

Fixed offer or competitive bid?

Choosing the right Medicaid managed care contracting methodology for your state's needs

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Medicaid managed care programs have grown significantly during the past five years, with more than 35 states providing healthcare benefits, partially or fully, in risk-based managed care plans. Using a review of statutory annual statements, the Medicaid revenue to risk-based managed care plans has grown from approximately \$48.1 billion in calendar-year 2009 to \$83.7 billion in calendar-year 2013, which represents an annual increase of nearly 15%.¹

Along with this increase in revenue comes a huge increase in the number of covered lives. Beginning in calendar year 2014, many states enrolled the newly eligible populations under the Patient Protection and Affordable Care Act (ACA) into managed care programs. These individuals—many of whom have had scant or no insurance coverage in the past—must suddenly be integrated into a large and complex healthcare system without breaking that system.

The pressure on state Medicaid agencies to deliver high-quality care at an affordable cost is intense—and they must consider the long-term stability of their Medicaid programs through changes in population, cost trends, and care practices.

How Medicaid contracts are awarded to managed care plans can have a significant impact on how well they support certain strategic outcomes—and can have unintended consequences if agencies do not carefully consider their specific markets and regulatory realities.

Broadly speaking, states tend to choose one of two methods to establish capitation rates: Either the states set the rates and plans accept or reject them, or plans are allowed to bid on the rates in a competitive environment. To choose the right approach, states need to know not only *what* the methods are but *why* they should favor one or the other.

The nuts and bolts

Capitation rates paid to Medicaid managed care programs must be certified as actuarially sound under federal law.² The certification must be performed by a qualified actuary who is a member of the American Academy of Actuaries. The certification states that the rates are appropriate for the populations served and the benefits covered

by the contract. However, the capitation rates are generally not certified to be appropriate for any one individual health plan. Rather, the capitation rates are certified as appropriate and attainable, in aggregate, for the health plans contracting within the state.

In addition to meeting technical qualifications, the contract with the plans may use one of two methods for determining the actual capitation rate paid to plans. The following provides a brief description of the two capitation rate methods utilized in the contracts between state Medicaid agencies and the managed care plans.

- **State-established capitation rate:** Under this contracting method, the state's actuary establishes a single capitation rate or capitation rate range. The state determines the value within the range or the single rate that will be offered to the managed care plans. The managed care plan may accept or reject the offered capitation rate—or, in some cases, may have an opportunity to negotiate the rate.
- **Competitive bid capitation rate:** Under this contracting method, the state's actuary establishes a capitation rate range. The capitation rate range may be shared fully or individually at one end of the range or the other with the managed care plans. The managed care plans will then provide a bid rate. The bid rate will ultimately need to fall within the state's actuary's certified rate range.

Procurement considerations to meet program objectives

Each contracting method sets certain forces in play, which can have different outcomes depending on the initial conditions and the state's goals for the Medicaid managed care program. In light of these factors, some of the major objectives and considerations for a new managed care procurement process as it relates to the capitation

1 Palmer, J.D. & Pettit, C.T. (June 2014). Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2013. Milliman Research Report. Retrieved February 19, 2015, from <http://us.milliman.com/insight/2014/Medicaid-risk-based-managed-care-Analysis-of-financial-results-for-2013/>.
2 See federal regulation 42 CFR 438.6(c).

rate component of the contract are outlined below. When reviewing the procurement considerations, the decision process would vary depending on the Medicaid population and rate setting scenario, as generalized by the following three scenarios.

1. New population with no experience data
2. New population with historical experience (e.g., fee-for-service conversion)
3. Managed care organization (MCO) renewal

Managing the number of plans in the marketplace: The number of eligible health plans currently in the market may determine how the state contracts with the health plans for a capitation rate. If the state would like to reduce the number of plans currently under contract, it can limit the number of slots available for winning bids. This can be more challenging in a fixed offer situation in which there are fewer factors to evaluate when distinguishing between plans.

Managing costs: States can choose to offer to enroll a greater percentage of auto-assigned lives to health plans that have the lowest bid. An auto-assigned life is a Medicaid member that did not choose a health plan at time of enrollment. Because members who are auto-assigned to a health plan often have lower morbidity than members who choose a health plan, this can incentivize health plans to develop lower-cost approaches for these populations while still maintaining the financial health of the plan. In other words, a state may be able to avoid overpaying for populations that inherently cost less to manage. The advantage of auto-assigned lives may be mitigated through the use of risk adjustment.

Other incentives that may be used in a competitive bid scenario which support the objective of managing costs include:

- Lower contracted medical loss ratio for lower bids
- Single MCO award for small rural counties
- Allowing a best-and-final buy-in for an MCO that is not one of the lowest bidding plans

Cost and budget certainty is also a consideration for states as capitation rates have become a larger percentage of Medicaid budgets. Under the state-set capitation rate scenario, the state would have a better understanding of the level of the capitation rate expenditures in a future period. The competitive bid rate scenario provides a greater unknown until the capitation rates are submitted and evaluated through the bid process.

Onboarding new populations: In developing the capitation rates, an actuary generally utilizes historical data to establish baseline utilization, cost per service, and overall per-member-per-month (PMPM) expenditures. If the managed care program is for a new population, the state's actuary may have limited data and information to establish the capitation rates. The limited data creates greater risk and uncertainty for the health plans and the state Medicaid agency. The greater risk and uncertainty should be considered and may not be appropriate for a competitive bid contracting method. If health plans base their assumptions on inappropriate comparable

populations, they are more likely to misjudge the actual risk involved, creating an unsustainable situation.

Minimizing procurement and contract management complexity: Choosing a health plan through the public procurement process can be a costly and time-consuming exercise in itself, especially considering the scope and stakes involved in these programs. In most cases the process needs to be undertaken anew every four to six years.

Procurement complexity is increased with competitive bidding, requiring consideration of the elements to bid (full capitation rates or administrative loads), how to structure the bidding, and the impact of state-specific procurement rules such as disadvantaged business contracting incentives. In balancing cost and quality factors of evaluation, the state will need to determine the number of points that are allocated to the competitively bid capitation rates. Once the contract is awarded, a degree of complexity is also added to the year-over-year rate adjustment process if differential rates among plans are to be maintained.

A request for proposals (RFP) for Medicaid managed care plans requires a significant amount of time to prepare, and it takes significant time and effort for each plan to prepare its response. State administrators must evaluate each proposal to ensure the plans used sound methods to arrive at their bids and are prepared to meet them. Additionally, competitive bids typically result in a market where multiple rates are in play, creating additional burdens on Medicaid Management Information Systems (MMIS) setups. States need to know that their systems can handle the complexity of a multi-rate marketplace to balance out the potential financial benefit.

Protests of contract awards are a fact of life in public procurement, making protest mitigation strategies a necessity—especially in critical and high-cost areas such as Medicaid managed care. Competitive bidding and state-set capitation rate approaches each bring unique considerations in this respect. Competitive bidding adds complexity to the procurement process, thus creating more avenues for protest. On the other hand, state-set capitation rates eliminate the quantitative cost element of scoring and thus increase the likelihood of attempts by protesting parties to question the details underlying the subjective evaluation process.

States should clearly understand what benefits they hope to achieve with the selection of either state set capitation rates or competitive bidding.

Sustainability and quality management: The viability of capitation rates—whether state-set or competitively bid—is an important consideration in planning for long-term program success. Competitively bid capitation rates submitted by an aggressive vendor can run a greater risk of proving unsustainable and requiring state intervention at a later time. Provider contracting and access is another factor to weigh, as low bidders may have less opportunity to pay competitive provider rates and thus may encounter access problems. Further, state budget agencies may look for continued savings in periods following a competitive bid scenario that resulted in aggressively bid rates.

Getting competitive bidding right

In a competitive bid process, states trust plans to perform due diligence and put forth their best efforts to deliver a reasonable capitation rate offer. In turn, states can design the bidding process to minimize unintended consequences and give plans the best chance of success. The following strategies can be employed in this process design.

Market dynamics: If Medicaid coverage is concentrated among a small number of plans, it can be difficult for states to switch members to new plan offerings. Large market players may interpret this as meaning that their chances of winning are higher, leading them to bid less aggressively. States that are willing to balance potential disruption can encourage more aggressive bidding by making all participants reenroll with a winning bidder, raising the stakes for plans. There is still a risk that competitive bidding may result in increased capitation rates, if the state has historically been very aggressive in the rate-setting process.

Publication of rate range: Under 42 CFR 438.6(c), capitation rates must be certified as actuarially sound. The capitation rates that are paid to a managed care health plan must fall within the capitation rate range certified by the state's actuary. In a competitive bid situation, the state will need to determine whether and how the capitation rate range will be published to the health plans. The state can choose to publish both ends of the range, only one end, or no information at all. In the latter case, the state needs to provide sufficient data and information to the bidding health plans to help them develop an appropriate bid rate—without biasing the competitive nature of the process.

Publication of number of slots to be awarded: Signaling to the market how many plans will be awarded contracts can change how plans bid. If there are many slots, plans may be concerned about spreading fixed administrative costs over a smaller number of lives, which can make them less likely to bid aggressively. If they are vying for a small number of slots, they may feel the competition is more intense, and that if they win they will have a large number of lives over which to spread administrative costs. In this case, they might be more inclined to bid lower.

Certification of capitation rate bid by health plan actuary: In a competitive bid scenario, it may be required to have the health plan submit an actuarial certification of the capitation rates that are being submitted in response to the RFP. The rate certification submitted by a health plan does not replace the state's actuary rate certification; rather, the health plan's rate certification indicates that the rate submitted in the competitive bid meets the actuarial soundness criteria for the specific plan. States need to be prepared to evaluate these certifications and have defensible criteria in place for how the certifications are judged.

EXAMPLE CONTRACTING SCENARIOS

Each agency has a unique set of circumstances that can affect whether fixed offer or competitive bid contracting is appropriate: how long they have to sign up new plans, the current makeup of the Medicaid marketplace, and the strength of pressure to reduce costs. These examples demonstrate how various decision factors can influence an agency's choice of contracting method—and how the decision is rarely a simple one.

Scenario 1: Ample time, strong cost pressure

A state is re-procuring an existing managed care contract and is planning well ahead, with more than 12 months until contract expiration. On the previous RFP, the state received proposals from a variety of qualified and interested bidders. Currently there is minimal variance among the contracted plans with respect to member enrollment. The state's budget is extremely tight and there is interest in reducing costs as much as possible.

Given the circumstances outlined above, this state may elect to competitively bid the rates for the new contract. With a competitive market with respect to both bidder interest and current member distribution, as well as time available in its procurement schedule, the stage is well set for competitive rate bidding. This is further supported by the budget considerations and a need to keep rates down.

Scenario 2: Not much time

A state is expanding its managed care contracting to include new populations under a new contract. Its current managed care contracts were not tightly contested in the RFP process, and membership is tilted strongly toward one plan with strong name recognition in the state. The state has fallen somewhat behind its planned procurement schedule, having well less than a year to start the new contracts. The procurement is taking place during the state's budget cycle, and there is a strong desire to narrowly define the budget impact of the new program.

Given these circumstances, this state would most likely elect to set the rates for its new program rather than engaging in competitive bidding. With an unknown amount of competition there is risk that rates will not be minimized, and the tight procurement schedule calls into question whether the extra effort will be fruitful. The desire for budget predictability suggests a preference for knowing the rates early in the process and not waiting until the end of the RFP process to understand the final impact.

Best and final offer: In a competitive bid scenario, a state Medicaid agency may choose to accept a best and final offer from Medicaid health plans. The best and final offer rate may or may not be considered in the establishment of the incentives. For example, the auto-assignment algorithm may be based only on the initial bid submitted by the health plan. This may encourage health plans to provide a near-best rate in the initial submission. A best and final offer may have limited impact depending on the capitation rate range and the initial bid submissions.

FIGURE 1: COMPETITIVE BID VS. FIXED OFFER: ISSUES AT A GLANCE

NEED	FIXED OFFER	COMPETITIVE BID
Control number of contracted plans	Fewer factors to apply when selecting awardees for a contract	Adds a key element of differentiation when choosing among plans
Manage costs	State controls the cost to a specific number or within a narrow range	Can offer incentives for plans to bid lower. Leaves cost decisions up to plans, which means some additional risk to the state
Minimize procurement complexity	Simpler administration and typically faster to complete	Can be more complex and costly and take longer to complete
Onboard new populations	State takes responsibility for establishing appropriate risk thresholds	Plans may have difficulty determining risk because of limited information, and may underbid or overbid, leading to financial instability
Manage quality	No need to connect technical criteria with pricing criteria as pricing is dictated to plans	Technical criteria must be integrated with bidding criteria

Conclusion

As Medicaid coverage continues to grow and change, states must take an active role in shaping the market for the benefit of their constituents. Driving cost down as far as possible is no longer the only or even the primary goal of states. Today, more states are taking an increased interest in sustainability and preventing disruptions in coverage, access, and the market as a whole.

No element of the process can be considered trivial. When choosing how to contract with managed care plans, states have significant control to manage the process. States wanting the simplest procurement method or needing to minimize risks associated with new populations might take a closer look at fixed offer contracting. States comfortable controlling the number of plans under contract, or wanting to reduce the cost of covering auto-assigned lives or increase competition in the marketplace, may want to consider carefully designed competitive bidding processes.

The key point to remember is that Medicaid contracting is not a one-size-fits-all process and can have significant effects beyond simply the price the state pays. Each state needs to examine its specific situation and the outcomes it wants to achieve, and design a contracting process most likely to support those ends.

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