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Medicaid Managed Care Oversight Toolkit

Prepared by Bailit Health

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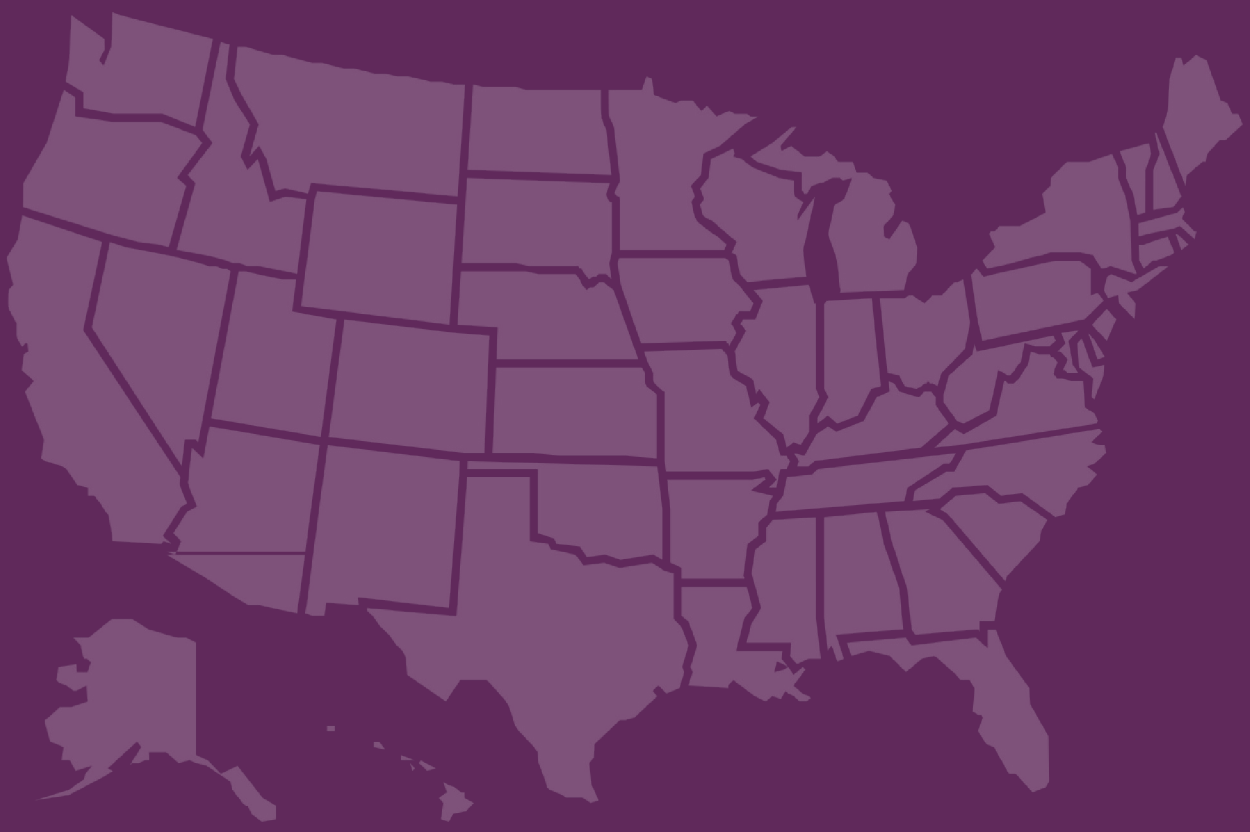

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Introduction

Today, three out of four Medicaid enrollees nationwide receive most or all covered services from comprehensive managed care plans.[1] Compared to fee-for-service (FFS), managed care provides an opportunity for states and enrollees to benefit from improved care management and greater accountability for enrollee outcomes. Managed Care Entities (MCEs)[2] are predominantly Managed Care Organizations (MCOs) covering a comprehensive set of Medicaid services but can also include plans offering a limited set of benefits, such as behavioral health services, dental services, or non-emergency transportation services.

Medicaid managed care contracts are among the largest state contracts from a financial perspective. In addition, MCE contracts are complex and lengthy, requiring state Medicaid agencies to have expertise, processes, and data to interpret, implement, and assess plan performance to ensure enrollee access to necessary covered services. A Medicaid MCE contract is different from many other types of state agency contracts. States are not just managing compliance with contract requirements. Once a state executes a new contract with MCEs, the state role shifts from payer of healthcare services to purchaser of services for enrollees.

This toolkit is designed to assist state Medicaid agencies in maximizing the value states obtain from contracted MCEs on behalf of enrollees and taxpayers. The toolkit consists of seven sections for state staff involved in overseeing MCE contracts related to:

- Improving accountability in Medicaid managed care programs,
- Using the managed care contract as a roadmap for the state and MCEs,
- Setting state expectations and monitoring MCE performance,
- Requiring and using MCE reporting for performance oversight,
- Elevating the state's MCE management approach,
- Prioritizing stakeholder input, particularly from enrollees, and
- Creating and using a menu of MCE performance incentives.

This toolkit takes a broad approach to contract management and suggests ways state agencies can develop and employ effective vendor management approaches to better achieve their vision and goals for Medicaid managed care programs to improve enrollee care and outcomes. Increasing managed care accountability and value requires Medicaid agencies to balance effective MCE oversight with active state and MCE participation in a demanding two-way partnership.

Improving Accountability in Medicaid Managed Care

States contract with Medicaid managed care plans for several reasons, including to:

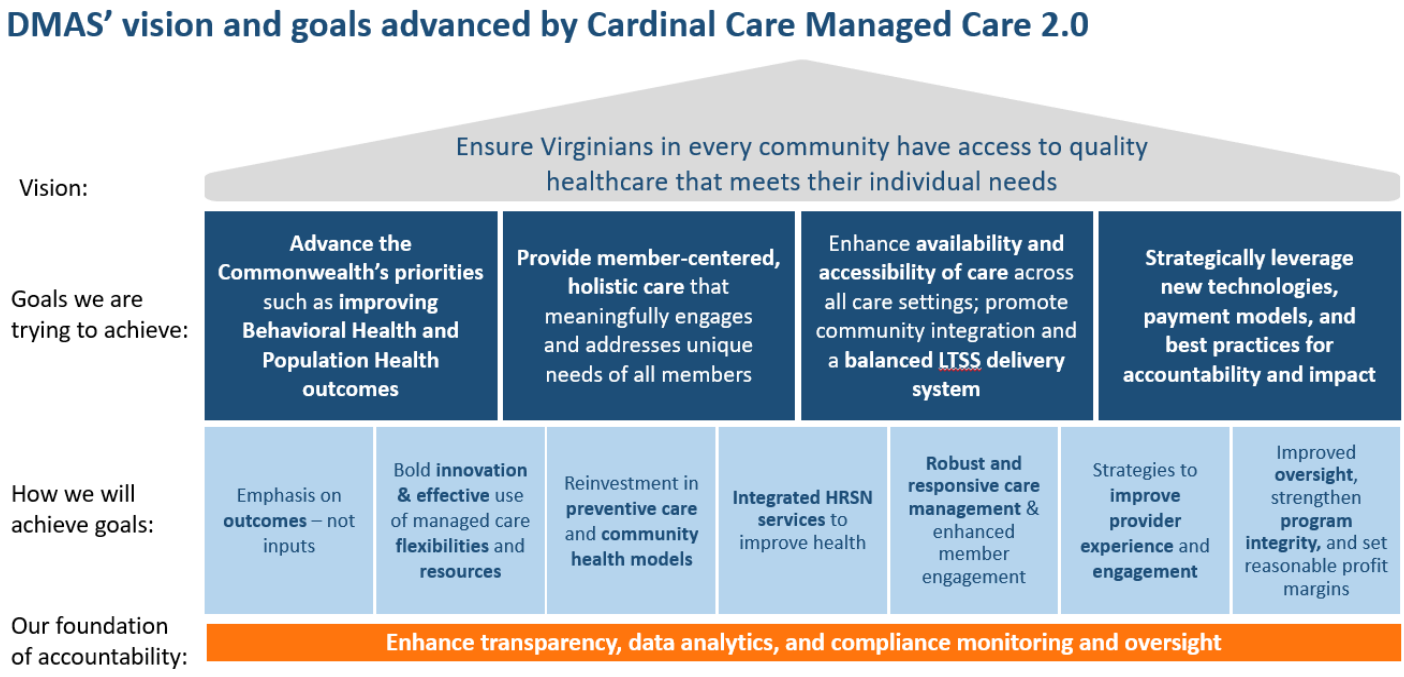
- Improve quality of care and health outcomes for enrollees
- Improve access to care for enrollees
- Better manage medical expenses

Tip: Clearly define "value" from state, enrollee, provider, and MCE perspectives, and include it in the state's managed care vision, procurements, and contracts. When defining value, consider:

- ***Soliciting input from enrollees, providers, MCEs, and related state departments and agencies on managed care objectives and challenges***
- ***Establishing clear strategic priorities for your Medicaid managed care program(s)***
- ***Identifying short- and long-term goals related to achieving your Medicaid priorities***
- ***Determining how you will measure managed care program success***

When Virginia's Department of Medical Assistance Services (DMAS) released their Cardinal Care Managed Care procurement in 2023, they included the following "strategy house" defining their vision for the procurement, goals, how they intend to achieve the goals, and their foundation for accountability (see Figure 1)[3] . DMAS uses this strategy house, internally and externally, to explain their managed care procurement strategy and to help prioritize state and plan activities focused on the identified goals. Virginia also referred to this strategy house when developing and refining their Cardinal Care Managed Care contracts.[4]

Figure 1: Virginia DMAS' Vision and Goals Advanced by Cardinal Care Managed Care 2.0



Source: Virginia DMAS, 2023

The Managed Care Purchasing and Accountability Cycle

To get the most value out of MCE contracts, Medicaid agencies must go beyond the traditional state-contractor relationship. Effective use of state purchasing leverage in Medicaid managed care requires a clear vision; strong leadership; a definition, in measurable terms, of what the state expects of its contracted plans; actionable data; a performance improvement cycle; and effective use of "sticks and carrots" to motivate MCEs. Figure 2 displays the purchasing and accountability cycle that Medicaid agencies can use in managing MCEs with a focus on leveraging state purchasing power to improve performance and increase value on behalf of enrollees. The first step is specifying what the state wants to buy and selecting the best MCEs, but steps two through seven happen after MCE contracts are signed.

Figure 2: Managed Care Purchasing and Accountability Cycle

Source: Bailit Health

Tip: States preparing for procurements should review "Medicaid Managed Care Procurements: A Toolkit for State Medicaid Agencies."

Using the Managed Care Contract as a Roadmap

State Medicaid staff must be very familiar with their managed care contract requirements in order to hold plans accountable. The MCE contract is both the legal document and the operational roadmap for a state's oversight and management of MCEs. At a minimum, MCE contracts should align requirements with the state's value objectives and:

- Clearly delineate state and vendor (MCE) responsibilities
- Describe formal aspects of the relationship between the state and the MCE(s)
- Identify MCE performance measurement processes, metrics, and expectations
- Include actionable reporting requirements
- Establish a framework and processes for continuous quality improvement and innovation
- Provide a menu of effective incentives and penalties related to MCE performance

Appendix A includes a sample table of contents from North Dakota's MCE contract, which includes sections consistent with the recommendations listed above. This toolkit also includes links to different state MCE contracts and reporting requirements referenced in specific examples.

Managed Care Entity Contract Oversight

Given the scope of MCE contracts and state objectives to improve quality and access to care for Medicaid enrollees, there are multiple opportunities for performance improvement and operational efficiencies. States should regularly use data and information to prioritize MCE oversight and performance improvement efforts. At the initiation of a new MCE contract, states should use MCE proposals or applications and available baseline data as the foundation for ongoing MCE contract management priorities.

For example, a top priority of all states should be assessing the extent to which managed care enrollees have appropriate access to covered services. Appendix B includes different state approaches related to MCE provider network adequacy oversight, including MCE contract provisions from Louisiana, New Jersey, and Ohio requiring MCEs to conduct and report on certain network activities and metrics, and a summary of Florida's 2025 procurement to select a vendor to provide enhanced MCE provider network auditing. The Centers for Medicare & Medicaid Services (CMS) has recognized that assessing MCE network adequacy and access to care is a challenge for many states. While states require MCEs to regularly submit a full provider network file and related network adequacy reports, the quality of these files and reports, and states' ability to effectively use them, varies. Federal rule changes and related updates to external quality review protocols have increased requirements for state Medicaid agencies to assess and validate managed care plans' network adequacy based on what CMS considers to be best practice to date.

If your MCEs are meeting all contractual geographic access (time and distance) standards but the state is aware of complaints and apparent issues with timely access to care, you may need to tighten your geographic access standards and use other ways to monitor MCE networks and access to care or work with your MCEs to increase capacity, where possible. See the box below for an overview of how some states monitor and act on MCE network adequacy. To minimize burden on the state, in all MCE oversight activities, consider how you can generate automated reports, improve MCE self-reported data, and engage your External Quality Review Organization (EQRO), MCEs, and state agency staff in monitoring MCE performance and communicating your findings and expectations.

Management Example - Network Adequacy and Access to Care Oversight

Engage your agency staff, enrollees, providers, EQROs, enrollment brokers, and other Medicaid vendors in reviewing, refining, and acting on available MCE network adequacy and access to care data. The state has information on all contracted MCEs and can utilize this data to assess how provider networks vary by region, by MCE, and by provider type and covered services. In addition, CMS has increased state requirements on appointment wait time standards and network adequacy through Medicaid managed care rule changes in 2024[5], with effective dates starting in mid-2026 and extending through 2028. In addition, effective in 2025, CMS External Quality Review protocols[6] require states with Medicaid managed care programs to conduct and report on MCE network adequacy validation (NAV).

To improve oversight of MCE network adequacy and access to care for enrollees, state Medicaid agencies, EQROs, and other vendors supporting state MCE oversight efforts should:

- Review federal Medicaid managed care rules, External Quality Review Network Adequacy Protocols, and approaches used by other states, such as those outlined in Appendix B, to identify network adequacy metrics and approaches to improve MCE Oversight, realizing that no one metric or approach tells the full story.
- Use a variety of approaches and metrics to assess MCE networks and access, such as timely appointment availability, provider to enrollee ratios, identifying MCE network providers that have not seen any enrollees, and secret shopper activities to verify providers in MCE networks, information in MCE provider directories, and appointment availability for MCE enrollees.
- Examine and compare availability of after-hours/weekend access to primary care entities in MCE provider networks and MCE use of out-of-network providers, single case agreements, and telemedicine.

Build Bidders' Promises into Contract Oversight

In competitive MCE procurements, bidders are trying to win a state's business and will make promises in their proposals. States should create mechanisms in their vendor management approach to hold awarded MCEs accountable for those promises. Establish a system and a timeline for revisiting MCE performance on specified activities and timelines identified in their proposals.

Tip: Develop a process to identify and monitor vendor commitments made during the MCE proposal or application process.

Many states specifically incorporate a bidder's proposal by reference[7] into the resulting MCE contract. This enables states to better hold vendors accountable for commitments made in their proposals that go beyond what is required in the model contract.

When a state completes an MCE procurement process and starts new MCE contracts, they should identify and review MCE responses to certain technical questions where a successful bidder was required to propose a specific approach it would use, such as where a bidder indicated it would implement a certain approach within a specific time period or that it would exceed certain metrics. For example, Louisiana asked bidders as part of its managed care procurement to commit to increasing their use of value-based payment (VBP) arrangements and then compared MCE VBP strategic plans submitted after contract execution to what MCEs proposed in their bids. The state then required any MCE that proposed a lower level of VBP use within its strategic plan compared to the MCE's proposal to revise and resubmit their VBP strategic plans to align with the full scope the MCE had included in its proposal.

Managed Care Entity Readiness Review

The first step in holding MCEs accountable to their managed care contracts is a readiness review and MCE oversight activities that occur before the operational start date of the new contracts. As soon as the state awards new MCE contracts, it should be preparing for MCE readiness reviews. With each new contract cycle, regardless of whether a state adds new populations, new services, or has new contractors, the state should conduct a comprehensive MCE readiness review process. The state should consider its top priorities and changes in the new MCE contracts and any related vendors or information technology systems to identify the key areas for readiness review. Just because a state changes the contract language does not mean that all MCEs will be ready and able to comply with the new requirements on the first day of operations. See the "Medicaid Managed Care Procurement Toolkit" for more recommendations on readiness review activities.

Training and Tools

States should not underestimate the need for staff training at the state, MCE, and provider levels to achieve desired results in new MCE contracts. In addition, each Medicaid agency should actively engage its Medicaid Advisory Committee (MAC) and new Beneficiary Advisory Council (BAC) in planning strategic managed care communications to enrollees. It is essential to provide appropriate notice and information to enrollees selecting an MCE, or considering whether they want to change MCEs, particularly if the state is offering different MCE options. In addition to complying with federal rules for notices, state agencies should work with their MACs/BACs to help make notices accessible and comprehensible to all enrollees so that they understand the implications of their selection, or lack of selection, of a managed care plan or primary care provider.

As a state prepares for the operational start date of new contracts, it should develop timelines and a checklist based on changes in MCEs and changes in the MCE contract and managed care program. A calendar of activities is a simple tool that can improve communication and increase predictability of state MCE oversight activities for both Medicaid agency staff and for contracted MCEs. Key elements in a managed care calendar might include:

- Planned reviews and updates to quality metrics and related MCE performance incentives
- Any special open enrollment processes for enrollees to select, or be assigned to, MCEs
- Periodic meetings with state Medicaid leadership and MCE leadership
- MCE contract amendment timelines, such as twice annually
- Medicaid budget and MCE contract rate development timelines

Since the timing of some processes may be uncertain, the calendar may not be a literal listing of dates but rather a list of ongoing and upcoming activities, with anticipated milestones and estimated completion timeframes. This type of managed care calendar gives state staff, plans, and other stakeholders better insight into the timing of Medicaid managed care activities and can enhance the quality of their participation in MCE oversight and policy development.

Setting Expectations and Monitoring Managed Care Entity Performance

Once MCE contracts are executed, Medicaid agencies must immediately set expectations and processes to measure MCE performance on key metrics and across a range of functions. Figure 2, displayed earlier, depicts a cycle of continuous performance improvement that state Medicaid agencies can use to more effectively manage contracted MCEs. Continuous performance improvement requires measuring initial MCE performance; identifying opportunities for improvement; setting measurable and attainable improvement goals; collaborating with and incentivizing MCEs to improve; and then re-measuring performance and applying incentives or penalties based on results.

Focus on specific aspects of MCE accountability and performance, such as:

- Enrollee access to care, including culturally and linguistically appropriate care
- Clinical quality of care
- Population health and care coordination, including enrollee-centered measures
- Enrollee satisfaction with care
- Administrative performance, including claims payment and call center responsiveness
- Financial performance metrics

States and MCEs cannot focus on all aspects of contractual performance simultaneously. Medicaid managed care oversight staff should identify and focus on performance and metrics that are most important to the state, its enrollees, and other stakeholders and revisit these MCE performance metrics and objectives at least annually. For example, in preparation for an upcoming managed care procurement, Illinois Medicaid publicly and specifically invited families and other stakeholders to share feedback on HealthChoice Illinois (HCI) managed care, both verbally and in writing.[8] The Medicaid agency held a series of in-person and virtual listening sessions to gather feedback from enrollees, providers, advocates, and other stakeholders to hear about their experiences. Illinois Medicaid also developed and marketed an online form for HCI enrollees and other stakeholders to provide written feedback.

In addition, Illinois announced and then received comments on its managed care program during the state's MAC and subcommittee meetings. The state agency asked enrollees questions such as:

- What works well for you with HealthChoice Illinois?
- Where do you see opportunities to improve?
- How else can the state agency and HealthChoice Illinois meet your needs?

Performance Measurement

Consistently monitor performance: Within MCE contracts, establish regular processes that focus on MCE performance on pre-established objectives and targets in high priority clinical and service areas. To support monitoring of MCEs, states can look to an MCE's private health plan accreditation status and findings, [9] as well as to an MCE's performance on standardized quality measures compared to national benchmarks and state targets. The Healthcare Effectiveness Data and Information Set (HEDIS®)[10] is a widely used set of standard performance measures for assessing Medicaid MCE and other health plan performance.

Choose quality measures: Based on short- and long-term goals for MCE performance, states should select quality measures that can be utilized to assess progress toward those goals. The Buying Value Measure Selection tool can be used to identify appropriate quality measures based on each state's prioritization. This free tool includes over 900 quality measures, including HEDIS measures, used by purchasers to assess the value of MCE and provider performance. Buying Value also includes the most recent versions of CMS measure sets such as: the Child and Adult Core Sets, Health Home Core Sets, and measures from the Hospital Value-Based Purchasing Program, among others.

Assess room for improvement: When reviewing MCE and statewide performance across HEDIS measures,[11] it is important to consider how individual MCEs are performing across specific measures, where there are opportunities for improvement, and how the state can support its MCEs in making those improvements.

Examine Sample MCE and Statewide Performance on Three HEDIS Measures

Table 1: Example of Managed Care Organization Performance Rates on Select HEDIS Measures								
Measure	**Overall**		**MCO #1**		**MCO#2**		**MCO #3**	
	Rate	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**
Prenatal and Postpartum care (postpartum)	76.22	<50th	74.75	<33rd	72.02	<25th	81.75	>66th
Prenatal and Postpartum care (timeliness of prenatal)	**80.41**	**<33rd**	**73.48**	**<25th**	**75.91**	**<25th**	**90.51**	**<75th**
Well child visits in first 30 months of life (15-30 months)	60.73	<25th	60.82	<25th	61.27	<25th	60.14	<25th

Source: Bailit Health, 2024

The "Rate" in Table 1 above is the absolute value of MCO performance on the HEDIS measure. The "Rank" is the National Committee for Quality Assurance (NCQA) percentile rank for Medicaid MCOs nationally based on calendar year 2022 performance. The "Overall" column presents statewide Medicaid managed care results in this scenario.

Questions to consider regarding MCE quality performance and state priorities when reviewing similar data:

- How does MCE HEDIS performance align with state priorities?
- How does MCE HEDIS performance compare to national Medicaid HEDIS percentiles?
- How does MCE HEDIS performance vary across plans?
- What areas should MCEs focus on as opportunities for improvement, individually and collectively?
- What other stakeholders need information about MCE HEDIS performance and possible actions?
- What levers can the state use to incentivize MCE and provider improvement on these HEDIS measures?

As noted in later sections of this toolkit, states should ask similar questions when examining MCE performance on metrics related to all aspects of performance, not just MCE performance on clinical quality metrics.

Measure MCE performance holistically: It is essential to monitor MCE performance more broadly than their clinical results on HEDIS measures or enrollee experience surveys, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS). A state should define MCE performance objectives to include all dimensions of the MCE contract and develop a system to methodically conduct targeted operational reviews of different areas of MCE contract performance. For example, a state can review MCE performance in areas such as call center response times, timely claims payments, grievance and appeals, and financial performance. Where possible, states should leverage and collaborate with their EQRO to support these MCE monitoring efforts. See Appendix B for information on how four states measure MCE network adequacy, including how Ohio uses its EQRO to help verify the accuracy of MCE provider networks.

Prioritize outcomes: It is important to focus on results rather than internal MCE processes. An MCE performance dashboard can be used to regularly investigate and act on MCE performance when it differs from established goals or contract expectations. Two levels of the dashboard can be created: 1) MCE program performance overall and 2) MCE-specific dashboards to use in contract management and in individual MCE performance meetings. Ideally, performance benchmarks should be set in a way that incentivizes all MCEs to make improvements.

Establish regular, substantive, in-person meetings on MCE performance and provide substantial internal and external transparency on the extent to which each MCE is meeting expected performance levels for quality, efficiency, or other priority measures, using comparative data and dashboards to support the discussions. In advance of these one-on-one meetings, identify the specific MCE performance areas to be discussed, the process and timeline for reviewing performance in the future, and specific performance goals.

For additional information on mechanisms that states can deploy when MCEs fall short on state performance objectives, see the toolkit section on Creating and Using Managed Care Performance Incentives and Disincentives.

Requiring and Using Managed Care Entity Reporting

States require significant amounts of data and reports from MCEs with various frequencies (e.g., weekly, monthly, quarterly, annually, and ad hoc). While states have significant discretion, some MCE data and reports are collected to meet requirements set by CMS or state law. Ultimately, all MCE data and reports should be actionable for the intended audience.

Track Compliance With Reporting Requirements and Managed Care Entity Performance

Managed care oversight staff must track MCE submission of deliverables to ensure that they are timely, complete, and accurate. Create a deliverables calendar to help ensure that both the state and the MCEs know what is due, when, and in what format. For example, Massachusetts lists all MCE reports, frequency of the reports, and method of submission in an appendix of the MCE Contract.

It is easier to track whether a report is submitted on time or completely than it is to assess MCE performance based on the data and information in the report. However, the full value of these reports is when state agency staff and MCEs use the reported information and data to identify MCE best practices, compliance issues, and opportunities for improvement. Make sure staff responsible for reviewing MCE reports know how to assess data and information provided in MCE reports. Train staff on what to look for in each type of report. Managed care oversight staff should know how to determine acceptable and unacceptable MCE performance and whom to ask for assistance in reviewing more complex deliverables. If a state is not receiving consistent or actionable data from a specific type of MCE report, consider how to revise the report requirements. If the state is just checking that a report is submitted, consider whether the MCE report is still necessary.

Streamline processes and utilize reporting templates: When possible, create standardized formats and processes for MCEs' reporting. Standardized does not necessarily mean automated reporting. Many states create and refine simple standard MCE reporting templates using Microsoft Word or Excel. Develop and share clear instructions for how and when MCE reports should be submitted to the state. Creating reporting templates and processes for reviewing these reports may take time initially, but they also improve the consistency of MCE reports and increase a state's ability to review and act on MCE reports in a timely manner. Consider adapting another state's Medicaid MCE report format(s). For example, Florida has an online 2025-2030 Medicaid Managed Care Plan Report Guide with links and downloads. Similarly, Oregon posts MCE reporting templates, related forms, and documents on their Coordinated Care Organization Contract Forms website. Louisiana posts templates and reporting instructions within their MCO Resources, and Texas has a Medicaid and CHIP Uniform Managed Care Manual.

Given the size and the scope of MCE contracts, states should maximize their time, data, reports, and services from other vendors to better understand, monitor, and direct MCE performance. For example, to obtain the value the state is seeking from MCEs and related vendors, consider how to align state Medicaid agency, MCE, and EQRO reporting and performance review cycles to more effectively manage time and utilize limited resources.

Tip: Sometimes less is better. Measure what matters. Don't ask for MCE reports that will not be used.

Reflect on what data will help the state achieve its goals: Consider what the state is measuring about the MCE's performance and why. Also make sure to understand the data that the state needs for each report, the source of that data, and what the limitations and time lag may be relative to that data. On a regular basis, states should review the reports that are received to determine what information is being used by the state to monitor its MCEs and to consider what additional data and/or reports could be helpful to the state. At a minimum, the state should be measuring population health and health outcomes, operational performance, and MCE financial performance.

Use Reports to Analyze Managed Care Entity Performance and Consider Opportunities for Improvement

In addition to the MCE deliverables calendar, state staff should also have a short and long-term plan for what MCE-related data they will receive and analyze, and how to act on the results of the analysis. Optimizing the state's MCE vendor management approach requires ongoing and timely use of available data and resources. Timely evaluation of MCE data and reports is essential to ensure that the information the state is reviewing is as up to date as possible.

Consider what the data says: To improve MCE performance, use data and reports on a cyclical basis to identify the state's most important managed care goals and then focus on those priorities in the oversight of MCEs. Consider the following questions for all aspects of MCE performance, not just for clinical quality performance metrics:

- In what areas is the MCE falling short compared to best practice or desired performance?
- In what circumstance(s) does the state need to act immediately on MCE information?
- Are there MCE or region-specific opportunities for improvement?
- Are there state priorities that would be appropriate for MCE improvement goals?
- To what extent can the MCE influence improvement in different areas?
- How can the state be of assistance?

Tip: Know the MCE contract, data, reports, and performance measures.[12]

Questions to consider related to MCE oversight:

- How are the state's MCE contracts, attachments, and reporting templates working?
- What could the state do to better measure MCE performance and hold plans more accountable?
- Is the state holding MCEs accountable for specific commitments they made in their proposals?
- Where can the state partner with MCEs, enrollees, and stakeholders to tackle challenges and questions related to key contract or reporting requirements?

Elevating the Plan Management Approach

To generate value from contracted MCEs, state agencies must go beyond clear contractual requirements and strong performance incentives. Shared purpose, active relationship management, and technical support matter too. It is an ongoing process for a state to build strong contract management capabilities throughout its organization. "Contract management maturity"[13] is a concept designed to recognize different levels of demonstrated expertise in managing contracts, from ad hoc approaches to more advanced practices. A state agency can utilize a similar conceptual framework and the following five-point scale when assessing its level of MCE vendor management maturity:

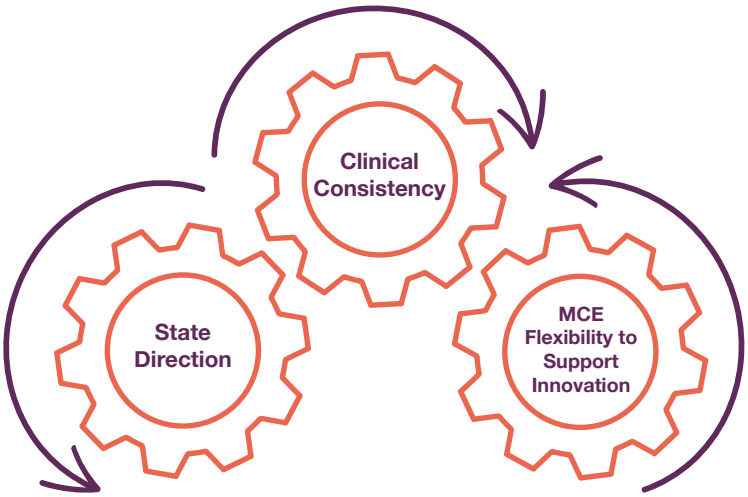
1. Ad Hoc – some processes are established, but are ad hoc
2. Basic – disciplined process capability
3. Structured – fully established and institutionalized process capability
4. Integrated – processes integrated with other enterprise processes
5. Optimized – processes are optimized, focused on continuous improvement and adoption of lessons learned and best practices

Self-assessment: Start by considering where the state's vendor management approach falls within this maturity scale, knowing the maturity of the approach may vary across the contract. For example, the state may have ad hoc or basic management approaches related to oversight of MCE care management and structured or integrated management related to standardized quality metric requirements.

Managing for Higher Value

Identify ways to increase contract management maturity: To advance MCE oversight and results, focus on managing and paying MCEs for higher value–where value is clearly defined and measured by the state. Wherever the state's managed care oversight approach falls on the scale of vendor management maturity (listed above), start there and consider ways the state can work its way up based on the state's priorities. Consider the extent to which the state knows what it wants MCEs to do, and how to measure performance in a specific area. Effective vendor management requires a balance of state direction, clinical consistency, and MCE flexibility to support innovation, and these approaches are interrelated (see Figure 3). For example, the more a state provides specific direction, the less MCE flexibility exists. To be most efficient, a state should consider where it wants to be specific and where the state is seeking innovation and therefore allows for more MCE flexibility.

Figure 3: Requirements for Effective Vendor Management



Source: Bailit Health, 2025

The most mature level of vendor management includes focusing on continuous performance improvement. Working as both a partner and a regulator with contracted MCEs using a collaborative and data-driven process, state Medicaid managed care staff can more effectively improve managed care performance on behalf of enrollees, providers, and stakeholders.

Utilize a Staffing Model That Enables the State to Be More Effective in Managed Care Oversight

Tip: Almost everyone's job is managed care. Coordinate within the Medicaid agency, with other state agencies, and with other vendors—such as the state's EQRO.

Holding MCE vendors accountable requires dedicated resources for contract compliance and oversight and regular support of subject matter experts (SMEs). State Medicaid agencies need the collective expertise of a wide range of staff to effectively manage MCEs. Despite how it looks on the Medicaid agency organizational chart or in job descriptions, with comprehensive managed care contracts, almost everyone's job is managed care. To obtain the highest outcomes from MCEs, Medicaid staff should routinely coordinate, internally and externally, to harness expertise, data, and resources to improve managed care outcomes and results.

Tip: Consider developing cross-functional teams to engage SMEs and more effectively oversee MCEs.

Create an MCE vendor management team: To have a comprehensive view of how MCEs are performing across different components of the contract, create an MCE vendor management team that supports the staff responsible for day-to-day MCE management. The state's MCE vendor management team should meet regularly and include representatives from relevant parts of the organization, including Medicaid staff with expertise in enrollment, quality, finance, information systems, and the variety of services included in the managed care contracts—such as maternity care, acute care, behavioral health, pharmacy, long-term services and supports, dental, and non-emergency medical transportation. This type of cross-functional team leverages diverse skills and expertise from different departments to support MCE oversight and promotes communication and learning across state agency departments.

Make sure that staff participating in the cross-functional MCE team are trained, accountable, and recognized for their role in MCE oversight. Remember that the managed care contract should be the collective roadmap for state staff and MCEs. Use the contract to train staff on MCE contract provisions, reports, and available data. Recognize that managing large external vendors may involve a learning curve and require a shift in perspective for staff that have traditionally

worked in fee-for-service Medicaid or other agencies, or who have not managed a vendor or such a large contract previously. Develop and offer staff training and use cross-functional team meetings to share tips and tools for managing these complex vendor relationships.

Involve the state's MCE vendor management team in identifying what data are needed for MCE oversight and in defining MCE reports and criteria for assessing performance. Use the MCE vendor management team structure to ensure that MCE monitoring does not default into checking whether plans submitted timely reports. In addition, make sure contracted MCEs know the state is reviewing and using the performance data being collected—ask MCEs questions on what they have submitted and use their performance results in regular meetings with the MCEs.

Enhancing MCE Vendor Management

Develop and utilize a vendor management approach that engages and involves SMEs within the Medicaid agency and other state agencies.

- Use available data and experts, including the EQRO!
- Identify skill sets and state staff that can play a larger role in MCE oversight and engagement.
- Consider accountability structures for state staff and refocusing resources to manage MCEs.
- Encourage internal and interagency collaborations in monitoring and managing MCEs.
- Have regular, structured meetings with each MCE and with all MCEs.

Conduct a Comprehensive Performance Review of Each Managed Care Entity and Provide Actionable Feedback

As part of the state's routine MCE management process, create a schedule and expectations for reviewing documentation and MCE performance on a variety of metrics. Provide transparency on the extent to which each MCE is meeting expected performance levels for quality, efficiency, and other priority measures; use comparative data and dashboards to support internal and external discussions. Initiate a cycle of meetings between the state and MCEs, identify specific MCE performance areas to be discussed, the process and timeline for reviewing performance, and specific performance goals. The state should have and use a menu of different approaches to require and encourage MCE performance improvement with a focus on priority areas affecting enrollee access to quality care and covered services. When issues are identified, determine the follow-up process for the state and/or EQRO to determine whether the MCE is implementing the improvements promised, according to the timelines and parameters required under the contract and/or proposed by the MCE.

Consider using a 360-degree MCE performance review process similar to Virginia. A 360-degree MCE performance review is a Medicaid agency meeting where SMEs present and review data and information with Medicaid leadership on an individual MCE's performance. In Virginia, SMEs with input on the following topics participate in these MCE performance reviews: appeals; behavioral health; contract compliance; costs and utilization data; enrollee engagement and programs; encounters and information system support; financial performance; managed long-term services and supports (MLTSS); maternal and child health; network adequacy and access to care; pharmacy; program integrity; quality; value-based purchasing; and transportation. These 360-degree reviews are designed to facilitate collaborative discussion of relevant metrics, trends, and actions pertinent to the MCE's core Medicaid operations. A 360-degree performance review is not an audit or a formal comprehensive review.

The 360-degree performance review process enables Medicaid agency staff to better understand MCE data, reports, and performance, both individually and collectively. See Appendix C for more information on how Virginia uses its 360-degree performance review process to be transparent with MCEs and hold them accountable for performance. During meetings with individual plans, the state Medicaid leadership team highlights strengths, opportunities for

improvement, and concerning findings to MCE leadership. After meeting with the state Medicaid leadership to review the 360-degree performance review findings, the MCE is required to share follow-up steps they will undertake based on the feedback.

The state Medicaid agency also needs to define how it will actively refine and advance MCE contract goals and management strategies over the course of the contract, and how it will collaborate with internal and external stakeholders to do so. As part of this effort, the Medicaid agency should use state and MCE data and reports to identify key issues and emerging trends, including oversight of MCE subcontractors. The state should widely and regularly disseminate and utilize comparative MCE performance data with MCEs and other stakeholders.

Open communication and collaboration: Lines of communication and collaboration between states and contracted MCEs need to be open at multiple levels and in multiple ways, including in person. State Medicaid leadership, in addition to managed care staff, should engage in performance and data-focused conversations with MCE leadership to build stronger relationships and increase accountability. MCE contract oversight is a demanding two-way partnership; increased value from MCEs is unlikely to occur without active direction from state staff. Regular management meetings should be held with each MCE and senior level agency staff. Between Medicaid staff and contracted plans, a shared understanding and respect for each other's skill sets must be earned repeatedly. This type of MCE vendor management approach enables more effective collaboration and better results. States should also work with MCEs to share best practices and lessons learned across plans.

Tip: Don't underestimate the state's role in managing MCEs.

Even though the state is contracting for managed care expertise, state agencies have a wealth of data and Medicaid expertise that can help MCEs achieve the state's objectives to improve care for enrollees. Data from the state and its EQRO can show each MCE how it compares to FFS and to other Medicaid managed care plans, highlight where the MCE needs to improve, and expedite the implementation of best practices across MCEs. When a state is transparent about the MCE-specific performance data and comparisons to national or other external benchmarks, it demonstrates for the plans and stakeholders what level of performance is achievable. In this context, transparency of MCE performance data means more than posting performance on a publicly accessible website or creating a dashboard on aspects of MCE performance. Sharing, using, and discussing unblinded, MCE-specific performance data with all MCEs, state agency staff, and other stakeholders in virtual or in-person meetings is often a more powerful motivation for improvement.

Partner With Managed Care Entities Separately and All Together to Improve Performance

Use the state's power as a convenor: To motivate and partner with MCEs, states can convene MCE meetings and workgroups to foster collaboration and expedite performance improvement. For example, Washington state worked with their MCEs to address Medicaid patients residing in hospitals who were unable to be discharged. Collectively the state and the members of the MCE complex discharge workgroup reviewed data and identified five types of patients who ended up in the hospital longer than medically necessary: 1) those needing substance-use disorder treatment; 2) bariatric surgery patients; 3) patients requiring hemodialysis; 4) patients with reported behavioral issues; and 5) patients experiencing homelessness. The state staff facilitating the workgroup assigned each MCE to research and present to the MCE workgroup on discharge barriers for one type of patient. MCEs took turns presenting their findings and offering insights. Each MCE then developed strategies designed to reduce discharge barriers for their assigned population types, working with hospitals, enrollees, skilled nursing facilities, and other providers and community organizations. As the MCEs refined their strategies and discussed results, all MCEs and patients benefited from their shared learnings. Most importantly, discharges were expedited, not just for individual patients but for groups of similar patients by changing MCO, hospital, and other processes, and access to both hospital care and non-hospital care increased.

Tip: Engage managed care stakeholders and use this input to make MCE oversight and program improvements that are meaningful to stakeholders.

Prioritizing Stakeholder Input, Particularly From Enrollees

Engage stakeholders: Ongoing stakeholder engagement is essential given the impact comprehensive MCE contracts have on enrollees and providers. States should seek broad input, share stakeholder feedback, and use the feedback to improve MCE oversight and contracts. Engaging stakeholders helps to build trust, refine policy approaches, and improve understanding of managed care programs and performance. Consider engaging the following types of managed care stakeholders:

- People with lived experience of the Medicaid program
- Healthcare providers and provider associations
- Community-based organizations (CBOs), including providers of social services
- Other state agencies and programs that interact with MCEs and enrollees
- Key state legislators

New Federal Requirements for Engaging Medicaid Enrollees and the Opportunity to Enhance MCE Oversight

CMS' final rule, Ensuring Access to Medicaid Services (the Access Rule) established new requirements for states to engage people enrolled in Medicaid to inform policy and program design. Each state Medicaid agency must establish a Beneficiary Advisory Council (BAC) and only current and former Medicaid enrollees, their family members, and paid and unpaid caregivers are eligible. In addition, each state must create a Medicaid Advisory Committee (MAC), comprising a diverse array of stakeholders, including members of the BAC. For more detail on the new BAC and MAC requirements, please refer to this summary and federal Medicaid rule requirements at 42 CFR 431.12[14].

The BAC and MAC provide states with the opportunity to: engage community members in a way that builds and maintains trust; strengthens the Medicaid program; and shifts from a transactional to a transformative relationship with the community. The BAC and MAC will advise states on effective administration of the Medicaid program. State officials responsible for MCE oversight should coordinate with colleagues supporting the BAC and MAC to serve as a resource on managed care and ideally co-design opportunities with BAC and MAC members to participate in the oversight of MCEs and inform the development of communications and outreach efforts. As members of the BAC and MAC identify challenges and opportunities related to managed care performance during their committee work, the state should engage with BAC and MAC members to inform the state's oversight and management of MCEs.

Depending on the type of MCE stakeholder, consider different engagement strategies. Beyond the BAC and MAC (see the box above), states may want to consider other opportunities to engage people with lived experience of the Medicaid program, including MCE requirements to have similar advisory groups. When doing so, it is key for states to implement community engagement strategies that move beyond "checking a box" and recognize the importance of community voice and the valuable insights and knowledge people with lived experience (PWLE) provide. For more information on transformational community engagement and a discussion of how to support participation of PWLE, please refer to the SHVS issue brief on the topic.

Expand opportunities for provider engagement beyond surveys by recruiting diverse providers for participation in MCE advisory groups, projects, and committees. To allow for participation, consider offering early morning, evening, and virtual meeting options. For example, New Jersey requires MCEs[15] to have a Community/Health Education Advisory Committee with demonstrated participation of enrollees and providers, including:

- Enrollees that are representative of the population served when considering race; ethnicity; language; eligibility categories; disability status; age; sex; sexual orientation; gender identity; geography; use of behavioral health services; and use of MLTSS;
- Individuals and providers with knowledge of and experience with serving elderly people, people with disabilities, or people eligible for MLTSS, including a representative from the MLTSS consumer advisory committee; and
- Representatives from community agencies that do not provide MCE-covered services but are important to the health and wellbeing of enrollees.

Include an education component in the stakeholder engagement process. Stakeholders need to understand the state's intentions and why it's relevant to them before they can offer input.

The state should develop mechanisms for receiving input on its managed care program through written comments as well as structured community listening sessions or focus groups, including by encouraging or requiring MCEs to adopt certain approaches for enrollee, provider, and other stakeholder engagement.

Creating and Using Managed Care Entity Performance Incentives and Penalties

"Sticks and carrots": States should motivate plans and providers to generate more value by utilizing a variety of MCE performance incentives and penalties. Effective use of state purchasing leverage requires good data, a continuous performance improvement cycle, and effective use of "sticks and carrots" to motivate MCE performance. Sticks include MCE performance withholds, financial penalties, and enrollment holds, while carrots include MCE recognition and awards, preference for default enrollee assignments, and financial incentives and bonuses. All MCE contracts should provide the state with a menu of financial and non-financial performance incentives to use in different situations.

Non-Financial Performance Incentives

Transparency of MCE performance is an effective non-financial incentive to improve performance. Sharing MCE-specific performance simultaneously showcases top performers and highlights poor performers. Transparency is more than posting MCE information on a state website. Transparency efforts should also involve sharing comparative performance data in person at MCE meetings, provider advisory committees, and/or with other stakeholders. For example, states can:

- Make HEDIS performance more transparent to enable state staff, MCEs, and stakeholders to clearly see how MCEs perform compared to each other and compared to external benchmarks.
- Periodically require MCE senior leadership to report in person (or virtually) to state Medicaid leadership on specific performance results; high-level, individual MCE meetings are a way to bring attention to data and performance results that might otherwise go unnoticed.

Virginia's 360-degree MCE performance review process is a good example of a non-financial performance incentive. Other examples include the state (and/or the EQRO):

- Providing technical assistance and support to MCEs, individually and through workgroups
- Requiring corrective action plans when MCE performance shortcomings are identified
- Conducting targeted MCE compliance site visits and audits

Financial Performance Incentives

Financial performance incentives for MCEs can include:

- Suspending default auto-assignment of enrollees or freezing MCE enrollment
- Performance-based auto-assignment preferences to MCEs
- MCE quality withhold or bonus
- Automatic sanctions or liquidated damages for specific instances of poor performance

Performance-based auto assignment has been used for years in states such as California, where a greater percentage of Medicaid managed care enrollees who do not select a plan are assigned to a higher performing MCE based on comparative plan performance on a set of identified measures.

Some states like Louisiana use a quality or performance-based capitation withhold, where a percentage (e.g., one to three percent) of the MCE capitation is withheld and plans have an opportunity to earn back withheld funds by meeting pre-determined standards for a set of quality, value-based payments, and potentially other metrics. An incentive program should include MCE performance measures that are a priority for the state and for which there is opportunity for improvement.

For financial incentives and penalties, also consider measures for which there is a large spread in the score between low and high performing MCEs. Some states like Florida, New Jersey, and Texas establish a limited table of pre-determined, standardized penalties for MCE performance on specific metrics and include this information in MCE contracts. This approach reduces ambiguity and makes it easier for staff to enforce and apply MCE financial sanctions. The following table highlights some automatic penalties included in Ohio MCE contracts that relate to provider networks, but states also use automatic sanctions related to other types of performance such as prompt payment of provider claims, accurate and timely reporting of encounter data, and call center response statistics.

Table 2: Automatic Penalties Included in Ohio MCE Contracts Related to Provider[16]

MCE Noncompliance	Automatic Financial Sanction
Failure to notify Medicaid agency and impacted members of provider termination of network provider within required timeframes	$250 per calendar day, per member, for Medicaid agency notification. $100 per calendar day, per member, for member notification
Failure to provide timely notification of network changes that impact 500 or more members or reduce the MCO's network by 10% or more	$5,000 per occurrence
Failure to meet access (time and distance) requirements (measured on a quarterly basis)	$1,000 per county, per provider type, per quarter
Failure to meet provider network information performance standards as reported by EQRO	$50,000 for each performance standard not met

Source: Ohio Medicaid Provider Agreement for Managed Care Organization, 2025

While all details do not need to be spelled out in the contract, MCEs should have sufficient information on the level of performance the state expects and how they will be held accountable for their performance. A state should also define a process that includes notice to MCEs of non-compliance, notice of intent to sanction, notice of sanction, and transparency of MCE compliance actions.

Conclusion

Effective vendor management is more than contract compliance with detailed requirements. The state-MCE relationship is a demanding and ongoing partnership. The state is contracting with and managing MCEs to obtain expertise and innovations to improve care and population health for Medicaid enrollees. To ensure that the state obtains full value from these contracts, the state must first have a clear vision for what it wants to achieve and clear requirements within its contract. State Medicaid leadership and managed care oversight staff must then use a continuous performance improvement approach based on data—as well as feedback from enrollees, providers, and other stakeholders—to make program adjustments and improvements. When states and MCEs work diligently and in partnership toward an aligned vision and priorities, there is the highest opportunity of success on behalf of Medicaid enrollees, providers, and taxpayers.

Appendix A:

Sample Medicaid MCE Contract - Table Of Contents

NORTH DAKOTA MEDICAID EXPANSION MCO CONTRACT[17] - TABLE OF CONTENTS

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Appendix B:

Examples of MCE Network Adequacy Metrics and Oversight Approaches

Florida - Enhanced MCE Provider Network Monitoring: 2025 procurement

Florida's procurement for a vendor to perform Enhanced Provider Network Auditing (EPNA) of Medicaid managed care plans can be found here: https://vendor.myfloridamarketplace.com/search/bids/detail/11303

Florida's newly proposed EPNA program is designed to assist the Medicaid agency with ensuring the accuracy of and access to provider networks reported by MCEs and implementing processes that hold MCEs accountable for maintaining adequate provider networks. The scope of this EPNA work encompasses all of Florida's statewide managed care plans, including plans offering managed acute, behavioral health, LTSS, and dental services. Florida's goals for this new EPNA vendor contract include the following:

1. Continuously audit and test provider networks reported and maintained by MCEs, including using onsite reviews.
2. Receive network access complaints from the Medicaid agency's Recipient and Provider Assistance bureau and research/audit the alleged network deficiency to determine potential findings.
3. Address and monitor identified network deficiencies with MCEs to ensure appropriate remediation.
4. Provide reports including analytics, dashboards, findings, and activities.

For automated MCE provider network reviews, the EPNA scope of work requires that all network providers are included and audited for all appropriate network standards at least monthly. Examples of automated reviews cited by Florida's Medicaid agency include ratio, time and distance, after hours, telemedicine, Person Centered Medical Homes, and accepting new Medicaid enrollees. Florida also requires the new EPNA vendor to consider each MCE's individual commitments to specific provider network standards when completing automated reviews.

For secret shopper reviews, the scope of work requires the EPNA Vendor to develop and submit a quarterly Sampling Methodology Plan that monthly draws a random sample of network providers across MCEs and is spread statewide. In determining the number of providers to be reviewed, the EPNA vendor must ensure the sample consists of onsite reviews in addition to telephonic reviews and proportionate to the number of required providers listed on the state's Provider Network Standards Table applicable to the specific MCE program. Florida seeks a strong focus placed on rural areas of the state, as well, to validate the participation of these providers.

Louisiana (LA) Network Adequacy – Exclusion of Certain Providers

In LA, for the purpose of determining network adequacy, the MCE can only count providers who meet the following criteria[18]:

- "Physical health providers who have submitted at least twenty-five (25) claims in an office setting within the prior six (6) calendar months;
- Behavioral health providers who have submitted at least twenty-five (25) claims within the prior six (6) calendar months; or
- Any provider who was credentialed and added to the MCO network within the prior six (6) calendar months, regardless of claim submissions."

New Jersey (NJ) Network Adequacy – Exclusion of Certain Providers and Required Sampling and Reports

NJ requires Medicaid MCEs[19] to:

- "limit the providers utilized in the geographical analysis of network adequacy to providers who have had at least $600 or greater than 10 paid claims in the previous year.
- review and investigate claims inactivity of all PCPs and PCDs for whom there were less than $600.00 or 10 paid (whichever is less) by the Contractor in a year to determine actual participation status.
- provide documentation in a format approved by the state, of the MCE's review and investigation of all PCPs and primary care dentists for whom there were less than $600.00 or 10 claims paid (whichever is less).
- conduct monthly provider network spot checks to verify the accuracy of its provider network file, including surveying, at a minimum, 50% of its specialty provider network, 50% of its PCP provider network, 50% of its OB/GYN providers, and 50% of its dental network per county annually and document corrective actions taken as a result of spot check responses.
    - Each survey shall be designed to verify provider name, including correct spelling, practice type/specialty, address, phone number, MCE participation status, office hours, open/closed panel, and the ability to accommodate special needs members.
    - Each monthly survey should be county-specific with all counties in which the MCE operates surveyed at least annually.
    - 100% of the Contractor's provider network should be reviewed every two (2) years."

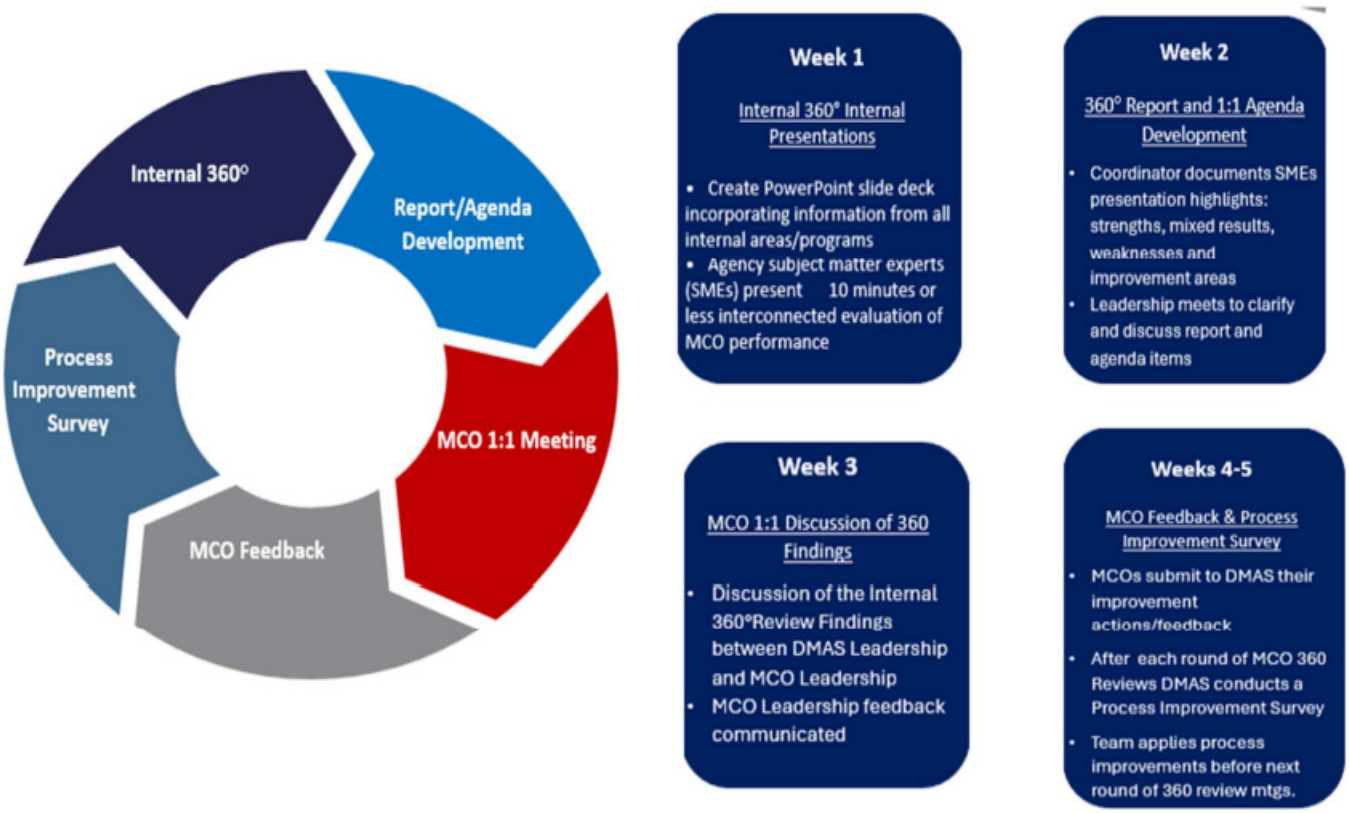
Ohio (OH) Use of EQRO to Verify MCO Provider Network Information

Ohio contracts with an EQRO to conduct telephone surveys of a statistically valid sample of providers' offices to verify information submitted to the state's provider network management system. OH uses these results to evaluate MCO performance, including but not limited to the following two measures[20]:

1. "PCP Locations Not Reached: A PCP is considered "not reached" if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the EQRO made two attempts at different times. To meet this performance standard, MCO's "PCP Locations Not Reached" percent must be 30% or less (at least 70% of PCP locations were reached).
2. Number of PCP Locations Not Contracted with the MCO: Reports the proportion of primary care provider (PCP) locations no longer contracted with the MCO at the time of the survey. To meet this performance standard, the MCO's "Number of PCP Locations Not Contracted with the MCO" percent as established by the EQRO based on the survey must be 8% or less (92% or more of the PCP locations were contracted with the MCO)."

Appendix C:

Virginia's MCO 360 Performance Review Monthly Cycle[21]



Source: VA DMAS, 2024

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ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

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ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

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ABOUT BAILIT HEALTH

This toolkit was prepared by Mary Beth Dyer and Beth Waldman with support from Caitlin Otter. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

ENDNOTES

1. Medicaid and CHIP Payment and Access Commission. 2024. MACStats: Medicaid and CHIP Data Book. Washington DC: MACPAC. See: Section 3, Exhibit 29. https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-July-1-2022.pdf.

2. Federal rules at 42 CFR 438.2 define MCEs including health maintenance organizations and limited benefit plans. For a summary see: https://www.medicaid.gov/medicaid/managed-care/managed-care-entities.

3. Commonwealth of Virginia Department of Medical Assistance Services (DMAS). 2023. RFP 13330, Cardinal Care Managed Care. Richmond, VA: Department of Medical Assistance Services. https://mvendor.cgieva.com/Vendor/public/IVDetails.jsp?PageTitle=SO%20Details&rfp_id_lot=28257&rfp_id_round=0.

4. Commonwealth of Virginia Department of Medical Assistance Services (DMAS). 2025. Cardinal Care Managed Care Contract. Richmond, VA: Department of Medical Assistance Services. https://www.dmas.virginia.gov/media/lspjeswx/cardinal-care-managed-care-contract-fy2025-mid-year-amendment.pdf.

5. For more information on federal Medicaid managed care network adequacy requirements, see 42 CFR 438.68.

6. For more information on CMS EQR protocols, including NAV, see: Centers for Medicare & Medicaid Services (CMS). 2023. CMS External Quality Review (EQR) Protocols. Washington DC: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf.

7. MCE contracts often do not actually attach a bidder's proposal to the actual executed contract but instead incorporate the contract by reference. For example, the Virginia DMAS Cardinal Care contract has the following language: "The documents listed below are hereby incorporated into this contract by reference. . Any conflict, inconsistency, or ambiguity among the interpretation of Contract documents will be resolved using the legal order of precedence, as follows:

    1. Federal statutes and regulations, as amended;
    2. State statutes and regulations, as amended;
    3. Virginia's State Plans for Medical Assistance Services and State CHIP;
    4. The Department's 1915(b) Managed Care Waiver, 1915(c) HCBS Waivers, ARTS 1115 Waiver, and FAMIS MOMS 1115 Waiver;
    5. This Contract, including any MCO specific terms and conditions negotiated and approved by the Department, all amendments and attachments, relevant provider manuals, the Cardinal Care Technical Manual, and the Department's Managed Care Model Member Handbook, including common managed care terms and definitions, per 42 CFR §438.10(c)(4);
    6. Cardinal Care Technical Manual (including Cardinal Care Managed Care Core Performance Measures List), Cardinal Care Encounter Technical Manual, ARTS Technical Manual, and other technical manuals, as updated;
    7. Medicaid memos, bulletins, and guidance as well as Department-issued memos, bulletins, manuals, and other guidance documents; and
    8. CCC Plus MLTSS RFP 2016-02 Proposal Response, Medallion 4.0 RFP 2017-03 Proposal Response."

8. The University of Illinois Chicago's Division of Specialized Care for Children. 2024. "Listening Sessions to Gather Input on HealthChoice Illinois." Accessed July 14, 2025. https://dscc.uic.edu/listening-sessions-to-gather-input-on-healthchoice-illinois/.

9. NCQA has a health plan accreditation process that evaluates plans' standards and processes for key operations including quality management and improvement, network management, utilization management, credentialing and re-credentialing. See https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/ and https://reportcards.ncqa.org/health-plans. In addition, CMS rules at 42 CFR 438.322 require state MCE contracts mandate the MCE to inform the state as to whether it has been accredited by a private independent accrediting entity, and share its most recent accreditation review, including its accreditation status, recommended actions or improvements, corrective action plans, summaries of findings, and the expiration date of the accreditation.

10. HEDIS® is a registered trademark of NCQA. For more information, see https://www.ncqa.org/hedis.

11. HEDIS® includes more than 90 measures across six domains. NCQA's State of Health Care Quality Report outlines the latest HEDIS® measures and definitions and provides an annual summary of national performance for key measures. NCQA issues detailed technical specifications, including annual updates, on how to calculate the numerator and the denominator of these measures, including for the three measures in Table 1.

12. Data typically includes numbers or other information collected from multiple sources and may require review before it can be used. Reports present cleaned data in an organized manner, often using charts, graphs, tables, and/or text. Reports provide context for the data and are designed to communicate data and information to a specific audience on a topic(s).

13. Garrett, Gregory A., and Rene G. Rendon. 2005. Contract Management Organizational Assessment Tools. McLean, VA: National Contract Management Association (NCMA), 2005.

14. Code of Federal Regulations at 42 CFR 431.12.

15. State of New Jersey Department of Human Services Division of Medical Assistance and Health Services. 2024. Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services, Contractor. Trenton: NJ: Department of Human Services Division of Medical Assistance and Health Services. https://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf

16. Ohio Department of Medicaid. 2025. Ohio Medicaid Provider Agreement for Managed Care Organization. Columbus, OH: Ohio Department of Medicaid. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/2025_02_MCO_Final.pdf.

17. North Dakota Department of Human Services. 2021. North Dakota Medicaid Expansion Managed Care Organization Contract. Bismarck, ND: Department of Human Services, Medical Services Division. https://www.hhs.nd.gov/sites/www/files/documents/ND%20MCO%20Contract.pdf

18. Louisiana Department of Health Bureau of Health Services Financing. Louisiana Medicaid Managed Care Organization Model Contract. Baton Rouge, LA: Louisiana Department of Health Bureau of Health Services Financing. https://ldh.la.gov/assets/medicaid/RFP_Documents/PBM21/AttachmentA-ModelContract.docx

19. State of New Jersey Department of Human Services Division of Medical Assistance and Health Services. 2024. Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services, Contractor. Trenton: NJ: Department of Human Services Division of Medical Assistance and Health Services. https://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf

20. Ohio Department of Medicaid. 2025.Ohio Medicaid Provider Agreement for Managed Care Organization. Columbus, OH: Ohio Department of Medicaid. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/2025_02_MCO_Final.pdf

21. From personal communications with Virginia DMAS in March 2025. See also https://www.dmas.virginia.gov/media/awlksl5m/2024-dmas-soar-accomplishments.pdf.