



DEC 7 1995

Dear State Medicaid Director:

As you know, HCFA recently issued a letter concerning our policy on competitive procurement of Medicaid managed care contracts. Since then, we have received many questions concerning the policy. This letter and the attached set of guidelines seek to clarify some of the issues that have been raised.

To assure the propriety of Medicaid managed care contracts, two standards have been developed against which States' managed care contracts will be measured. The effects of applying the two standards may at times overlap, but the policies behind the two standards are distinct. First, States must guarantee beneficiary choice. States can meet this standard by, for example, offering beneficiaries a choice of HMOs, a choice of a primary care case management program and HMO, or a choice between an HMO and a prepaid health plan (PHP). Second, as with all contracts involving federal payments, States must competitively bid managed care contracts, unless they can show that there would be little or no utility in doing so. (45 CFR section 74.43).

Meeting one of these two standards does not affect a State's obligation to meet the other standard, i.e., using a competitive bidding process to award a managed care contract does not by itself permit a State to offer beneficiaries only one, albeit competitively bid, managed care option. Similarly, offering beneficiaries a choice of several managed care plans does not permit a State to award those managed care contracts on a noncompetitive basis.

Because there are two separate standards to be met, there are two separate sets of guidelines by which we evaluate the procurement of managed care contracts, and we have tried to clarify those guidelines in the enclosed attachment. Part A of the guidelines is meant to help evaluate whether a decision to let a contract noncompetitively is appropriate; that is, whether competitive bidding would be of little or no utility. For previously approved contracts that were not competitively bid, we encourage States to use the attached guidelines to develop the justification for renewal of these contracts prior to the end of the contract period. Part B of the guidelines is meant to help evaluate whether sufficient protections are in place to justify limiting beneficiary choice.

These guidelines affect only the procurement of managed care contracts. HCFA's Medicaid Bureau recently issued a separate clarification of our policy relating to competitive procurement of other types of contracts.

We will seek to continue providing information as this issue evolves. If your staff has questions regarding our policies on competitive procurement and State contracts with managed care plans, please contact Rachel Block, Acting Director, Medicaid Managed Care Team, at (410) 786-0704.

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce Merlin Fried". The signature is stylized with a large, looped initial "B" and "M".

Bruce Merlin Fried
Director

cc: Associate Regional Administrators
for Medicaid, HCFA Regional
Offices

Attachment

A FRAMEWORK TO ASSESS PRACTICALITY OF NON-COMPETITIVE PROCUREMENT AND LIMITING BENEFICIARY CHOICE

PART A: COMPETITIVE PROCUREMENT

- What criteria did the State use for determining that a competitive procurement process is impractical?
 - What type of public process did the State use to identify potential bidders?
 - Did the State determine that only one entity would bid? How was that determination made?
 - Did the State determine that only one entity was qualified for the contract? How was that determination made?
 - Did the State conduct a cost-benefit analysis to assess if a competitive procurement process would be practical? What were the results?
- What criteria will the State use in the future to determine the continued use of a contract that was awarded without going through a competitive procurement process?

PART B: LIMITING BENEFICIARY CHOICE

- Describe the Provider Network (Current and Proposed)
 - Are any provider types excluded? Identify the types and reason for exclusion.
 - How many and what types of providers (primary care, specialty and subspecialty) are furnishing care currently?
 - How many and what types of providers will participate under the contract?
 - What is the current ratio of providers to beneficiaries?
 - What will the ratio of providers to beneficiaries be under the contract.
 - How accessible will the contractor be in terms of:
 - travel times and distance
 - obtaining appointments
 - waiting times in provider offices
 - 24-hour, 7 days a week access
 - translation services
 - Other

- **How will beneficiary free choice of providers be maintained?**
 - **How will beneficiary choice and access be maintained if the beneficiary wants to disenroll from the contracted entity?**

- **Describe the Quality Improvement Plan**
 - **What are the quality improvement standards?**
 - **How will the standards be measured?**
 - **What data will be collected and how will it be used for continuous quality improvement?**
 - **What kinds of clinical studies will be done and how will the results be used?**
 - **What quality criteria will the sole source contractor use to determine provider participation?**