CHCS

Center for
Health Care Strategies, Inc.

Informed Purchasing Series

RESOURCE PAPER

Reprocurement: The Role of Competition in Changing Public Managed Behavioral Health Systems

By Richard H. Dougherty, PhD
Dougherty Management Associates, Inc.

Funded by the Center for Health Care Strategies, Inc. under The Robert Wood Johnson Foundation's Medicaid Managed Care Program

May 2003

243

TABLE OF CONTENTS

Abstract

This Resource Paper reviews and provides guidance on the major issues in public behavioral health reprocurement efforts. Reprocurements are now taking place in a nation and an economy that is substantially different from when many of these programs were first implemented. As a result, they deserve careful planning and consideration of many of the alternatives. There are many reasons, beyond the end of a current contract, why states should consider reprocurement. These include changes in the scope of services, changes in program design, contractor performance, and implementation problems, a desire to change financing and risk provisions, and regulatory compliance. Key issues to consider include the role and benefits of competition in the market, staff and politics, and the benefits and costs of incumbency. The Paper closes with 14 specific recommendations for reprocurement efforts to ensure an effective and fair process. State policymakers should carefully consider how their program design and its benefits should change to better meet goals for cost effectiveness and service quality in the management of the behavioral health system.

Executive Summary

Our country is entering the second, and in some cases, third generation of public managed behavioral health care. The political landscape has changed and a consumer backlash against managed care continues. As a result, states seeking to reprocure their managed care programs should consider new program designs and efforts to improve quality as a part of their procurement. New initiatives in commercial health care purchasing also have relevance to the public sector, particularly the focus on the use of incentives and prudent purchasing techniques.

Reprocurement procedures should mirror the procedures used for initial procurements, though they differ in one major respect – there is an incumbent! There is no question that reprocurement is a time consuming and potentially expensive process, but it is one that deserves adequate time and a careful analysis of the options for change. Potential areas for change include: changes in the scope of services or populations; changes in program design; contractor performance improvement; changes in financing or risk; and regulatory compliance. Each of these has implications for the reprocurement process and can result in savings or increased costs and changes in program quality. The important point is that the reprocurement should be an opportunity for public administrators to make important changes to the scope of the program in a fair and open procurement process. While some states may plan significant changes in the program, other states may simply need to comply with purchasing regulations and seek a new price for the services. Either situation requires a high level of competition to achieve the best outcomes.

Incumbency has its costs and benefits for the current contractor. Having a satisfactory relationship with an incumbent may make it difficult to get other proposals in a reprocurement. Yet, competition is essential to get the best price proposals possible. To maximize competition, it is critical to implement a process that is fair and that maintains a separation between operations and the procurement process. In addition, the process should ensure that all factors have been carefully considered. This Resource Paper includes 14 recommendations to be considered as a part of the planning process. These range from a clarification of goals, assessment of the program, and review of the current contract to the use of a Request For Information (RFI) and preparation of a solicitation document that has a clear relationship to the evaluation criteria.

In this economy, effective reprocurements are increasingly important because they can result in significant savings and improvements in performance. During reprocurements, purchasers can easily implement new performance criteria and achieve significant cost savings in their programs. The public managed behavioral health care organizations that survive the next several years will demonstrate an ability to retain their clients, respond to new markets, and be cost effective through successful competition.

Introduction

Public managed behavioral health care has grown dramatically over the last decade. What began experimentally a decade ago with federal Medicaid waivers for behavioral health systems, grew significantly following the Clinton health care reform efforts. However, these efforts have slowed significantly. In the last two or three years the number of new procurements has slowed markedly. There have been no new risk-based contracts for managed care in the last two years; those new procurements that have occurred have been for administrative services only.[1]

States are taking stock of what their needs are and how the political landscape for managed behavioral health care has changed in the new economic climate. Across the country, state budgets are shrinking and the consumer backlash against managed care continues. As the needs of the public market have changed, so too have the major national managed behavioral healthcare organizations (MBHOs). Over the last decade, most have consolidated through mergers and acquisitions. They are finding that their profits are increasingly squeezed in both the public and private markets. Given the changing economic and political landscape, we believe that public purchasers must use the occasion of reprocuring a behavioral managed care program to reconsider their needs and seek the most effective way to meet them, possibly with new strategies, modified scopes of work, and new financing methods.

Health Care Purchasing: The State of the Art

Much has been written on the topic of public sector purchasing for general goods and services. Attention to this area certainly increased in the late 1980s, with the public outcry over the "$400 dollar hammers and $7,000 toilet seats" purchased by the Defense Department. State and local purchasing efforts always have been under careful scrutiny. However, relatively little systematic attention had been paid to public purchasing of health and human services until the advent of managed care. With managed care in both physical health and behavioral health, suddenly states were confronted with extremely large procurements that attracted significant public attention.

Over the last five years, many of the gaps in knowledge and policy on health care purchasing have been addressed with a focus on effective purchasing techniques to maximize value and performance.[2] Many of these examples have focused on employer sponsored and commercial health plans. Over the last several years, the National Health Care Purchasing Institute, funded by The Robert Wood Johnson Foundation, provided guidance to employer based purchasing initiatives. While that program has now ended, it raised many important issues, such as the value and role of incentives, in purchasing high quality services for employer sponsored health plans. For Medicaid managed care agencies, numerous publications and technical assistance are provided by the Center for

1 Administrative service contracts do not involve the assumption of service risk by the contractor

2 For an excellent review of value purchasing in health care for private and public purchasing see: Kindig DA. *Value Purchasers in Health Care: Seven Case Studies*. Milbank Memorial Fund, September 2001.

Health Care Strategies (CHCS).[3] These have addressed most of the dimensions of public purchasing managed care, including financing, special populations, and behavioral health services. A focus of these value-based purchasing efforts has been the alignment of performance and financial incentives in health care contracting to improve health outcomes, quality, and cost effectiveness.[4] A recent Center for Health Care Strategies Resource Paper sums up some of the key elements of the so-called "prudent purchasing" concepts in health care:

> "Prudent purchasing has become the informal gold standard for state Medicaid agencies in their dealing with (health) plans. Becoming a prudent purchaser requires states to incorporate measurable performance standards in contracts with plans, collect data… and take action to penalize or reward plans according to their compliance."[5]

In recent years, a number of state Medicaid agencies and large employers have joined forces to collaborate on the purchasing of health care services. Local business groups for health care have sprung up and collective purchasing efforts increasingly have occurred. These group-purchasing efforts can significantly change the balance of power in health purchasing for small and mid-sized employer groups. Until several years ago, employers and some state agencies felt that they had to accept what the managed care organizations provided with few changes. Now, however, purchasing groups have increased their purchasing power and knowledge by pooling efforts and have begun to set quality standards and require new types of care and reporting.

Some purchasing groups, such as the Buyers Health Care Action Group (BHCAG) also have "pushed the envelope" to experiment with purchasing services directly from providers and provider groups, skipping the health plan or insurance entity.[6] With exemptions from insurance requirements, or with risk being ultimately retained by the public purchaser, this may be an option for behavioral health plans in certain states. Others have used their increased marketing power to create new health care quality and purchasing standards.[7] Both the BHCAG efforts to pilot health purchasing directly from providers and The Leapfrog Group's improvements in purchasing standards have changed the face of employer purchased health care.

---

3 For example, Verdier JM. and Young CG. *Medicaid Managed Care Purchasing: What Works and What Doesn't?* Center for Health Care Strategies, July 2000. Bailit M., et al. *Purchasing in a Turbulent Market: An Assessment of Medicaid Managed Care in the Mid-Atlantic States*. Center for Health Care Strategies, August 1999.

4 Kaye N. and Bailit M., Innovations in Payment Strategies to Improve Plan Performance. *National Academy for State Health Policy*, October 1999.

5 Fosset W., et al. Can Medicaid Managed Care be Managed? Center for Health Care Strategies, July 2002.

6 Lyle A. and Weiner J.P. et al. "Cost and Quality Trends in Direct Contracting Arrangement." *Health Affairs*, January/February 2002. Also Christianson J.B. and Feldman R. "Evolution in the Buyers Health Care Action Group Purchasing Initiative" *Health Affairs*, January/February 2002.

7 For example, The Leapfrog Group, an initiative of the Business Roundtable, has set new purchasing standards for its group of 100 employers. These include: inform and educate employees; use comparative rating; use substantial incentives; focus on discrete forward leaps in patient safety; hold health plans accountable for Leapfrog implementation; and encourage the support of consultants and brokers.

The ability of states to succeed in implementing prudent purchasing methods depends to a great extent on health care market conditions in the state.[8] If there is a relatively high level of competition among health plans for public business, it is reasonable to assume that public purchasers of health or behavioral health plans can exert more pressure on plans for compliance and more stringent contract terms. Similarly, market conditions for managed behavioral health influence the ability of purchasers to negotiate new contract conditions during the term of the contract and directly influence the level of competition by potential contractors.

The market power of Medicaid agencies is mitigated somewhat by generally low rates of reimbursement, but where rates may be low, volume often compensates for this. In mental health and substance abuse treatment, the market dynamics are even more complex, both because of significantly lower funding levels and because public mental health spending is divided between state Medicaid and mental health agencies in most states, reducing the leverage of each. This also complicates services and administration of the program.

Public Sector Purchasing

Public behavioral health procurements of managed care services are among the largest contracts in state and local governments. As a result, they garner considerable attention. As with other contracts, they are generally governed by procurement regulations in each jurisdiction. These procurement rules vary for counties and states, though there are many common themes. Since services are purchased with federal funds, certain federal rules also apply to the procurement.[9] The basic premise of these regulations is that competitive procedures should be used, wherever possible, to purchase goods and services with federal funds. The details are a result of the methods to implement these competitive procedures, the exceptions to the rules and allowable cost standards for the contracts.

These rules on the use of public funds and fair purchasing requirements for public sector procurements are some of the major reasons that public purchasing differs from private health care purchasing. However, public programs are much more complex because there are more program requirements, more need to interact with multiple state and local agencies, and many voices to satisfy – taxpayers, politicians, administrators, providers, the press, and, of course, consumers.

Trends in Public Managed Behavioral Health Care

There now has been almost a decade of experience operating public managed behavioral health care programs, and a number of the early programs still are operating. Some have changed in response to external pressures; others have remained relatively stable.

---

8 For example see Bailit Health Purchasing, LLC, *Recommended Health Care Markets for Provider Incentive Demonstrations*. National Health Care Purchasing Institute, March 2002.
9 48 CFR Chapter 1, et al. Federal Acquisition Circular 2001-08 Final Rule.

Reprocurement has been the mechanism for the implementation of most of these changes.

- The Massachusetts Mental Health and Substance Abuse program had a change of vendor in 1997 and was expanded considerably to include the oversight of non-Medicaid funds for acute services and quality improvement for the Medicaid primary care physician program.
- In early 2001, San Diego Mental Health Services reprocured a significantly reduced scope of services, clarified each party's responsibilities, and modified reimbursement provisions.
- Early on, TennCare Partners had multiple HMOs that each partnered with one of three Behavioral Health Care Organizations (BHOs). The three BHOs all eventually merged into Magellan Behavioral Health, which had two separate legal entities, with slightly different ownership. The state currently is planning the reprocurement.[10]
- Iowa has remained surprisingly stable, with few changes in the design of the program between the first procurement and the procurement completed in 2000, other than the combination of the substance abuse and mental health contracts.
- Nebraska also merged its separate mental health and substance abuse management contracts into one upon reprocurement, but few other functions changed.

During this decade of public managed care, state and county models have developed somewhat differently. Most statewide Medicaid managed behavioral health care programs have involved large contracts with managed behavioral health organizations, rather than the state choosing to manage the waiver program directly. This is changing, however, as more hybrid models emerge, including administrative service contracts with a range of functions. Waiver programs that have been implemented at a county level are mixed in whether they use private MBHOs. Partly this is a result of the economies of scale and the size of the risk. Counties have an advantage over most states in implementing Medicaid managed care because they may integrate the services with their county (non-Medicaid) funding more easily. Larger counties often have hired a private contractor to administer the mental health benefits rather than administer the managed care benefits themselves, though California offers examples of both approaches in San Diego, Los Angeles, and San Francisco. Smaller counties have implemented managed care within their own organizations, modifying their contracts with service providers to allow for utilization management and fee-for-service or case rate payment methods, and developing new information system and reporting functions. Other small counties have pooled their resources into partnerships or collaborations between counties. Examples of this are seen in Pennsylvania, Michigan, and Washington State.

---

10 At the time of this report, it is not clear what direction the state will move. For a full discussion of many aspects of the TennCare Partners program, see Dougherty R. H. and Boughtin A. *TennCare Partners: Behavioral Health Reprocurement Strategies*. Center for Health Care Strategies, April 2002.

Overall, the pendulum toward managing behavioral health care in Medicaid has begun to swing away from full risk or even capitated plans toward a hybrid of public and private sector functions for overall administration of the program. During the currently tight fiscal climate, some public officials have been eyeing their managed care contracts as a source of savings, thinking that they might be able to perform some functions themselves, eliminate profit margins, co-locate staff, reduce the scope of services – all with the intention of further reducing costs. How quickly they may forget the savings they realized on implementing the program. The "business challenge" for public administrators is determining what balance of functions to perform themselves and which to purchase in order to most effectively and efficiently provide those functions. Reprocurement is the natural time to redetermine what makes most sense under current circumstances.

Why Reprocure?

No one really likes thinking about the time and costs involved with a reprocurement. It can take more than a year to complete a large-scale reprocurement, from the first stages of pre-planning, RFP development, proposal development, selection, and contract negotiations. At least three months must be allowed for post selection implementation in the event a new contractor is selected. The reprocurement will involve the efforts of many individuals, including program and/or policy staff, fiscal, executive, and legal staff, and it may involve outside agencies as well. It can be a time consuming and highly politicized process and if people are generally happy with the incumbent, the reprocurement can threaten that stability.

Reprocurement is an opportunity, however, for public administrators to make important changes to the scope of the program in a fair, open, and competitive environment. Some purchasers may be dissatisfied with their contractor's performance and may want to find another contractor. Other times, however, state officials just may want to ensure that they are not paying more than they have to, since the market may have changed or become more competitive, or they may want to make modifications to the program that will require a new procurement. Other purchasers may be happy with their current arrangement but be forced to comply with state or county procurement rules that require periodic reprocurements. In summary, several factors motivate public agencies to conduct a new procurement. These include:

- Desire to change scope of services or populations.
- Changes in program design.
- Contractor performance problems.
- Reduce costs or improve performance through implementing changes in financing or risk sharing.
- Regulatory compliance.

Each of these factors is discussed further below.

Changes in Scope

Administrative Services The need to make significant changes in the scope of services may arise for several reasons. Sometimes, these can be amended into the existing contract. However, reprocurement is an ideal time to revisit these functions and make new decisions. For states or counties that have amended their managed care contracts multiple times, a reprocurement may offer an opportunity to consolidate the changes and save money. Often, some of the goals of restructuring the provider network have been accomplished by the MBHO in the first round of the contract; subsequent contracts are more oriented to maintenance of the program.

> **Case Study: San Diego**
> San Diego implemented such a change in the reprocurement of its adult mental health system. The reprocurement scaled back the functions to be purchased, and relative roles of the county and contractor were specified more clearly. The county also demonstrated cost savings from this reprocurement.

At the most basic level, public officials may reconsider which functions should be purchased from a contractor and which the state or county should perform. Managed behavioral health care generally consists of functions that traditionally are not performed by government. These include: utilization management, call centers for customer service functions, credentialing and network management activities, and implementing new information systems for claims payment, among others. However, after a number of years of overseeing these functions, some public purchasers may understand these functions well enough to consider performing them itself, or alternatively, identify additional functions that the contractor can perform cheaper or better than the state.

Populations Served Another reason for changing the scope of managed care services is the addition or deletion of key services or new populations that modify the cost and organization of the contract sufficiently so that a new procurement is ultimately necessary. Some states, such as Nebraska, may choose to merge certain functions in their reprocurement. States are under increasing pressure to develop rehabilitative services and other community services to avoid litigation and as a part of their *Olmstead* compliance plans[11] and may wish to add these services and their funds to an existing managed care contract. However, finding creative ways to maximize federal revenue for rehabilitative services within a capitated managed care contract is challenging, and states may choose to leave the matching funds for the rehabilitation option outside the

11 In a letter to Governors, dated January 14, 2000, former HHS Secretary Donna Shalala, wrote, "The recent Supreme Court decision in *Olmstead v. L.C.* affirms … that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act (ADA). In the decision, the Court explained that a State may be able to meet its obligation under the ADA by having comprehensive, effectively working plans ensuring that individuals with disabilities receive services in the most integrated setting appropriate to their needs."

capitation. Other additions that have been made to behavioral managed care programs include the addition of children's services or a new group of eligibles (e.g., SCHIP).

> **Case Study: Nebraska**
> Nebraska officials recently modified terms of their two contracts for managed mental health and substance abuse services, providing an opportunity to merge functions, change risk provisions, and seek lower-cost proposals. Magellan Health Services, in fact, bid at a level 22 percent to 31 percent below the other three competitors, including the incumbent. Magellan cited savings from the use of its service center in Iowa as the principal reason for the lower bid.

Changes in Program Design

Carve-in or Carve-out Significant changes in the environment or new political pressures may trigger reconsideration of some aspects of the design of the system.[12] In public plans, this kind of change may occur as a result of changes in leadership or politics, but it also may occur as a result of contractor performance or community opinion. While it is conceptually possible for states and counties to change the basic business model, such as a shift from a carve-in to a carve-out model of care, or a move from statewide to regional plans, these major changes require considerable fiscal and political capital. Other than New Mexico, which changed from a carve-in with mandated use of a specialty carve-out company to a full carve-in, there have been no reprocurements to date that have included these kinds of changes.

Nonetheless, there is a continuing dynamic tension between carve-in and carve-out contracts[13] that will affect reprocurements over the coming years. Mental health consumers, advocates, and some providers have tended to favor carve-out arrangements over the last decade. Others have strongly argued for the benefits of carve-in models of care because of the importance of primary care physicians in the initial treatment of mental health and substance abuse conditions and because of the savings that can be achieved on the physical side of the benefit from the proper treatment of behavioral health conditions. The new regulations enacted by the Centers for Medicare and Medicaid Services (CMS) to implement the provisions of the Balanced Budget Act also reflect a preference for consumer choice of health plans that seem to favor carve-in plans.

Carve-in arrangements generally involve contracts between the state Medicaid agency and two or more HMOs that provide both physical health *and* mental/behavioral health services. In a carve-in, the reimbursement for the behavioral health benefit is usually

12 For a comprehensive discussion, see Dougherty R.H. "The 'Business Models' for the Delivery of Public Managed Behavioral Health Care: An Assessment." 1999 Medicaid Managed Behavioral Care Sourcebook. Faulkner and Gray: 1999.

13 In "carve-out" plans, mental health and/or substance abuse specialty services are separately purchased from other physical health services. A "carve-in" approach includes the behavioral health services as a part of an integrated medical and behavioral health system.

part of the total monthly capitation premium, and in the past there generally have been few, if any, financial reporting requirements for spending on behavioral health. Ironically, the majority of HMOs contracting with Medicaid also have their own separate carve-out sub-contracts. Sometimes, the same behavioral health contractor is serving more than one HMO but with different networks.[14] Carve-ins usually offer enrollees a choice between two or more managed care plans. Under new Balanced Budget Act provisions, when a Medicaid managed care program offers choice and is not serving the disabled or special needs children, no waiver of Medicaid's Freedom of Choice regulations is necessary. Carve-ins also are often structured to best integrate behavioral health services with primary care because primary care physicians are a part of the network of providers. A disadvantage of carve-ins is that officials generally feel they have less ability to monitor the provision of mental health and substance abuse services and to specify conditions for the behavioral health services. Problems with behavioral health services often are more difficult to assess and remedy, not due to any unwillingness by the contractor, but because the benefits are "less visible." They are part of a much larger benefit plan.

Carve-outs involve a separate contract, which focuses exclusively on behavioral health services. Partly because they are separate contracts, carve-outs almost always involve more detailed specification of services, reporting requirements, and special payment provisions. As a result, they are easier to monitor, but there also is reason to believe that the special focus on behavioral health increases the management focus on cost savings[15] and may improve quality. For instance, a new study documents that carve-outs may be more successful than carve-ins at delivering quality mental health care as evidenced by their use of clinical guidelines for depression.[16] States frequently contract with just one MBHO for a carve-out program,[17] and therefore do not provide the choice in plans favored by the Balanced Budget Act. However, even if a choice of MBHOs were to be offered, behavioral health plans are likely to still require waivers because they usually involve children with special needs and individuals on SSI. Many primary care physicians and advocates argue that carve-outs need to ensure that procedures are in place to reimburse PCPs for behavioral health services, since many individuals with depression, anxiety, and other mood disorders initially are identified and often can be most effectively treated in a primary care setting.[18]

---

14 In the ultimate extension of this, the TennCare Partners Program has given consumers a choice of behavioral health plans. Consumers now enroll in one of two BHO plans, but their services are managed by exactly the same entity. The imminent procurement (at the time of this writing) may change this.

15 Sturm R. "Cost and Quality Trends under Managed Care: Is there a Learning Curve in Behavioral Health Carve-Out Plans?" *Journal of Health Economics* 18 (5) (1999).

16 Busch S. "Specialty Health Care, Treatment Patterns, and Quality: The Impact of a Mental Health Carve-Out on Care for Depression." *HSR: Health Services Research*, Dec. 2002.

17 Notable exceptions are Texas and Tennessee. In both cases, mergers and market pressures cause competitors to drop out, resulting in no consumer choice at the plan level, i.e. Magellan operates the only plan in Tennessee and Value-Options is the only choice in the Dallas area. In both states, there continues to be choice of providers.

18 Often the decision to include primary physicians in a carve-out plan is made, consciously or not, during the data analysis for rate setting purposes. HMO and carve-out rates that are established including all primary care services, regardless of diagnosis, in the HMO rate will make the integration of services between behavioral health and primary care more difficult.

When services for people with serious mental illness (SMI) are included in the managed care plan, it requires a focus on the special needs of this group. For this reason, SMI populations are most likely to be blended into carve-out programs, rather than carve-ins, because the contracts can include the greater specificity needed to monitor these services. Contracts involving individuals with serious mental illness usually include more performance criteria addressing the key treatment issues of people with SMI.[19]

Blended Funding Some carve-out contracts focus exclusively on Medicaid-funded services, while others blend non-Medicaid funds for those without insurance or to cover non-Medicaid services. A number of models for "blended funding" contracts have been developed by Montana, Tennessee, and Massachusetts, and by some of the counties in California and Washington. The contracts differ in the ways they blend funds, their methods of reimbursement, and how risk is shared. All have capitated premiums for services, but Montana's included a fixed budget to cover a comprehensive benefit for the uninsured. Massachusetts also had a small fixed budget to cover services for uninsured individuals requiring emergency services and inpatient care.

> **Case Study: Massachusetts**
> In the first reprocurement of the Massachusetts Mental Health and Substance Abuse Program, the Massachusetts Department of Mental Health (DMH) partnered with Massachusetts Medicaid and pooled funding for the purchase of emergency and inpatient services. This functioned to increase the size of the benefits, maximize federal revenue, and provide efficiencies in hospital rates. DMH was able to reinvest millions of dollars in community services as a result of the interagency agreement.

The inclusion of non-Medicaid populations and sources of funding changes the nature of the financing and payments to the MBHO. While the capitation arrangements by which MBHOs are paid are now well understood in the Medicaid system, the use of a block grant or fixed pool of funding for the uninsured may be more complex. Most managed care plans expect to move service providers to fee-for-service, since this allows the funding to more readily follow the client, rather than be restricted to providers. However, in many states, these methods are not well understood by the provider community that traditionally serves the SMI population, because they are accustomed to being paid on a grant or cost reimbursement basis. It is a mistake to underestimate the amount of change that this requires of providers, from developing new record-keeping and billing infrastructure, to recognizing and effectively managing the programs under a system with vastly different incentives. If a reprocurement introduces such changes in payment methods, the purchaser and MBHO should allow at least a 12- to 18-month period following implementation of fee-for-service to ensure that providers remain stable and that they have sufficient training and support to transition to the new payment methods.

---

19 Dougherty Management Associates, Inc. *Medicaid Managed Behavioral Healthcare Benchmarking Project*. Substance Abuse and Mental Health Services Administration, June 2002.

A number of blended funding programs serving people with SMI have been effective and are well regarded by consumers. However, large scale blended projects have not always been very successful. To a significant degree this is a result of underestimating and over promising, something that often occurs in planning for large-scale procurements. [20] This is frequently the result of an overly political planning process, where administrators seek to satisfy competing demands from groups such as providers and taxpayers with sometimes opposing interests.[21]

Contractor Performance and Implementation Problems

Ask people in Montana or Tennessee about the political damage that can be done by a troubled behavioral health program! Opposition can have a significant impact on the design of a program and timing of a reprocurement. Consumer and provider resistance, coupled with implementation and financing problems, have led to delays, early termination or major changes in programs in Montana, New York, Tennessee, New Mexico, Texas, and Arkansas. While the reasons for the problems in each of these programs were different, they highlight the importance of paying attention to politics and effective planning in program design, procurement, and implementation.

- Montana's difficulties were brought on by a contested contract award, industry consolidation, and ongoing provider resistance in a rural market with very low managed care penetration.
- New York had a complex benefit plan design and continuing resistance from hospitals and provider groups, leading to legislative action to terminate the authorization for the Special Needs Plan.
- Tennessee aggressively expanded entitlements and benefits, had challenges to its disenrollment practices and has continued to face a great deal of provider resistance.
- New Mexico's initial model had too many layers of administration with excessively high administrative costs leading to federal pressure to change the program.
- The NorthStar program in Dallas, Texas had one of its two plans drop out because of a perceived enrollment bias and the lack of sufficient risk adjustment in the rates, leading to a lack of choice among plans.
- Arkansas attempted to start a children's mental health initiative that terminated before it began operations.

---

20 Croze C. "Managed Behavioral Healthcare in the Public Sector." *Administration and Policy in Mental Health*, September 2000.

21 For example, the initial contract in San Diego County required the contractor to establish basic managed care functions – utilization review, network management, and outpatient claims among other functions, in addition to developing a plan for and contracting with regional networks of providers with some shared risk. It was too much, too fast. The ASO and regional plan was an attempt to balance the competing demands of consumers for non-risk contracts, with providers' desire for independence and county supervisors' goal to limit their risk. In the reprocurement, the contractor's services were scaled back considerably and the supervisors no longer looked to transfer risk to a contractor.

Privatization, politics, and provider involvement in their communities result in extremely complex and challenging behavioral health procurements. These system change initiatives often are heavily loaded with concerns about government effectiveness, job security of unionized workers, provider survival, the feared loss of services, and social justice issues. Add multi-million dollar contracts and performance problems to this potentially "toxic" mix and you have trouble! Experts in the field agree on the need for the purchaser and contractor to maintain effective working relationships and to manage communications and public relations during times of recurring performance problems. This becomes even more important when reprocurement raises the program's visibility and impending change increases the level of anxiety for all stakeholders.

Financing and Risk

Financial risk arrangements vary widely across different programs. MBHOs are reimbursed for managed care services using global budgets, capitation, case rates, and blended rates. This is an area that has been studied extensively.[22] Each financing method establishes a different set of incentives and degree of risk. The methods most commonly used to finance public managed care have changed from those used by the first implementation efforts. More and more states are assuming a level of the risk themselves, rather than contracting with BHOs on a full-risk basis. For instance: TennCare Partners recently increased the state share of the risk in their contract with Magellan; the Massachusetts program always has been a shared risk and savings type of plan; and New Jersey and Connecticut are both implementing administrative service (non-risk) contracts for their children's mental health system.

> **Case Study: Financing**
> Risk sharing provisions in the first Massachusetts contract limited how much the MBHO profited from the contract (profits and losses shared at different levels until a cap was reached). Most of the shared savings were achieved by the MBHO's success in negotiating favorable inpatient rates through a competitive contracting process conducted during the first six months of the contract.

Reprocurements offer an opportunity to evaluate the type and extent of risk that is used in the program. Generally, consumers and family members express preferences for non-risk arrangements because of a belief that the incentives are more balanced and the costs are less. Economists suggest that in fact there is a "risk-premium" that states pay for capitated full risk contracts. Thus, managed care contractors theoretically add a price or

22 Frank R.G., McGuire T.G. and Newhouse J.P. "Risk Contracts in Managed Mental Health Care" Health Affairs. Fall 1995. Frank R.G. et al. "Some Economics of Mental Health Carve Outs." *Archives of General Psychiatry*, October 1996. Frank R.G., Goldman H.H. and Hogan M, "Medicaid and Mental Health: Be Careful What You Ask For." *Health Affairs*. January/February 2003. Ma C.A. and McGuire T.G. "Costs and Incentives in a Behavioral Health Care-Out." *Health Affairs,* March/April 1998.

margin to their rates that is designed to protect them from variation in costs (risk). That might be fine with state officials if the premium is still less than what they are paying under fee-for-service and managed care can contain future cost growth. It may be somewhat naïve, however, to think that a capitated contract will stop cost increases for more than a year or two. Most states have experienced significant increases in their capitated contracts in the last several years and some recent efforts to control costs have begun to drive providers out of the network. Thus, over time, the elimination of risk from the financing method may help to reduce costs to the state.

Many public administrators, after operating with a risk-based system for a year or more, may increasingly wonder why they did not keep more of the upside risk (the benefits) of the reimbursement. Essentially, familiarity with the risk reduces the perception of risk. As a result, these administrators often ask how they could benefit if they retained some of the risk. In some circumstances, this can be negotiated into the terms of the contract. In others it may be more difficult. Many administrators also may find that they have waited too long and the likelihood of additional savings may be substantially lower.

Changes in the marketplace, economies of scale, and practices in other areas also may give purchasers a reason to put a contract back out to competitive bid. Nebraska, as noted earlier, saved more than 22 percent below the next closest bid. By considering cost to be 40 percent of the evaluation points, Nebraska officials were clear on their priorities!

Regulatory Compliance

Many states or counties require contracts to be reprocured after a certain period of time or at the end of the contract period. Federal rules also drive reprocurement policies. Sometimes state policies specify limits on contract terms, after which there must be a formal reprocurement; other times it is routinely performed at the end of the initial contract and option periods. As a general rule of thumb, competitive reprocurement is good public policy and the Federal Acquisition Regulations lay out a complex but generally fair set of procedures for procurement. It can be problematic at a state level, however, when administrators do not allow exceptions. Given the expense of reprocurements for both the contractors and purchasers, it may be desirable to justify not using competitive procedures in many situations where the contract is running smoothly, costs are not increasing, and the relationships between purchaser, contractor, providers, and consumers are all in "balance." For example, partnering with suppliers to improve quality and reduce costs has been extremely successful in many manufacturing operations that had previously used competitive bidding.

Federal Requirements
Federal Acquisition Regulations require the use of competitive procedures as a part of procurements and reprocurements (FAR 6.101) and these are often enforced as a part of the waiver review by CMS and its approval of contracts.

In the early days of managed care, contracts were often for two years plus extensions. Recent contracts have extended that period significantly such that some contracts are now five years with five-year options (e.g., Massachusetts). The contract can be written with language for option years that permits the purchaser to use the options to extend, but also have options to exit when it is in the purchaser's interest. At a minimum, having longer-term contracts has the following advantages:

- Permits a greater level of capital investment and a longer period of time to recover the investment.
- Encourages longer term focus on quality improvement.
- Maintains stability in the provider system and continuity for providers and
- Minimizes the additional costs of re-bidding and transition between contractors.

It can be a significant disadvantage to have a long-term contract when the relationship between the purchaser and the contractor is unknown and the program is new. Where feasible within current regulations, purchasers should consider the use of initial contract terms of two years with three one-year options, or three years with a two-year option. Experienced purchasers may want to have a four- to five-year contract for their managed care program, knowing that they have sufficient performance measures so that they could terminate for cause if the situation warranted. The longer term of the contract will increase the interest of contractors in bidding and will help keep annual costs down. Obviously, provisions need to be made to ensure that the quality of services is maintained and that contracts can be terminated for cause or subject to appropriation.

Performance Measures

Over the last decade, there have been numerous efforts to develop performance measures in publicly funded behavioral health services. It has long been recognized that the field needs to adopt consistent measurement methods. Early efforts by the Mental Health Statistics Improvement Program led to the development in 1996 of a survey instrument for consumer satisfaction and feedback. The Center for Substance Abuse Treatment has long required the use by states of standardized data collection on treatment admissions and episodes, known as the Treatment Episode Data Set. This data set recently has been expanded with discharge data. Other efforts were developed by the Joint Commission on Accreditation of Healthcare Organizations,[23] the National Committee on Quality Assurance,[24] the American Managed Behavioral Healthcare Association,[25] and the National Association of Mental Health Program Directors.[26]

---

23 Joint Commission on Accreditation of Healthcare Organizations. Oryx: The Next Evolution in Accreditation." 2000.
24 National Committee for Quality Assurance. "Health Plan Data and Information Set (HEDIS 2000)." 1999.
25 American Managed Behavioral Healthcare Association, "Performance Measures for Managed Behavioral Healthcare Programs (PERMS 2.0)." 1998.
26 National Association of State Mental Health Program Directors. "Report of the Technical Workgroup of the NASMHPD's President's Task Force on Performance Indicators." 1997. (www.nasmhpd.org.nri)

In 1997, the American College of Mental Health Administration developed a consensus model for outcome measures across many of the key accrediting and behavioral health purchasing and treatment organizations. The final report was released in 2001.[27] In 2001, SAMHSA convened a group of 75 leaders from the mental health and substance abuse field at the Carter Center in Atlanta to further pursue the development of a core set of measures. A framework and a foundation were developed at this meeting for the further work of four different groups: the Adult Mental Health Workgroup, the Washington Circle Group, the Adolescent Substance Abuse Workgroup, and the Children's Outcomes Roundtable. Each of these groups is coordinated by the Forum on Performance Measures and each is currently developing recommendations for further review.

As all these efforts developed, several issues became clear as noted in a recent article by Richard Hermann: "First, there are fundamental tensions between maximizing the quality of measures and broadly representing diverse features of the mental health system. Second, competing priorities among stakeholders become manifest in the process of selecting what to measure."[28] Hermann describes a model for selecting process-based measures that is based on meaningfulness, feasibility, and actionability. To facilitate the process of reviewing all of the different measures proposed by the various groups, DMA reviewed proposed and current performance measures for behavioral health care.[29] The information assisted the various committees of the Forum on Performance Measures in their development of proposed consensus measures. Despite all the previous work, it is fair to say that new measures are still being developed by these committees, often refining previous proposals. Meanwhile, largely because of inadequate reporting and information systems, many behavioral health systems still have difficulty reporting on unduplicated recipients, lengths of stay, numbers of units of service, expenditure, and other measures.[30]

While all this work has helped develop a consensus group of measures, managed care and other behavioral health contracts have been slow to adopt core measures, or in some case, any formal measures. A study of Medicaid managed care contracting in 1998 notes:

> "Throughout our research, we have consistently observed an absence of clear and articulated measures for reviewing the extent to which contractors are in compliance with performance specifications, as well as a failure to specify the

27 American College of Mental Health Administration. "A Proposed Consensus Set of Indicators for Behavioral Health." 2001.
28 Hermann R.C. "Common Ground: A Framework for Selecting Core Quality Measures for Mental Health and Substance Abuse Care." *Psychiatric Services*, March 2002.
29 Dougherty R.H. "A Review of Proposed and Current Performance Measures for Behavioral Health Care." Unpublished analysis for the Children's Outcome's Roundtable, September 2001 (available at http://www.doughertymanagement.com/reports.htm).
30 "Children's Mental Health Benchmarking Project: Third Year Report." Dougherty Management Associates, Inc., May 2003. (Available at http://www.doughertymanagement.com/reports.htm).

data that contractors will be expected to submit to demonstrate their compliance."[31]

A subsequent review noted some progress in several contracts at specifying standards for performance in the contracts.[32] Most contracts, however, required the development of quality improvement and specification of performance measures as a part of the contract, but left the specification of measures to the contractor. The result has been additional confusion in the field and continued difficulty in comparing contractor performance.

Based on all this work, several conclusions about the use of performance measures can be developed for reprocurement efforts:

1. Wherever possible, a core set of performance measures should be specified as reporting requirements in the contract. These reports should be summarized in a trend analysis for ease of analysis by administrators.
2. The performance of the contractor on these core measures and the trend reports should be made available to key stakeholders early in the cycle of administering the contract. Concerns about negative reactions from stakeholders to the data will diminish quickly as constituents become familiarized with the data and key stakeholders will ally themselves with purchasers to ensure change.
3. Purchasers should consider the adoption of several key measures and deliverables in the contract for financial incentives. These should be chosen carefully because if the incentives are meaningful, the area will be a major focus of activity for the contractor.
4. Only a small number of key performance measures and incentive payments should be developed because the cost of monitoring services and administering the incentive payments can become burdensome and the impact of each measure is diminished as the numbers increase.
5. All measures should be developed keeping in mind the perspective and experience of the consumer.

Competition in Today's Managed Care Market

Gone are the days in the early 1990s when significant profits could be made in managed behavioral health care just from changing networks and managing care through gatekeeping. However, consumers and providers perceived that the methods used, such as service denials and limitations of the provider network, were overly restrictive. If there were profits in the first public contract, things will have changed with the reprocurement. Usually the initial savings have been pulled out of the benefit. Few

31 Rosenbaum S. et al. "Special Report: Mental Illness and Addiction Disorder Treatment and Prevention." *Negotiating the New Health System: A Nationwide Study of Managed Care Contracts – Second Edition*. Center for Health Policy Research, George Washington University, 1998.
32 Rosenbaum S., Teitelbaum J. and Mauery D.R. "Special Report: Mental Illness and Addiction Disorder Treatment and Prevention." *Negotiating the New Health System: A Nationwide Study of Managed Care Contracts – Third Edition*. Center for Health Policy Research, George Washington University, 2000.

mental health authorities or Medicaid agencies have been able to retain their initial savings to reinvest or save for "a rainy day."

MBHOs and their executives clearly have good motivations. They generally entered the field because they genuinely want to help improve health outcomes and contribute to society, but their businesses also are motivated by profits and valuations. Sometimes, they have to pay more attention to that than to the public service goals that originally motivated them. The current business environment makes it difficult to achieve the kinds of returns to which MBHOs and their investors have become accustomed. The easy savings from provider discounts and gatekeeping are generally gone, and now the opportunities for savings come from the more difficult tasks of improved service quality, care coordination, and reductions in unnecessary practice variation. There are three freestanding MBHOs among the four that have carve-out contracts.[33] One has had its stock price fall from $14 in July 2002 to under $1.50 in less than one year; another has been actively trying to sell portions, if not all, of the business; and the last is actively seeking an IPO. They clearly want to improve their bottom line and they have to consider the financial impact of all of their decisions. The days are gone when increases in gross revenue, but not profits, will improve stock valuations. As a result, these organizations are pressured into seeking returns of approximately 10 percent to 15 percent from their overall business. Current public sector contracts may not look very appealing to many of the MBHOs because of their limited return on investment (ROI), as a result of lower fees for a sicker population and limits on profit margins in many contracts. However, the whole field is suffering for lack of profits because the industry has matured, there is increased competition, and commercial rates are now quite low.

The impact on reprocurements should be clear. The only reprocurements that will be competitive are for programs where a solid return on investment is possible. This is likely to be in programs with high utilization rates, the largest programs (economies of scale), and those that have not had strong managed care programs in the past. It would not be surprising to see some MBHOs pulling out of public business if they cannot expect to get their needed ROI. Thus, purchasers should make sure that changes that they introduce in the program are not so costly as to reduce the attractiveness to potential bidders in this market.[34] Furthermore, purchasers should identify every way possible to increase competition – share information and data, provide ample time for proposal preparation, etc.[35] Most importantly, public purchasers should consider ways to improve cost effectiveness through economies of scale and the reduction of unnecessary tasks and deliverables.

33 Magellan Behavioral Health, Value Options, and APS Health Care are the freestanding BHOs. United Behavioral Health is a subsidiary of United Health.
34 Fosset, et al., op.cit.
35 Ensuring competition in public purchasing is so important that the Federal Acquisition Regulations have an entire section devoted to the function of Competition Advocates whose job is to promote competition.

Staff and Politics

Implementing public sector managed care, and particularly managed behavioral health care, is a complex and challenging effort, requiring specialized skills and leadership from both MBHO and public sector staff. Implementations in public systems require careful attention to organizational issues as well as attention to the functional requirements of the program. The necessary functions to effectively manage care include access related services, medical and clinical standard setting, professional credentialing, utilization management and information systems, claims payment, and reporting. These tasks require a unique blend of skills in the staff that are hired, including clinical skills, information technology, and general management. More importantly, the unique characteristics of the public sector require people who are first of all knowledgeable about the regulations and financing of health care delivery systems, but who also are effective leaders and collaborators, who reflect the values and the philosophies of the public sector, and understand the special needs of the poor and seriously mental ill populations they serve.

Case Study – Massachusetts
In the most recent reprocurement of the MBHO in Massachusetts, the Division of Medical Assistance (DMA) and the General Counsel's office assigned staff to the procurement team. The legal staff was responsible for ensuring that the process met state and federal regulatory requirements and for writing the proposal. In fact, because of the extensive writing requirements in this and other proposals, DMA hired technical writers to put the program and technical requirements into an RFP and related documents. As a result, DMA has not had to retain consultants for these tasks.

In effective public managed care programs, the relationships between public purchaser and private managed care organization are based on trust and collaboration. Obviously it is important to have satisfied consumers and providers in the network. Ultimately, however, it is the quality of the relationship between the purchaser and managed care organization that will determine why the government managers will want to reprocure services.

As with most public benefit programs, there is likely to be a political dimension in any reprocurement effort. Unfortunately, politically driven decisions sometimes result in bad program design or programs unresponsive to the needs of the community. Bad design decisions over the last decade include: carve-ins that cut behavioral health service and funding levels and do not monitor their impact; competitive bidding of contracts in systems with already low levels of funding; and terminating initiatives with high per capita costs because of provider resistance.

Conservatives are likely to favor privatization and liberals to favor increased benefit levels and new populations to be covered. Both parties can likely agree that the

government should be an effective health care purchaser with effective procurement processes, contracts, and oversight.

The Benefits and Costs of Incumbency

Incumbency can be a double-edged sword. In a contract where the relationships are good between all stakeholders, it is a clear benefit to the incumbent that the purchaser knows the organization and its key officials. Incumbents know the program intimately, and they generally are in a position to have many political ties within the state. These ties may be with consumers, providers – particularly those who have benefited from the changes that the program has made – and with elected and appointed officials. These relationships may not directly influence the decision of the procuring officials, but they function indirectly to make it harder to award the contract to another bidder. In this situation, new bidders are not likely to appear unless they have information that suggests that the incumbent is "vulnerable" on cost or some other areas of performance or where competitors are able to offer unique services or program designs.

Being "known" also can be a disadvantage for incumbents in contracts where the performance is deemed to be poor or even neutral. Outside bidders may be able to portray themselves, accurately or not, as being able to perform better. Competitors may seek to assemble a unique team of individuals to differentiate themselves. They will generally use lobbyists and consultants to build a political case for the reprocurement and will seek to identify any weaknesses of the incumbent and build their strategy on those. Incumbents also may need to cut costs as bureaucracy and staffing layers build up in the organization, particularly if amendments have added services and functions to the program since the first award.

However, the costs of start-up are high for a new bidder, and may increase their proposed cost above the level of the incumbent, who is likely to be in a position to take greater discounts because they have already recovered many of their start-up costs. Furthermore, a new bidder will need time to commence operations and frequently, public reprocurement schedules do not allow sufficient time. Finally, public (and private) managers often are quite risk averse, which will make them tend to desire to avoid the extra time, expense, and friction of changing contractors.

Finally, the presence of an incumbent in a competitive reprocurement makes it particularly important for the purchaser to manage the procurement in a fair and balanced way that maintains a clear separation between operations and procurement decisions. Purchaser staff need to create a "Chinese Wall" between the operational staff of the purchaser and reprocurement staff. Stakeholders involved in planning the reprocurement should not include incumbents, and they should be informed of and required to complete non-disclosure agreements. Purchaser staff also should announce key decisions as publicly as possible and ensure that competitors have equal access to data and staff for background information and an understanding of the program design.

The "Chinese Wall" between purchaser and contractor becomes even more important in some county operated programs where the county may both function as purchaser and provider. San Diego County staff started planning for a county bid on the managed care contract, initially requiring very clear separation between county purchasing staff and operational staff who intended to bid. They cancelled that plan in the middle of the procurement planning process. Other states, such as Pennsylvania, have implemented a somewhat different process that avoids some of the problems of the Chinese Wall for counties involving a "right of first refusal." Essentially this requires county submission of a business plan (proposal) for the program that might involve them issuing their own RFP for administrative services. In the case of Philadelphia County, the county established its own public authority to operate the program with public employees, but outside some of the existing personnel regulations and other county requirements. This gave them greater flexibility with program administration and management.

Reprocurement Planning Process

All of the issues discussed above should be carefully considered as a part of all the planning steps for any reprocurement. This is a critical time to make important improvements and changes to the program. The following procedural steps should help guide the reprocurement process:

1. Clarify the immediate and long-term goals of the reprocurement within the administration and with key stakeholders and funders.
2. Assess the program as objectively as possible. Many states find that it is useful to bring in outside consulting assistance or to facilitate planning sessions of existing stakeholders to review the program. The review should cover virtually all the areas of program operation from access points and utilization management through to claims and information systems. Seek initial input from stakeholders on program design and contract terms through interviews and focus groups. In the future, new methods to provide structured feedback using the internet may provide more effective ways to get public input in such a process.
3. Select a group of staff from within and, if necessary, outside the agency to plan the procurement. These staff must have the necessary combination of programmatic, regulatory, managerial, and fiscal expertise to plan the procurement and produce the procurement document. This staff must be formally insulated from ongoing operations with the current contractor and the agency staff that oversee them.
4. Review the current contract in detail to 1) identify areas where the program may be out of compliance with the terms of the contract and 2) to compare contract

language and performance requirements to other state contracts and to national data on performance.[36]

5. Benchmark the program, where possible, to other plans or other trends in the field. Data on program performance should be reviewed in detail to identify problem areas, to understand the reasons for any problems, and to understand areas where the program is functioning well. Conduct any needed special studies of the data and other operational issues, if time is available. Provide data and other background information to all potential bidders.
6. Develop preliminary options for new program features and review with the stakeholders. This will allow for a more detailed review and it will ensure that public officials know about the barriers and obstacles for the different options.
7. Consider issuing a Request for Information for formal feedback from stakeholders and potential contractors. This process requires time, but is relatively easy to implement and can encourage formal feedback from consumer and family groups, providers, advocates, and other beneficiaries of the service to ensure that the design of the program and its quality standards are responsive to the needs of citizens. Equally important, the RFI allows for input from other contractors on program design issues. It can provide information to the design team in a fair and unbiased way about contractors' capabilities, advances in computer systems, and new models of administration and program management. Finally, the RFI process ensures that all contractors are given notice of the reprocurement and have opportunities to evaluate their chances for success in a more comprehensive way than would otherwise be possible. Options for the RFI include written responses to a set of specific questions and/or a more open request for information. Responses can be requested in writing or verbally, or both. Oral response can be limited to a certain amount of time per respondent, and grouped according to the type of person responding – consumers and families, providers, advocates, and potential contractors.
8. Incorporate the feedback received from the RFI or other sources into the final procurement document. It is important to provide feedback to people that you have heard them and considered what they have to say. This can be done by summarizing the comments received and identifying the key issues and comments in later communications about the RFP.
9. Prepare the solicitation document. Many states have different standards for the solicitation document. In Florida, for instance, a Request for Proposals requires a detailed specification of the product or service being purchased and proposals that are received are not negotiated. An Invitation to Negotiate (ITN) provides more general specification and solicits proposals that outline approaches from various bidders. These proposals are evaluated to select the most qualified proposer based upon the quality of the ideas, the corporate experience, and

36 Rosenbaum S., Teitelbaum J. and Mauery R. "Special Report: Mental Illness and Addiction Disorder and Medicaid Managed Care." *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts – Third Edition*. Center for Health Policy Research George Washington University, 2000.

proposed approach to the project; then state or local officials will enter into negotiations with the successful proposer. If the negotiation cannot be successfully concluded, the purchaser may begin negotiations with the next most qualified contractor. This process requires a greater level of negotiating skill but less detail in the specification process. States or local governments who are not completely clear whether they can afford certain options they would like to have in the program, or those who are seeking more creative approaches to the program, may want to consider some variation on this type of ITN process if their procurement regulations allow it. Other states have other procedures. For example, recent federal procurements for the Environmental Protection Agency and other agencies have shifted to qualifications statements, cost proposals, and oral presentations. In these proposals, there may not be any written programmatic proposal.

10. Decide on the scope and type of proposal required to fairly evaluate the proposers. Proposals from potential contractors should clearly spell out their approach to the project and the costs of their approach. Page limits are generally a good idea, both for proposers and more importantly for the reviewers. Require that proposals be structured according to the evaluation criteria and to the questions or areas that are being requested. List questions and required responses by areas, such as Capabilities, Program Design, Staffing, and Reporting. Cost proposals should be separately bound and evaluated by a separate group of appropriately qualified reviewers.
11. Ensure that evaluation tools have a direct relationship to the questions and material requested from the bidders. Reviewers should know exactly where to look in the proposal for responses that relate to the evaluation criteria. Generally, it is a good idea to construct a scale or matrix that references evaluation criteria to relevant sections of the proposal.
12. Select a group of internal proposal reviewers as well as some external stakeholders. They should collectively have the necessary expertise and familiarity with the population to be served to enable them to fairly evaluate all aspects of the proposals. They should be screened for conflicts of interest and sign a form to certify that they do not have conflicts. They should be formally informed of the confidentiality requirements governing their review work and trained in the expected use of the evaluation tool.
13. Reviewers should rate the sections that they are assigned and come together for a discussion facilitated by a neutral party. The purpose of the discussion should be to ensure full consideration of all aspects of the proposals and identify and explore the reasons for significant discrepancies in ratings between reviewers. This group should develop a final set of recommendations for approval by leadership.
14. Based on the award recommendations, enter into contract negotiations with the top bidder and seek to clarify and resolve any outstanding issues. Inform other bidders once all the contract terms have been negotiated.

Conclusion

There are many debates about the best designs for behavioral health programs as a part of Medicaid waivers. As programs have begun over the last decade, there have been many, often unique models used: These various models reflect differences in state and county politics and financing and service structures. During reprocurements, despite pressures on many of them for change, most of the initial designs have remained substantially the same, with modifications perhaps in the scope of work or the financing of the program.

Reprocurements have generally functioned to restrain costs for the purchaser. Often, this has been at the margins, but other times, as in Nebraska, the cost savings have been substantial. Competition is an enormously powerful incentive for managed care administrators to ensure that they are delivering the best value for the price in their programs. This is one of the most important functions for reprocurements.

The use of competition also has a significant role in maintaining performance of the contractor. There is little question that in the period prior to and during a reprocurement, the incumbent is extremely careful to ensure that they have met their contractual obligations and that they seek to exceed customer expectations. This may not always be evident to people outside the administration; however, it is a powerful motivator. This includes quantitative performance measures as well as qualitative measures, e.g., willingness to collaborate on special projects or willingness to negotiate new tasks or work products. Effective contract management is of course essential to maintain these performance levels beyond the reprocurement period.

As our economy has weakened and tax revenues have significantly declined, pressure is being put on every budget line item at the state and local levels. Most states that have expanded Medicaid eligibility during the last several years now are faced with difficult decisions to cut back on these new enrollments. Many have cut back on benefits, and some states, such as Oregon, even have taken steps to eliminate the mental health benefit completely for certain populations. In the wake of these levels of cutbacks, states will be seeking ways to ensure that they have the most efficient and effective programs possible. This surely will include steps to negotiate budgetary changes in their contracts, including cuts in administrative costs and benefit changes. It also will lead to more pressure on administrators to reprocure contracts and redesign programs where negotiations fail or costs are otherwise deemed excessively high.

The managed behavioral health care industry has undergone enormous change over the last decade, particularly in the public sector. MBHOs have seen the public sector market emerge in the early 1990s, consolidate through mergers and acquisitions, stabilize, and now begin to retrench. New models of care are being developed, including consumer directed care (where consumers are given a much more active role in service planning and purchasing) and new approaches for primary care integration. The MBHOs that survive the next several years will demonstrate an ability to retain their existing clients,

work closely with consumers and families, creatively respond to new markets, and administer their programs on declining benefit levels. To be cost effective, these programs will need to be more creative in how they coordinate care, purchase high quality services from providers, and find new ways to shift some levels of care from institutional settings to the community. This will require close collaboration between purchasers and contractors and between MCOs and providers. It also will require purchasing agreements with clear measures, quality improvement processes, and effective oversight.