>55</sup>

- ▶ Administrative and account management support
- ▶ Member services
- ▶ Pricing, payments, and risk adjustment
- ▶ Systems and data reporting management
- ▶ Provider network
- ▶ Medical management services (clinical quality and hit connectivity)
- ▶ Integrated health care model

In addition, CalPERS staff requires a "quarterly business review" with each plan; in advance of these meetings, the plans are required to complete a financial and clinical template.

CalPERS aggregates plan data in a data warehouse. These data are used to monitor health plan and CalPERS performance. Based on its data analysis, CalPERS initiates cost-efficiency and performance improvement projects over time; examples include reference pricing for hip and knee replacements. These data also feed into a "Population Health Dashboard" for CalPERS to monitor overall and plan-specific performance (only aggregated results are shared publicly). The CalPERS dashboard focuses on outcome measures in specific clinical areas (e.g., diabetes).

CalPERS plans that fail to meet performance expectations are typically required to file CAPs. CalPERS recently added a "liquidated damages" clause to its contract, but CalPERS must demonstrate a material financial loss to

CalPERS before invoking the clause, and CalPERS staff report that they see liquidated damages as a tool of last resort.

CalPERS also conducts a survey of its members annually to determine member satisfaction with the plan, providers, and access to care. In addition, CalPERS generally

relies on DMHC rules and oversight. In contrast to DHCS, which is legislatively mandated to also conduct audits, CalPERS does not have those same mandates and instead relies primarily on DMHC to perform oversight and monitoring of its plans, all of whom must be licensed under the Knox-Keene Act. This leaves CalPERS with both time and resources to focus on key policy issues.

KEY TOPICS	CALPERS CONTRACT
Link to contract and contract term	Bailit Health did not have access to a contract for this review but did review Attachment D and CalPERS’s 2017–22 Strategic Plan (available at <a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a> [PDF]), as well as conduct an interview with CalPERS staff. Most of the information contained in this table comes from the strategic plan.
Number of MCP members and plans	Six carriers and three association plans covering 1.4 million lives (employees, retirees, and dependents) as of June 30, 2017. In addition, OptumRx is the pharmacy benefits manager for CalPERS.
Member access	<p>CalPERS:</p> <ul style="list-style-type: none"> <li>▶ Relies on DMHC standards for network adequacy.</li> <li>▶ Conducts an annual member survey, a modified version of CAHPS, which asks members to report their accessibility to health care including emergency room and after-hours care. (Strategic Plan)</li> <li>▶ Assesses whether there has been a material change in network access from one year to the next.</li> </ul> <p>MCPs must:</p> <ul style="list-style-type: none"> <li>▶ Maintain a minimum of a two-star rating for “Getting Care Easily” in the “Member Ratings” section of the Office of the Patient Advocate’s Health Care Quality Report Card.</li> <li>▶ Conduct ongoing participating provider network reviews for quality and appropriate care and report findings to CalPERS.</li> <li>▶ Submit to CalPERS a copy of any financial audit report and any public quality-of-care study or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., The Joint Commission, NCQA, or URAC).</li> </ul>
Clinical quality	<p>Large MCPs that contract with CalPERS are required to submit HEDIS data specific to CalPERS members on an annual basis.</p> <p>MCPs must:</p> <ul style="list-style-type: none"> <li>▶ Use best efforts to require participating providers and hospitals to undertake the safety and quality initiatives supported by the Leapfrog Group consisting of computer-based physician order entry, evidenced-based hospital referral, and appropriate intensive care unit physician staffing.</li> <li>▶ Provide data on inpatient acute care quality and clinical quality.</li> <li>▶ Review, measure, and improve the quality of services provided and the clinical practices of their participating providers and report to CalPERS.</li> <li>▶ Maintain internal quality improvement policies designed to achieve significant, sustained improvement in clinical care, plan member satisfaction, and health outcomes for plan members receiving capitated services.</li> <li>▶ Perform an assessment of access to noncapitated services by plan members, including but not limited to the quality of outcomes and timeliness of these services, review the assessment with participating noncapitated services providers, and report semiannually to CalPERS.</li> <li>▶ Submit to CalPERS a copy of any financial audit report and any public quality-of-care study or access study prepared by a federal or state regulatory agency or by an accrediting body (e.g., The Joint Commission, NCQA, or URAC).</li> </ul>



KEY TOPICS

CALPERS CONTRACT

Member satisfaction	CalPERS conducts an annual member survey, a modified version of CAHPS, to assess members' experience and satisfaction with their health plan over the last 12 months. Members are asked to rate their satisfaction with the health plan, personal doctor, specialist, and pharmacy service. This survey is required for MCPs with an enrollment of at least 2,000 eligible members. The data results, by plan, are shared publicly. CalPERS analyzes data separately for rural members as well.
Population health	Requires MCPs to offer diabetes prevention program at no cost to members. (Strategic Plan) Conducts population risk analysis by state and contracting agency and geographic region.
Cost/Utilization	<p>CalPERS:</p> <ul style="list-style-type: none"> <li>▶ Maintains a data warehouse called the Health Care Decision Support System, which contains more than a decade of anonymized claims data for all CalPERS Health Benefits Program enrollees. These data enable CalPERS to analyze health plan performance, disease management programs, member utilization, and health care costs, including pharmacy costs.</li> <li>▶ Has used the following strategies to manage the costs of its premiums: promoting narrow hospital networks, adding narrow health plan networks, utilizing value-based purchasing, integrated health models, competition, and flex funding.</li> </ul>
Administrative performance	MCPs must adhere to a number of performance standards outlined in Attachment D of the contract. Failure to do so may result in a percentage repayment of administrative services fees. These measures include Administrative and Account Management Support, Member Services Pricing, Payments and Risk Adjustment Systems and Data Reporting Management, Provider Network, Medical Management Services (clinical quality and health information technology connectivity), and Integrated Healthcare Model, among others.
Other	Administers a staff satisfaction survey annually.

## Appendix C. Summary of Contracts for Select Medicaid Programs

The following information was garnered primarily from Bailit Health's review of state contracts and from the authors' knowledge of these states' managed care programs. Also interviewed were state MCP staff from Florida, Massachusetts, Tennessee, and Texas. The authors included in the tables that follow information on whether contracts included specific requirements for MCPs to support the safety net, address disparities, and focus on population health initiatives; however, this information was not always readily apparent from review of MCP contracts themselves and may not have been directly addressed in the interviews.

### Florida

#### Overview

Florida's Medicaid agency is the Agency for Health Care Administration (AHCA). Florida's earlier Medicaid managed care pilot program was expanded to a mandatory, statewide program in 2014. The Statewide Medicaid Managed Care (SMMC) program has five types of plans across 11 regions:

- ▶ **Managed Medical Assistance (MMA).** Provides acute services to recipients not eligible for long-term care (LTC).
- ▶ **Long-Term Care (LTC) Plus.** Provides MMA and LTC services to eligible LTC recipients.
- ▶ **Comprehensive.** Provides MMA and LTC services to all eligible recipients.
- ▶ **Specialty.** Provides MMA services to defined specialty populations, (e.g., people with HIV/AIDS, children with special needs, people with severe mental illness, etc.) in some regions.
- ▶ **Dental.** Provides dental services to all recipients in managed care and all and fully eligible fee-for-service individuals.

#### Procurement Approach

In developing its "Intent to Negotiate" (ITN) procurement, Florida Medicaid articulated strategic objectives for its upcoming five-year contracts as well as quality results to date for its prior MCP contract cycles.<sup>56</sup> By state law, AHCA is required to competitively reprocure its Medicaid managed care contracts every five years. In addition, state law requires Florida's ITN to include

more details on its scoring criteria than most states. In the recent ITN, MCPs were required to bid by region and submit price and technical components. Given the size and scope of the Florida managed care program, the procurement process takes almost two years from start to finish. Bidders were scored separately for each region and program type. Preference was given for qualified bidders proposing to serve more regions and more managed care program types. The state identified the maximum number of plans (e.g., 2 to 10 MMA plans) with which they will contract in each region based on eligible managed care population. Under state law, there is a preference for at least one Medicaid provider-sponsored network (PSN) plan in each region if the state receives a bid from a qualified PSN.

Responses from bidders were evaluated, scored, and ranked by plan type in each region. The state selected a predetermined number of top-ranked respondents to enter into negotiations. The state has credited this "best and final" offer-negotiation process for getting bidders to commit to higher levels of performance and to offer additional value-added benefits at no cost to the state. Florida received and resolved a few protests as part of its 2017–18 procurement process and started regional transitions of affected members to new plans in December 2018.

#### Contract Structure

Florida has a multilevel managed care contract to align standard contract requirements across the different types of plans. Florida's main MCP contract includes "Attachment I - Scope of Services" and core contract provisions for all MCOs in Attachment II. The state organizes its exhibits by type of managed care plan. (Exhibit II-A is for acute MMA plans, Exhibit II-B is for LTC plans, and Exhibit II-C sections apply to child welfare, HIV/AIDS, severe mental illness, and chronic disease "specialty plans.") For the new contract, MCPs must provide four services that were previously fee-for-service: (1) early intervention services / Early Steps, (2) medical foster care, (3) targeted case management, and (4) nursing facility services for MMA-eligible populations.

AHCA maintains the Managed Care Policy and Contract Development page,<sup>57</sup> which includes Medicaid agency communications to SMMC plans, similar to Medi-Cal All Plan Letters. Florida issues a Medicaid managed care

plan report guide<sup>58</sup> as a companion to its MCP contract, with detailed reporting instructions, templates, and submission directions.

### Contract Management and Oversight

Florida's contract indicates that the "Agency shall be responsible for establishing incentives to high-performing plans." However, MCP performance incentives spelled out in the contract and currently used by Florida largely include financial penalties for poor performers rather than positive incentive payments for high performers. Florida has detailed sanctions and liquidated damages specified in its SMMC contracts, which include pages of very specific penalties for certain contract violations. Florida also posts MCP compliance actions online.<sup>59</sup> According to Florida Medicaid, the financial penalty strategy as a performance incentive has worked. Approximately 69% of the state's CY2017 Medicaid Managed Care HEDIS scores are above the national average and the state has seen specific improvement in MCP performance over the past several years.<sup>60</sup>

The Florida contract contains extensive requirements regarding MCP oversight of delegated entities. Attachment II and Exhibit II-A provide the specific requirements that are summarized below.

- ▶ The MCP cannot delegate any aspect of the grievance and appeal or provider complaint system to subcontractors.
  - ▶ The MCP's annual network development plan must include a description of the overall monitoring strategy of subcontractors delegated to network management functions.
  - ▶ If the MCP has delegated credentialing and/or recredentialing, the agreement must ensure that it is done in accordance with the MCP's and the agency's credentialing requirements.
  - ▶ The MCP maintains ultimate responsibility for the provision of services and for adhering to and otherwise fully complying with all terms and conditions of the contract.
- ▶ The MCP must submit all subcontracts for agency review at least 90 days before the proposed effective date of the subcontract or change.
  - ▶ The MCP cannot delegate provider network management to a subcontractor who is owner or has controlling interest in any provider included in the network, and the subcontractor also limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.
  - ▶ The MCP cannot delegate key (minimum) staff positions required by the contract.
  - ▶ If the MCP delegates claims processing and payment or enters into a risk-bearing contract, the MCP must:
    - ▶ Require the subcontractor to submit quarterly unaudited and annual audited financial statements.
    - ▶ Provide to the agency, upon request, copies of the financial statements, including documentation of the plan's financial review.
    - ▶ Notify the agency within two days if the MCP has reason to believe that the subcontracted vendor is insolvent or becoming insolvent.
    - ▶ Require the subcontractor to maintain an insolvency account to meet its obligations.
    - ▶ Require that, if the MCP delegates claims processing and payment, the subcontractor maintain a surplus account to meet its obligations.
  - ▶ If the MCP fails to comply with any of these delegation requirements, the MCP may be subject to sanctions or liquidated damages, as specified in the contract and as determined by the agency.

KEY TOPICS	FLORIDA MCP CONTRACT
Link to contract	Statewide Medicaid Managed Care (SMMC) contract can be found at: <a href="http://www.fdhc.state.fl.us">www.fdhc.state.fl.us</a> .
Contract term	New contracts effective 2019–23.
Background	Plans are contracted by region with a standard statewide contract that includes common items across all Medicaid managed care programs, acute, long-term care, and specialty plans.
Number of MCP members and plans	Thirteen acute care, five specialty, and three dental plans provide services to 3.1 million Medicaid managed care enrollees across 11 regions.
NCQA accreditation	MCPs must be accredited by a nationally recognized accrediting body or have initiated the accreditation process within one year of contract execution. The state can suspend auto-assignment to any plan that is not accredited or has not applied for such accreditation within one year. If a MCP is not accredited within 18 months of executing the contract, Florida may terminate the contract.
Member access	<p>Created an automated MCP network adequacy review tool. Network adequacy standards vary by region and plan type. MMA standards include requirements such as MCP agrees that:</p> <ul style="list-style-type: none"> <li>▶ At least 40% to 50% of required participating PCPs, by region, offer after-hours appointment availability to Medicaid enrollees.</li> <li>▶ No more than 5% to 10% of enrollee hospital admissions, by region, shall occur in nonparticipating facilities, excluding continuity-of-care periods.</li> <li>▶ No more than 8% to 10% of enrollee specialty care (physician specialist) utilization, by region, shall occur with nonparticipating providers, excluding continuity-of-care periods.</li> </ul> <p>MCP reporting requirements related to access. For example, MCPs are required to track and annually report ED visits for members who have not recently had a PCP visit as well as to report monthly on the denial, reduction, termination, or suspension of services to enrollees.</p> <p>MCP’s annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including:</p> <ul style="list-style-type: none"> <li>▶ Immediate short-term interventions to address network gaps, including the process for enrollees to access services.</li> <li>▶ Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers.</li> <li>▶ Method for accessing a nonparticipating provider to address any potential gaps, including a description of the plan’s provider outreach strategy.</li> <li>▶ The extent to which the plan uses telemedicine services to resolve network gaps.</li> <li>▶ Ongoing activities for network development, including network management functions delegated to subcontractors.</li> </ul> <p>“Attachment II – Scope of Services” also includes a list of liquidated damages for core program requirements that apply to all MCPs. For example, “Failure to have a rate at or above ninety percent (90%) for the Call Answer Timeliness* measure as described in the Contract. \$25 per each case in the denominator not present in the numerator for the measure up to the ninety percent (90%) target rate.”</p> <p>Liquidated damages for a variety of compliance issues including lack of timely transportation to medical appointments.</p>
Clinical quality	<p>Florida has significant detail on quality measures and approaches in its MCP contract. This section of the Medicaid website has significant information on Florida’s MMC quality approaches and measures: <a href="http://ahca.myflorida.com">ahca.myflorida.com</a>.</p> <p>MCPs must submit 30 HEDIS measures annually as well as 9 other measures including Adult and Child Core Measures. MCPs are subject to sanctions for failure to achieve minimum scores on performance measures after the first year of poor performance. AHCA may require a MCP to complete a Performance Measure Action Plan.</p> <p>AHCA groups measures to create a composite score for each group. A MCP may receive a monetary sanction of up to \$10,000 for each measure group where the MCP’s composite score is below 3 (the assigned score for the NCQA Medicaid 50th percentile). Florida may also assess specific liquidated damages on MCPs based on poor HEDIS performance.</p> <p>The contract also includes incentives for achieved savings rebates (ASRs): In accordance with state law, a MCP that meets or exceeds the NCQA 75th percentile performance on at least 5 of 10 agency-identified quality measures may retain an additional 1% of revenue. Such a MCP is allowed to retain 100% of net</p>

## KEY TOPICS

## FLORIDA MCP CONTRACT

Clinical quality, <i>continued</i>	operating income (NOI) up to 5% of MCP premium revenue and half of NOI between 5% and 10% of premium revenue. A MCP can only benefit from the ASR if the MCP achieves savings at a level where the ASR comes into play. As part of 2019 contracts, MCPs committed to specific reductions in (1) potentially preventable admissions, readmissions, and ED visits; (2) c-section rates, preterm deliveries, and babies born with neonatal abstinence syndrome.
Member satisfaction	Both Exhibit II and II-A include significant details on MCP requirements to conduct and act on annual member surveys. MCPs must conduct an annual survey for both adults and children separately, using the CAHPS Medicaid Survey 5.0. For adults, MCPs must include questions related to behavioral health and assistance with tobacco use cessation. MCPs must use CAHPS survey results to develop and implement plan-wide activities to improve member satisfaction. Activities conducted by MCPs must be reported to the agency on a quarterly basis. MCPs must provide a written proposal for survey administration and reporting by December 1st of each contract year, identify the survey administrator and provide evidence of the survey administrator's NCQA certification as a CAHPS survey vendor as well as a sampling methodology, administration protocol, analysis plan, and reporting description.
Safety net health	MCPs are required under state law to contract with essential providers, some regional, some statewide including: <ul style="list-style-type: none"> <li>▶ Faculty plans of Florida medical school faculty physician groups</li> <li>▶ Regional perinatal intensive care centers</li> <li>▶ Hospitals licensed as specialty children's hospitals</li> <li>▶ Accredited and integrated systems serving medically complex children</li> </ul> MCPs are required to make a good faith effort to execute memorandums of agreement with public health providers, including County Health Departments, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) under state rules.
Addressing disparities	Florida's comprehensive quality strategy refers to goals of addressing disparities, particularly related to birth outcomes. See <a href="http://ahca.myflorida.com">ahca.myflorida.com</a> (PDF).
Population health	The contract has detailed care coordination / case management requirements, including behavioral health (BH) integration and a healthy behaviors program. Quality enhancements, including domestic violence screening and referral, are also included.
Value-based payment	MCPs must develop and implement a value-based purchasing program to reduce costs associated with potentially preventable events and improved birth outcomes. The agency reserves the right to develop mandatory program parameters, performance metrics, and alternative payment methodologies at a later date.
Administrative performance	"Attachment II – Scope of Services" includes core program requirements that apply to all managed care plans such as enrollee tollfree help line requirements. The liquidated damages (LD) matrix includes 123 different items — many of which are for poor administrative performance, including the following standard: "Failure to have a rate at or above ninety percent (90%) for the Call Answer Timeliness measure as described in the Contract. \$25 per each case in the denominator not present in the numerator for the measure up to the ninety percent (90%) target rate." In addition, a MCP cited for failure to comply with claims processing as described in this contract is subject to LD of \$10,000 per month for each month that the agency determines that the MCP is not in compliance.
Other (PIPs)	MCP required to perform four agency-approved statewide PIPs. One shall: <ul style="list-style-type: none"> <li>▶ Combine a focus on improving primary c-section rates, preterm delivery rates, and neonatal abstinence syndrome rates.</li> <li>▶ Focus on reducing potentially preventable events, including hospital admissions, readmissions, and emergency department visits.</li> <li>▶ Be an administrative PIP focusing on the administration of the transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving at their scheduled appointment on time.</li> <li>▶ Be a choice of PIP in one of two topic areas: behavioral health or integrating primary care and behavioral health.</li> </ul> The first three PIPs listed above shall be collaborative PIPs coordinated by AHCA and the EQRO. The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the MCPs for review and feedback.

## Massachusetts

### Overview

The Office of Medicaid within the Massachusetts Executive Office of Health and Human Services (EOHHS) is the single state authority responsible for the administration of the Medicaid program, known as MassHealth. Massachusetts first began providing coverage through managed care in 1997.

Massachusetts began the restructuring of its mandatory Medicaid managed care program in 2016 with the introduction of a new purchasing strategy focused on providers having more accountability for outcomes, and with that more opportunity to share in savings. To implement this approach, Massachusetts released three procurements in late 2016 and early 2017 that allow for accountable care organizations (ACOs) and managed care organizations (referred to here as MCPs) to partner together as a contracting entity, for ACOs to contract directly with the Medicaid program, and for ACOs to contract with MCPs that contract with the state. In addition to contracting for ACOs, the state also released a procurement for MCPs. With this change in approach, the state went from managing six managed care plans for its under-65, non-dually eligible population to managing almost 20 entities. Massachusetts also offers voluntary managed care for its dually eligible population through the OneCare program (combining Medicare and Medicaid for the under-65 population) and the Senior Care Options program (combining Medicare and Medicaid for those 65 and older).

### Procurement Approach

Massachusetts conducts a competitive procurement process through a request for response (RFR) process that is run completely through EOHHS. Massachusetts's MCP contracts have historically been for a minimum of five years, with the potential for three one-year extensions. In developing procurements, MassHealth draws from a wide number of staff across the Office of Medicaid and other relevant agencies within EOHHS (e.g., the Department of Mental Health and the Department of Public Health, among others) to promote as much alignment as possible.

The state has made various efforts in the past to align purchasing with the Group Insurance Commission, which is responsible for the state's employee and retiree purchasing, but there is no official structure to ensure that alignment continually happens.

Based on our conversation with MassHealth staff, the contract seems to be at the center of the management strategy. Currently, the state and its contractors (including ACOs, MCPs, and community partners) are focusing on implementation of the program.

### Contract Structure

Massachusetts includes a model contract as an attachment to its procurement and then uses that contract to manage its vendors on an ongoing basis. The Massachusetts MCP contract includes a detailed table of contents. It includes responsibilities for both the MCP and for the Office of Medicaid. Within the contract EOHHS reserves the right to amend the contract to implement new initiatives or to modify contract provisions for a variety of program and policy changes.

All required information is included within the model contract, appendices, and exhibits. Massachusetts does not have a separate operations manual that expands on the detail within the model contract, and it does not use All Plan Letters. There is a provision within the contract that states "EOHHS may, from time-to-time, issue memoranda clarifying, elaborating upon, explaining or otherwise relating to contract administration and other management matters."

### Contract Management and Oversight

Massachusetts's model contract reflects the state's contract management and oversight activities, including requirements regarding MCP organization, key staff and responsibilities, and a series of contract requirements focused on contract management, including quarterly, in-person performance reviews on key contract activities and strategies, and ongoing performance reporting. In addition to holding regular meetings with MCPs, the state also holds regular meetings with stakeholders to obtain feedback on the MassHealth program, including performance of the MCPs.

The contract includes detailed provisions regarding material subcontractors, including a requirement that all material subcontractors be approved by EOHHS, and that material subcontractor's performance be formally reviewed at least annually. The contract also makes clear that the MCP remains ultimately responsible for any functions delegated to the material subcontractor.

## KEY TOPICS

## MASSACHUSETTS MCP CONTRACT

Link to contract	The MassHealth MCO Contract is available at: <a href="http://www.commbuys.com">www.commbuys.com</a> .
Contract term	The contract was released as part of the state's procurement in 2016; the contract extends through December 2022.
Background	The MCP contract is statewide, covering members without Medicare or other third-party insurance who are under age 65.
Number of MCP members and plans	Approximately 1.2 million members are enrolled in managed care. Members can choose from two MCPs (both local nonprofit plans) or 17 ACOs (based on primary care physician). Depending on their region of the state, members can choose from 4 to 11 plans. Approximately 200,000 members are covered through MCPs.
NCQA accreditation	NCQA accreditation is required to bid on the contract. A plan can be terminated if it loses its NCQA accreditation.
Member access	The contract includes access and availability standards that detail the time in which services must be provided, and time/distance standards.
Clinical quality	<p>The contract includes extensive quality requirements, defining quality management and quality improvement (QI) principles.</p> <p>The quality appendix clarifies that the QI goals measurement cycle spans a two-year period, which includes baseline, midcycle, and final evaluation periods to allow for tracking of improvement gains. For each QI goal cycle, EOHHS will establish a series of QI goal domains as well as required measurement and quality improvement activities. QI goals are selected based on three priority areas for improving quality and health outcomes developed by the Department of Health and Human Services Public Health Quality Forum:</p> <ul style="list-style-type: none"> <li>▶ Impact: The extent of significant improvements in population health, health equity, quality, and safety that could result from changes in this area.</li> <li>▶ Improvability: The potential for changes that could lead to desired health, process, or system outcomes.</li> <li>▶ Practice variability: The potential for standardizing areas where wide variability in practice exists and where gaps between current practices and knowledge can be closed without hindering innovation.</li> </ul> <p>MCPs are expected to collect and report on all measures and interventions in each QI domain as specified by EOHHS. There are 74 quality measures included in the appendix.</p> <p>Plans are subject to a performance incentive withhold of up to 5%, and can earn up to 105% of their capitation rate based on performance.</p>
Member satisfaction	EOHHS conducts a biennial member satisfaction survey that includes MCP members.
Value-based payment	Massachusetts includes specific requirements for MCPs to contract with the state-certified ACO. In addition, MCPs are required to report on APM usage and must show that a certain percentage of enrollees utilizing physicians that participate in APMs (60% in CY1–2, 70% in CY3, 80% in CY4).
Other	EOHHS responsibility section signals the role of the state in overseeing MCPs.

## Tennessee

### Overview

Tennessee's Medicaid managed care program (TennCare) is statewide and mandatory for all coverage groups. The MCP contract currently carves out dental and pharmacy services.

TennCare contracts with two national for-profit plans and one local for-profit plan. All three MCPs are required to be statewide and cover the same comprehensive set of acute and long-term services and supports, which simplifies monitoring. Tennessee divides the state into three regions for MCP reporting and oversight purposes, given some of the differences in the underlying population and health care marketplace across the state.

### Procurement Approach

Tennessee selects MCPs through competitive procurement roughly every six years. Most recently, the initial contract term was for three years, and the state elected to exercise three one-year extensions to date. TennCare has a maximum MCP contract term of eight years.

In its 2013 procurement, TennCare limited the number of awarded MCP contracts to three. All bidders had to agree to serve the full state and to provide acute care services to all eligible Medicaid beneficiaries as well as long-term care services and supports to all dually eligible Medicaid/Medicare beneficiaries in the TennCare CHOICES program. The state sets payments rates for MCPs based on competitive bids. Bidders were required to submit a cost proposal for rate cells in all three regions within a range established by the data book. MCP RFP responses were evaluated out of 1,000 points spread across general requirements and technical, oral, and cost proposals.

### Contract Structure

Tennessee has a detailed 600+ page contract, with its MCPs providing significant leverage with the plans. The responsibilities of the MCP and TennCare are clearly organized in the contract. Areas that are important to the state have an associated report or liquidated damage provision that is clearly laid out in the contract specifications. While MCPs are statewide, they often have to report separately for each of the three regions defined by the state.

TennCare updates its contract twice a year via amendment. This allows the state to be responsive to perceived gaps in its contract and in MCP performance as well as to change direction and address evolving needs. In the yearly process to set capitation rates, the state takes the opportunity to think about budgetary impact to make sure MCPs are appropriately resourced and to avoid unfunded mandates.

### Contract Management and Oversight

TennCare's contract management approach has evolved over the last decade with a core focus on quality and quality improvement. TennCare has established a collaborative process and culture across the plans. With only three MCPs, the state is able to have both combined and individual meetings with the plans to work together.

TennCare's quality strategy is somewhat more flexible than other areas of the contract and provides some choice to MCPs regarding areas of focus. TennCare has a dedicated data analytics team with strong content knowledge and capability that both push and support MCP performance improvement. For example, if Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) rates have been declining, TennCare notices and asks the MCPs about where this is happening, for whom, and how the MCP will create targeted strategies to improve the rates.

If a plan is not performing in a certain key area, the state will use a CAP approach, followed by liquidated damages if needed, and/or retaining withhold amounts for nonperforming MCPs. The contract specifies three levels of liquidated damages: category A issues pose significant threat to patient care, category B items threaten the integrity of TennCare, and category C issues pose threats to smooth and efficient operation of TennCare. A detailed table of deficiencies and associated liquidated damages is included in the contract.

TennCare audits MCPs annually regarding transportation. TennCare's program integrity unit audits annually for fraud, and the Department of Commerce and Insurance conducts annual financial and prompt pay / internal access audits. All MCP provider agreements are approved by TennCare and the Department of Commerce and Insurance.



## Stakeholder Engagement

By limiting its managed care contracting to three MCPs, the state is better able to use a more collaborative plan management approach. Similar to other states, TennCare facilitates combined meetings quarterly with its plans, but there appears to be a stronger culture of collaboration.

At these MCP meetings, TennCare reviews current initiatives to determine if any additional direction or course correction is needed. TennCare also organizes itself into units similar to those in the MCP. These state and MCP counterparts meet on a regular basis.

KEY TOPICS	TENNESSEE MCP CONTRACT
Link to contract	<a href="http://www.tn.gov">www.tn.gov</a> (PDF)
Contract term	2014–19, with potential to extend
Background	Plans are contracted statewide to serve all those eligible for Medicaid managed care including dual eligible members; all acute and LTSS provisions are included in the same model contract.
Number of MCP members and plans	Three MCPs serve over 1.4 million members statewide (all 95 counties). The plans operate across three geographic areas (West Grand, Middle Grand, and East Grand Tennessee).
NCQA accreditation	All MCPs must be NCQA certified.
Member access	Provider validation survey conducted by EQRO quarterly to determine that providers are available and accessible. A CAP is required if timely access to providers is not met or if the member-to-provider ratio is exceeded.
Clinical quality	<p>Capitation withholding for noncompliance with contractual requirements. Withholds a portion of the annual capitation amount each month (10% for the first six months, and between 2.5% and 5% thereafter); it is returned to the MCP each month it meets state’s performance expectations.</p> <p>Four quality goals: (1) assure appropriate access to care; (2) provide high-quality, cost-effective care; (3) assure satisfaction with services; and (4) improve health care.</p> <p>Measurable objectives set for each quality goal above as follows:</p> <ul style="list-style-type: none"> <li>▶ EPSDT screening rates = 80%, travel time, HEDIS metrics, patient-centered medical home (PCMH) requirements (34% of patients must be served by PCMH by 2019).</li> <li>▶ Timely access to and frequency of prenatal care and postpartum care. Also developing metrics for each of 66 episodes of care (by 2019), measurement of performance for providers serving patients with high behavioral health needs, and immunization rates.</li> <li>▶ Member satisfaction and getting care when needed (both assessed by survey).</li> <li>▶ Measurement of weight management, ED use, readmissions, neonatal intensive care unit use, End Stage Renal Disease use.</li> </ul> <p>Pay-for-performance (P4P) up to 105% of capitation. Use 10 HEDIS measures, \$0.03 per member per month (PMPM) for “significant improvement” (NCQA definition) from baseline.</p> <p>Report full set of HEDIS and CAHPS data, submit PIPs, use population health strategies, conduct provider satisfaction surveys, and comply with EPSDT and dental requirements.</p> <p>EQRO conducts annual quality survey for each MCP and annual audits, and helps facilitate collaborative workgroups with MCPs around quality, ED diversion, high-risk maternity, EPSDT outreach, etc. EQRO facilitates awards meeting annually.</p> <p>MCP agrees to participate in workgroups as required.</p>
Member satisfaction	<p>MCP must conduct annual CAHPS using approved NCQA vendor, use adult/child/children with chronic conditions modules, and submit data to EQRO and TennCare for analysis.</p> <p>The University of Tennessee also conducts an annual household survey (N = 5,000) to assess perceptions of health care and compares TennCare households to non-TennCare households.</p>

KEY TOPICS

TENNESSEE MCP CONTRACT

Safety net health	Encouraged to contract with FQHCs and RHCs in the region, and must contract with at least one FQHC and RHC per service area. Encouraged to contract with community mental health agencies, and must contract with each local health department.
Addressing disparities	<p>TennCare developed a health care disparities action plan in 2016 using data from member survey, including access to care, provider communication, provider rating, MCP communication, MCP rating. Analyzed data by race/ethnicity, language, disability status, and sex.</p> <p>MCPs must collect data on race/ethnicity and include quality measure / quality indicator (QM/QI) activities to improve health care disparities identified through data collection.</p> <p>MCPs are required to include QM/QI activities to improve health care disparities:</p> <ul style="list-style-type: none"> <li>▶ Ensure adequate provider network.</li> <li>▶ Provide an opt-out strategy for population health services.</li> <li>▶ Provide screening and preventive health care.</li> <li>▶ Implement adult and child health disparities “opportunity gaps” survey.</li> </ul>
Population health	<p>PCMH requirements (34% of patients in each MCO must be served by PCMH by 2019, 35% by 2020).</p> <p>MCPs must stratify members into one of three groups within 90 days of enrollment and quarterly thereafter. MCPs must offer a set of services, care management, and education depending on members’ assigned strata.</p>
Value-based payment	<p>Requires MCPs/providers to participate extensively in state-defined episodes of care, which is part of a large State Innovation Model effort and involves significant data analysis and stakeholder engagement.</p> <p>If MCP wants to employ a physician incentive program with quality incentives with providers, it must let TennCare know of its plans.</p>
Cost/Utilization	<ul style="list-style-type: none"> <li>▶ MCPs are required to bid on price within a rate range set by the state.</li> <li>▶ The contract requires an extensive utilization management program.</li> <li>▶ MCPs must review and report on excessive ED use and coordinate with population health efforts.</li> <li>▶ Liquidated damages are imposed for excessive readmissions.</li> </ul>
Administrative performance	<p>Liquidated damages for noncompliance with contract requirements. (Schedule found in “Appendix 7: Performance Standards of Contract.” Detailed schedule includes measure, data source, benchmark, definition, frequency of reporting/audit, and liquidated damages amount).</p>
Other (PIPs)	<p>MCPs are required to submit at least two clinical (one must be BH), three nonclinical (one must be LTSS), and one EPSDT PIPs annually.</p>

## Texas

### Overview

Texas's Medicaid agency is the Health and Human Services Commission (HHSC). Texas started with managed care in large urban counties covering acute care services and over time expanded to multiple regions, populations, and services. Today, its managed care programs are statewide. Over 94% of Texas Medicaid enrollees and all Children's Health Insurance Program (CHIP) enrollees are enrolled in one of seven distinct managed care programs for low-income individuals and families, elderly individuals, adults and children with disabilities, and foster children. For example:

- ▶ STAR is Texas's largest Medicaid managed care program, covering over three million beneficiaries statewide including children, newborns, pregnant women, and some families and children.
- ▶ STAR+PLUS is also statewide and provides acute, primary, behavioral health, and LTSS to seniors and persons with disabilities; provides medical services to persons with intellectual and developmental disabilities; and covers women in the Medicaid for Breast and Cervical Cancer program.
- ▶ STAR Health coordinates health care of children in foster care and kinship care (and now mentally dependent children) through one statewide MCO providing comprehensive and integrated physical health, LTSS, behavioral health, vision, dental, and pharmacy benefits.
- ▶ STAR Kids covers children with disabilities and provides comprehensive benefits, such as primary and specialty care, hospital care, prescription drugs, preventive care, and personal care services, and private duty nursing services.
- ▶ CHIP provides primary and preventive health care to over 450,000 low-income, uninsured pregnant women and children who are not eligible for Medicaid, including children with special health care needs.

This appendix primarily focuses on the STAR program, contract, and related documents.

### Procurement Approach

MCP contracts in Texas are limited to no more than eight years total, but typically have shorter time frames and give the state flexibility to extend or reprocure during that time frame. Texas has had issues with its Medicaid managed care procurements recently, including errors in math calculations for CHIP awards and a majority of bidders failing to correctly complete mandatory sections related to minority contractors. Consequently, HHSC has had to rescind and reprocure a few different STAR and CHIP managed care procurements.

The state uses a regional procurement approach within a statewide procurement, dividing the state into 13 service areas (SAs) in the January 2018 STAR/CHIP RFP, for example. Bidders must indicate in which SA(s) they propose to bid and must agree to serve all counties in their proposed regions. In January 2019, HHSC released a request for information (RFI), noting that the number of SAs poses an administrative challenge, as HHSC seeks to enhance MCP contract oversight through mechanisms such as routine on-site operational reviews. The RFI proposes reducing the number of SAs from 13 to 7, taking into account geographic distribution of clients and provider networks; utilization patterns, particularly among hospitals; and health outcomes. Through the RFI, HHSC is seeking to gather recommendations on how to (1) create financially viable service areas that would create potential savings to the Medicaid system and ultimately to the state, (2) improve client access to care, (3) reduce administrative burden, and (4) address network adequacy issues.

In the 2018 STAR/CHIP procurement, RFP evaluations included the following four components:

#### 1. Extent to which goods and services meet HHSC's needs and the needs of members

- a. Extent to which the proposal exhibits the respondent's expertise in providing services to comparable populations.
- b. Administrative payment bid and past medical cost performance.
- c. Quality and reliability of goods and services, including the ability to retain and recruit a provider network.

## 2. Indicators of vendor performance

- a. Past performance in the state including ability to integrate physical and behavioral health.
- b. Financial solvency.
- c. Capacity of organizational structure.

## 3. Effect of contracting with respondent on HHSC productivity

- a. Level of agency effort needed to monitor and maintain a good working relationship with respondent.

## 4. Delivery terms

- a. Ability to complete transition phase and implement services by operational start.
- b. Maintain services through contract.
- c. Comply with potential termination of contract.

In relation to 1b. above, this RFP required that MCPs submit an administrative expense PMPM rate for both STAR and CHIP by service area and risk group. HHSC reserved the right to negotiate an alternative rate if the MCP's proposed rate was too high and instructed bidders to include administrative components of any subcontracted services such as pharmacy, behavioral health, and vision. HHSC proposed to set the medical components of the STAR PMPM rates.

### Contract Structure

HHSC's fundamental commitment is to contract for results. Texas defines a successful result as "the generation of defined, measurable, and beneficial outcomes that satisfy the Contract requirements and support HHSC's missions and objectives."

In addition to its contracts, HHSC publishes a *Uniform Managed Care Manual (UMCM)* that details many operational aspects of its managed care program for MCPs.<sup>61</sup> For instance, the UMCM contains a 66-page "Consolidated Deliverables Matrix" that details extensive MCP reporting requirements. HHSC also publishes a manual for providers participating in any of the state's contracted managed care programs.<sup>62</sup>

The state also has a detailed liquidated damages clause in the MCP contract, which includes 21 pages of specific penalties for contract violations. The violations are largely procedural (e.g., late reporting) and operational (e.g., member service commitments). There are also liquidated damages penalties for certain member access requirements (e.g., geographic access and out-of-network care).

### Contract Management and Oversight

HHSC has four teams dedicated to managing and monitoring MCPs. Each team has two tiers — senior contract managers and more entry level. The MCPs are assigned to teams based on risk and size of the plans. Given the differences in the size of some plans, some teams may have all the smaller plans, for example. All managed care contracts with a single corporate entity will be under the same team. HHSC generally rebalances the teams about once per year so that staff get different perspectives and are not so familiar with plans that they lose objectivity. For oversight of state contracts more than \$10 million, Texas requires specific contract management classes to be taken; applicable HHSC staff need to be certified by Office of Comptroller.

HHSC has made an effort to make clear that all functional areas within Medicaid have a MCP monitoring and oversight role. If there is noncompliance in any area (e.g., quality, financial), the involved subject matter experts report the issue and the need for a Corrective Action Plan or more severe contract remedy to the MCP contract managers. HHSC has a standing monthly managed care oversight meeting for each Medicaid product to discuss general plan performance, review dashboards that compare plan performance, and create opportunities for functional areas to report on issues. The Medicaid director and HHSC managed care leadership team attend the oversight meetings.

HHSC has an operational review (OR) process that includes a biennial review of each MCP, involving a "boots on the ground" approach to look at claims processing, hotlines, etc. HHSC is expanding ORs to include other functional areas including finance, quality, and pharmacy.

HHSC uses a financial Performance Indicator Dashboard to monitor MCPs. HHSC gives special scrutiny to MCP administrative costs and arrangements (through RFP responses, reporting requirements, approval of subcontracts, and audits), which the state reports has yielded meaningful savings.

KEY TOPICS	TEXAS MCP CONTRACT
Link to contract	The managed care contracts and manuals are available at: <a href="https://hhs.texas.gov">hhs.texas.gov</a> . The STAR contract can be downloaded at: <a href="https://hhs.texas.gov">hhs.texas.gov</a> (PDF).
Contract term	Effective July 1, 2015 for the STAR contract through at least 2020, may be extended but cannot exceed a total of eight operational years.
Background	MCPs are contracted by region with a standard statewide contract that includes common items across all Medicaid managed care programs.
Number of MCP members and plans	Eighteen MCPs and two dental organizations serve 3.6 million Medicaid managed care enrollees statewide including rural regions.
Member access	Detailed geographic access requirements with liquidated damages. MCP must provide access to at least 90% of members in each service area within prescribed standard. HHSC uses members' residence in eligibility files and MCP provider files to run a quarterly geo-mapping report to measure distance and travel time. MCP may be subject to liquidated damages as specified in Attachment B-3. Access/appointment availability (secret shopper calls done by the EQRO). Limits on out-of-network care with liquidated damages.
Clinical quality	Effective for CY2018: Medical Pay-for-Quality (P4Q) Program: 3% of capitation at risk — not a withhold — the state pays but if the MCP fails to meet benchmarks, the state recoups the funds. MCPs may access unearned funds if another plan forfeits; any remaining dollars are pooled and distributed on different measures. P4Q program and Performance Indicator Dashboard detail can be found in the <i>Uniform Managed Care Manual</i> , chapters 6.2.14 and 10.1.14, available at: <a href="https://hhs.texas.gov">hhs.texas.gov</a> . P4Q had process for developing measure selection: <ul style="list-style-type: none"> <li>▶ Looked at priorities of HHSC, public health, previous measures.</li> <li>▶ Wants impact based on where big populations are (health outcomes that affect large portions of the population).</li> <li>▶ Areas where improvement is needed (may retire a measure where the MCP has hit the HEDIS 75th percentile).</li> <li>▶ Trying to stick with standardized measures. Decreases complexity.</li> <li>▶ Need to include Potentially Preventable Events PPEs (legislatively required).</li> </ul> Does not explicitly take into account rural and urban differences for quality benchmarks and financial incentives. For some initiatives, health plans are evaluated at the service delivery area (e.g., report cards), but the majority are not. Texas Healthcare Learning Collaborative Portal has quality metrics: <a href="http://thlcportal.com">thlcportal.com</a> . Auto-assignment: see 1 Tex. Admin. Code § 353.403(d)(3)(B) for Medicaid. MCPs must reduce or deny payments for provider-preventable conditions that were not present on admission, including any hospital-acquired conditions or health care-acquired conditions.
Member satisfaction	The EQRO conducts surveys to measure experiences and satisfaction of adult members and caregivers of child and adolescent members in Texas Medicaid and CHIP. The surveys conducted rotate annually by program, with specific member groups surveyed every other year. During 2017, the EQRO conducted STAR Child and CHIP caregiver surveys using the CAHPS survey, child dental surveys adapted from the adult CAHPS Dental Plan Survey, and behavioral health surveys using the Experience of Care and Health Outcomes survey. Additional questions were adapted from the Behavioral Risk Factor Surveillance System, the National Health Interview Survey, and the National Survey of America's Families.
Safety net health	Under the Delivery System Reform Incentive Payment (DSRIP) program, hospitals and other providers have established regional health care partnerships, conducted regional needs assessments, and developed and implemented projects addressing local gaps in service. The DSRIP initiative helps safety-net providers prepare for the related MCP value-based payment approaches required by HHSC.

KEY TOPICS	TEXAS MCP CONTRACT
Value-Based Payment	Significant Medicaid HHSC value-based payment focus, including detailed MCP standards and reporting requirements, requirements to increase APM use, and increased use of risk-based APMs with Medicaid providers. MCPs are required to submit annual plans and reports of payment methods that encourage achievement of quality outcomes and reduction of inappropriate utilization of services.
Cost/Utilization	Experience rebate on plans above a certain profit level (per National Association of Medicaid Directors survey); scrutiny of administrative costs has yielded savings.
Administrative Performance	Texas audits plan performance annually. Some legislative requirements for audits. Performance Indicator Dashboard (financial), including “Related party expense” to monitor self-dealing / administrative costs. Liquidated damages: 21-page matrix attaching specific penalties to specific contract violations. The violations are largely administrative, including timely reporting. Many address member service commitments (e.g., BH services hotline).
Other	<i>Uniform Managed Care Manual (UMCM):</i> <ul style="list-style-type: none"> <li>▶ “Consolidated Deliverables Matrix” is 66 pages.</li> </ul> Strong MCO oversight team at the state; mission objectives include: <ul style="list-style-type: none"> <li>▶ Network adequacy and access</li> <li>▶ Quality</li> <li>▶ Timeliness of claims payment</li> <li>▶ Prenatal care timeliness</li> <li>▶ Behavioral health services</li> <li>▶ Care delivery to diverse populations</li> <li>▶ Disease management requirements</li> <li>▶ Service coordination</li> <li>▶ Continuity of care</li> </ul> “Frew Incentives” pursuant to settlement.

## Washington

### Overview

Medicaid managed care has a long history in Washington State beginning in the early 1980s. It began as a voluntary effort with contracts with two MCOs. Based upon the successes of that voluntary effort, mandatory managed care started in Washington in one county and with continued success, expanded statewide. The Washington State Health Care Authority (HCA) now contracts with five MCOs through three Apple Health contracts. Apple Health is a mandatory program, but enrollment is voluntary in several counties either because there is only one MCO or because the contracted MCOs do not have sufficient capacity to serve all enrollees. Approximately 80% of Apple Health enrollees are currently enrolled in managed care.

### Procurement Approach

The lead HCA division for the implementation and oversight of Washington’s Apple Health managed care contracts, the Medicaid Program Operations and Integrity Division, secures managed care contracts through a competitive procurement process conducted periodically. There are a number of areas where Apple Health and the public state employee benefit program (PEB) are aligned, including MCP performance metrics.

### Contract Principles

Value-based purchasing principles are included in Exhibit D of the model contract and include quality improvement withholds and qualifying provider incentives. The state implements a capitation withhold of 1.5%, which can be earned back by meeting various contract requirements. Most (75%) of the withhold is tied to a quality measure

set. The balance of the withhold is tied to value-based purchasing goals, including a percentage of payments made pursuant to non-FFS, value-based contracts, and a percentage of overall payments associated with value-based contracts. Any remaining withheld funds are pooled as part of a Challenge Fund from which additional incentives can be earned.

Auto-assignment to MCPs for members not choosing a plan is based on capacity to accept new members and two clinical and one administrative performance measures — HEDIS measures Childhood Immunizations Combo and Comprehensive Diabetes Care - Retinal Eye Exam, and an Initial Health Screening rate.

### Contract Management and Oversight

In order to implement the contract requirements and manage the oversight of the MCPs, Washington has established an interdisciplinary “TEAMonitor” group. This group has formal responsibility for a variety of periodic and ad hoc oversight activities. Washington uses a variety of tools to promote value-based purchasing and

plan accountability, including (1) a minimum medical loss ratio (MLR) standard and gain share program, (2) a capitation withhold tied to QI scores and certain value-based contracting requirements, and (3) a “challenge pool” that can be earned based on pay-for-reporting (P4R), P4P, and contracting targets.

### Stakeholder Engagement/Quality Strategy

There are two agencies that sponsor and monitor the Washington Medicaid Managed Care Quality Strategy (QS): (1) the Washington State Health Care Authority, Medicaid Program Operations and Integrity Division, Compliance Review and Analytics section (hereafter, MPOI) and (2) the Department of Social and Health Services, Behavioral Health Administration, Division of Behavioral Health and Recovery. In 2017, the HCA formed a committee structure to guide the agency’s CMO in the selection of valid, reliable, evidence-based clinical performance measures. These measures are included in Washington Apple Health and PEB managed care contracts for MCP reporting.

KEY TOPICS	WASHINGTON MCP CONTRACT
Link to contract	<a href="http://www.hca.wa.gov">www.hca.wa.gov</a>
Contract term	Calendar Year 2019
Number of MCO members and plans	Five plans serving 1.5 million members across 11 regions.
NCQA accreditation	MCPs must maintain NCQA accreditation.
Member access	<p>A 24/7 telephone service for enrollees with questions about medical, mental health, and emergency services.</p> <p>MCPs are required to maintain and monitor an appropriate provider network. To fulfill this expectation, MCPs provide documentation of their provider network, including six critical provider types and all contracted specialty providers, quarterly. The report includes information regarding the contractor’s maintenance, monitoring, and analysis of the network. Provider network information is reviewed by state staff for completeness and accuracy. MCPs are required to conduct quarterly quality assurance reviews on 25% of the combined network of primary care, pediatric primary care, and obstetrical providers. MCPs must verify contact information; open/closed panel status, including whether the provider is currently accepting Apple Health clients; and any current or anticipated limitation.</p> <p>Every three years, the EQRO evaluates and reports on the efforts of each prepaid inpatient health plan (PIHP) to ensure and maintain an adequate delivery network. MPOI submits an assurance of compliance to CMS that the MCO or PIHP meets the state’s requirements for availability of services. The submission includes documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO or PIHP related to its provider network.</p>
Clinical quality	<p>Auto-assignment is based on two HEDIS measures and the rate that the MCP conducts an initial health screen.</p> <p>Quality Assessment and Performance Improvement.</p>

## KEY TOPICS

## WASHINGTON MCP CONTRACT

Safety net health	<p>MCPs must pay hospitals subject to the “safety net assessment” no less than FFS rates published by HCA.</p> <p>P4P payments to critical access hospitals upon achievement of certain benchmarks.</p> <p>HCA provides lump sum payments to enhance rates of payment to FQHCs and RHCs.</p>
Addressing disparities	<p>Collaborate with peer MCPs and the Department of Health on the health care disparities work group to reduce disparity in one performance area. Collect and examine data on ethnicity, race, and language.</p>
Population health	<p>Integrated patient record / clinical data repository project.</p> <p>MCP will collaborate with peer MCPs, HCA, and the state health information exchange to establish and maintain an integrated patient record to be housed in a clinical data repository to include physical, dental, and BH data.</p>
Value-based payment	<p>Capitation withhold (1.5%) earned back for quality performance. MCPs can earn back up to 75% of the premium withhold based on their overall QI score. The remaining 25% premium withhold is earned back after MCPs provide evidence of passing qualifying, value-based provider incentive payments to sub-contracted providers. To meet targets, at least 1% of premium payments must be incentives and disincentives in LAN Alternative Payment Model (APM) Framework Category 2C or higher. Provider incentives are defined as additional payments or withholds based on provider performance. Additionally, a MCP needs to pay at least 50% of provider payments in the form of VBP arrangements in LAN Category 2C or higher, which is HCA’s definition of VBP.</p> <p>Challenge Pool Value-Based Purchasing Incentives — provider can earn DSRIP funds and undistributed withhold money by demonstrating APM adoption, timely reporting of data (P4R), and high performance on quality metrics (P4P).</p>
Cost/Utilization	<p>Participate in 14-day readmission program.</p> <p>Participate in provider-preventable conditions payment policies per WAC 182-502-0022.</p> <p>Minimum measure set for over/underutilization including measures on preventable hospitalizations/readmissions, avoidable ED visits, childhood immunization and EPSDT services, BH treatment and penetration, primary care access, prenatal and postpartum care, and comprehensive diabetes treatment.</p>
Administrative performance	<p>Failing to meet general provisions of contract can result in withholds of up to 5% capitation.</p> <p>Sanctions/penalties for significant contract breaches.</p> <p>Gain share program: 85% minimum MLR; some or all gains above 3% are recouped.</p> <p>Expansion population risk corridors based on MLR (additional premiums paid if MLR &gt;91%; recoupment of premium if MLR &lt;85%).</p> <p>Requirement of 85% to 87% MLR, with remittance required (per National Association of Medicaid Directors survey).</p> <p>Plan Report Card at: <a href="http://www.hca.wa.gov">www.hca.wa.gov</a> (PDF).</p> <p>Provider payment reform requires participation in future payment reform efforts without any specifics noted.</p> <p>Auto-assignment is based on two HEDIS measures and the rate that the MCP conducts an initial health screen.</p>
Other (PIPs)	<p>MCP performs three PIPs:</p> <ul style="list-style-type: none"> <li>▶ Clinical PIP that is evidence-/research-based focused on mental health intervention.</li> <li>▶ Clinical PIP in partnership with the Department of Health on well-child visit rates for infants, children, and adolescents.</li> <li>▶ Nonclinical PIP selected by MCP.</li> </ul>



## Endnotes

1. In determining the number of MCPs that DHCS oversees, all contracts with the same parent organization were counted as a single plan, with the exception of Health Net and California Health and Wellnesses, which recently merged. For example, Kaiser Permanente is counted as a single plan, although its Northern California and Southern California regions operate separately. Specialty managed care plans are excluded. See Table 1 (page 11) for the number of MCPs by plan type. Some MCPs operate in multiple regions and some operate in both the GMC and the Two-Plan models. In addition to these Medicaid plans, DHCS has some level of oversight and/or responsibility for a separate dental managed care system, a Drug Medi-Cal Organized Delivery System, and county mental health plans.
2. Such as California's Assembly Bill (AB) 205.
3. HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance.
4. The Massachusetts MCO procurement is available at: "Bid Solicitation: BD-17-1039-EHS01-EHS01-10209," Commonwealth of Massachusetts, last modified September 19, 2017, [www.commbuys.com](http://www.commbuys.com).
5. More detailed information is included in Florida's Medicaid MCO core contract provisions in Attachment II and Exhibit II-A at "2012–2018 SMMC Plans," Florida Agency for Health Care Administration (AHCA), n.d., [www.fdhc.state.fl.us](http://www.fdhc.state.fl.us).
6. More information on how PRIME measures disparities is available in *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*, DHCS, April 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF); and *2015–16 Disparities Focused Study 12-Measure Report*, DHCS, July 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
7. "Calendar of Events," DHCS, last modified March 21, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
8. Many state Medicaid programs use the strategies identified here. However, this report focuses its examples primarily from the six states that were studied for this project.
9. Value-based purchasing is not the same as value-based payment or alternative payment models. More information on value-based purchasing is available in: Mary Beth Dyer and Beth Waldman, "Value-Based Purchasing for Managed Care Procurements: A Toolkit for State Medicaid Agencies," State Health and Value Strategies, October 18, 2017, [www.shvs.org](http://www.shvs.org).
10. Margaret Tatar, Julia Paradise, and Rachel Garfield, "Medi-Cal Managed Care: An Overview and Key Issues," KFF (Kaiser Family Foundation), March 2, 2016, [www.kff.org](http://www.kff.org).
11. See *California DHCS Managed Care Performance Monitoring Dashboard Report*, DHCS, September 26, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF); and *Medi-Cal Managed Care Program Model Fact Sheet*, DHCS, n.d., [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
12. DHCS has published a draft MCP RFA/RFP schedule at [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
13. "Medicaid Managed Care Final Rule," DHCS, last modified March 28, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov); and *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval*, CMS, January 20, 2017, [www.medicaid.gov](http://www.medicaid.gov) (PDF).
14. *2018–2019 Medicaid Managed Care Rate Development Guide: For Rating Periods Starting Between July 1, 2018 and June 30, 2019*, CMS, May 2018, [www.medicaid.gov](http://www.medicaid.gov) (PDF).
15. "State Medicaid Strategies," Center for Medicaid and CHIP Services, n.d., [www.medicaid.gov](http://www.medicaid.gov).
16. Office of the Governor, "In First Act as Governor, Gavin Newsom Takes on Cost of Prescription Drugs & Fights for Health Care for All," press release, January 7, 2019, [www.gov.ca.gov](http://www.gov.ca.gov).
17. "Bid Solicitation," Commonwealth of Massachusetts.
18. *DHCS Strategy for Quality Improvement in Health Care*, DHCS, January 2017, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
19. *Value-Based Purchasing for Managed Care Procurements: A Toolkit for State Medicaid Agencies*, State Health and Value Strategies, n.d., [www.shvs.org](http://www.shvs.org) (PDF).
20. *Uniform Managed Care Manual*, Texas Health and Human Services, n.d., [hhs.texas.gov](http://hhs.texas.gov).
21. Design elements like size and timing may also affect how influential these tools are (for instance, some research suggests that people are more likely to change their behavior based on the fear of a downside financial penalty than they are based on the hope of an upside bonus).
22. *Making Quality Matter in Medi-Cal Managed Care: How Other States Hold Health Plans Financially Accountable for Performance*, California Health Care Foundation, February 27, 2019, [www.chcf.org](http://www.chcf.org).
23. CAPs are further described below in Section VII, "Corrective Action Plans."
24. Kathleen Gifford et al., "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018," KFF, October 2017, [www.kff.org](http://www.kff.org).
25. More information on TennCare's requirements is available within their *Statewide Contract with Amendment 9*, State of Tennessee, January 1, 2019, [www.tn.gov](http://www.tn.gov) (PDF).
26. More information on Texas's approach is available in "Medical Pay-for-Quality Program," Texas Health and Human Services, n.d., [hhs.texas.gov](http://hhs.texas.gov).
27. As defined in 42 CFR § 438.6(a), arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. The targets for a withhold arrangement must be distinct from general operational requirements under the Medicaid managed care contract.

28. For more information on Texas's approach, see *HHSC Uniform Managed Care Manual: Medical Pay-for-Quality (P4Q) Program*, Texas Health and Human Services, n.d., [hhs.texas.gov](https://hhs.texas.gov) (PDF).
29. "Auto Assignment Incentive Program," DHCS, accessed October 1, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov). Note that the Auto Assignment Incentive Program does not apply to COHS or the San Benito models, where there is no choice of plans.
30. "Welcome," Texas Healthcare Learning Collaborative, n.d., [thlcportal.com](http://thlcportal.com).
31. "Health Plan Accreditation (HPA)," NCQA, n.d., [www.ncqa.org](http://www.ncqa.org). NCQA has developed an accreditation model for Medicaid managed care plans that evaluates plan standards and processes for key health plan operations, including quality management and improvement, network management, utilization management, credentialing and recredentialing, and member's rights and responsibilities.
32. 42 CFR 438.332(a); and 42 CFR 438.332(b)(1)–(3).
33. *Medi-Cal Managed Care Quality Strategy Final Report*, DHCS, June 29, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
34. For example, Chad Terhune, "Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit," *Los Angeles Times*, December 19, 2018, [www.latimes.com](http://www.latimes.com).
35. For example, DHCS posted a summary of the 2018 CAPs related to MCP network adequacy: *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report*, DHCS, January 30, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
36. See 42CFR 438.358(c).
37. "Welcome," Texas Healthcare Learning Collaborative.
38. Information on Florida's statewide reprocurement of Medicaid managed care contracts is available at "SMMC Re-Procurement," AHCA, accessed October 1, 2018, [ahca.myflorida.com](http://ahca.myflorida.com).
39. Florida's statewide Medicaid managed care contract: "2012–2018 SMMC Plans," AHCA.
40. *2019 Approved Alternative Access Standards Report*, DHCS, January 30, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
41. 2019 Approved, DHCS.
42. *Health Benefits Program: 2017 Annual Report*, CalPERS, November 1, 2018, [www.calpers.ca.gov](http://www.calpers.ca.gov) (PDF).
43. *Engaging All Affected Stakeholders: Guidance for Investors, Funders, and Organizations*, World Economic Forum, November 2017, [impactmanagementproject.com](http://impactmanagementproject.com) (PDF).
44. More information on how PRIME measures disparities is available in *External Quality*, DHCS; and *2015–16 Disparities*, DHCS.
45. *Dashboard Report*, DHCS; and *Model Fact Sheet*, DHCS.
46. *Quality Strategy Final Report*, DHCS.
47. DHCS.
48. "Medi-Cal Managed Care," DHCS, last modified March 21, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
49. For example, "Coverage Denied," *Los Angeles Times*.
50. Exhibit A, Attachment 17 of the "Two Plan Boilerplate" contract includes a list of reports.
51. "Managed Care Performance Monitoring Dashboard," DHCS, last modified April 2, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
52. "Auto Assignment," DHCS. Note that the Auto Assignment Incentive Program does not apply to COHS or the San Benito models, where there is no choice of plans.
53. PIPs were formerly referred to as quality improvement projects.
54. See *Quality Strategy Final Report*, DHCS.
55. Attachment D2 of the CalPERS contract includes metrics related to pharmacy services for which the plans are also held accountable.
56. Information on Florida's statewide reprocurement of Medicaid managed care contracts (acute, LTC, dental, and specialty plans) is available at "SMMC Re-Procurement," AHCA.
57. "Managed Care Policy and Contract Development," AHCA, n.d., [ahca.myflorida.com](http://ahca.myflorida.com).
58. "2018–2023 Medicaid Managed Care Plan Report Guide," AHCA, n.d., [ahca.myflorida.com](http://ahca.myflorida.com).
59. "Compliance Actions," AHCA, n.d., [ahca.myflorida.com](http://ahca.myflorida.com).
60. Florida Medicaid Managed Care Presentation by Beth Kidder, Deputy Secretary for Medicaid Agency for Health Care Administration House Health and Human Services Committee January 8, 2019; [www.fdhc.state.fl.us](http://www.fdhc.state.fl.us) (PDF).
61. "Managed Care Contracts and Manuals," Texas Health and Human Services, n.d., [hhs.texas.gov](https://hhs.texas.gov).
62. *Texas Medicaid Provider Procedures Manual: Volume 2 — Provider Handbooks*, Texas Medicaid and Healthcare Partnership, April 2019, [www.tmhp.com](http://www.tmhp.com) (PDF).