Examples of Factors Other States Consider in Competitive Bidding Processes

States with competitive processes consider a wide array of factors that they outline in their Requests for Proposals. Here are some examples of the kinds of thing NY could make plans demonstrate in their bids that NY could consider in evaluating and selecting plans to participate in the program:

A. Managed Care Experience required by other states - both in the state and in other states
   1) Medicare Advantage Experience
   2) Experience Providing Medicare to Dual Eligibles
   3) Medicaid Experience and Length of Contract Experience
   4) Prior LTSS Experience
   5) Prior work with Behavioral Health and other populations
   6) Presently provide Medicaid managed care services or the applicant or its corporate family must currently serve at least 100,000 lives across all lines of business in all states
   7) A list of contracts with other states as well as the value of the contract, the name and contact info for the contract if the state wishes to contact the other state for a corporate reference.

B. Organizational Structure, Personnel, and Executive Management elements including
   1) Names and qualifications of key personnel, contact information for personnel references.
   2) Staffing Plan.
   3) Description of all subcontractors

C. Soundness of approach. Examples of state requires of bidders:
   1) Ability to cover a county's entire population of dual eligible
   2) Inclusion of additional benefits beyond the minimum Medicare and Medicaid benefits
   3) Work Plan for Implementation of program requirements.
   4) Experience and your approach for screening for needs, conducting assessments and reassessments, and using existing or developing new tools and systems to support these processes.
   5) How your plan will work with each plan population and their different needs with particular emphasis on the different strategies for the different populations.
   6) Process for service planning that is person centered, is conducted in a cognitively accessible manner and has a Participant's goals and preferences at the center of the process. Include the communication process with the Participant and how he or she will be supported in the most integrated setting with preference and priority for supporting the Participant in their own home.
   7) Experience and plan for using technology such as assistive technology, telehealth, telecare, social media, electronic visit verification, and other methods to deliver services to the participants.
   8) Policies and processes which will be used by staff and service coordinators to communicate with Participants with disabilities, limited English proficiency, or have low literacy levels.
   9) Techniques, policies, procedures or initiatives you have in place and those that will be used for the program to:
      - Provide Participants with adequate in-home services to divert them from entering or returning to acute or long-term care facilities.
      - Use community resources, such as community health workers, and natural supports to improve wellness, education on health options, and to improve community involvement.

- Effectively and appropriately control avoidable nursing facility, hospital, and emergency department admissions and other high-cost services and to increase the use of health promotion, primary care, and Home and Community Based Services (HCBS).

10) How you will determine the level of full time equivalent licensed and non-licensed telephonic and community based personnel that will be involved in these activities. Include the plan of care monitoring, and the documentation and sharing of background checks, licensures, and necessary trainings credentials.
11) How you will consider feedback from your Participant Advisory Committee (PAC) in relation to your operations and policies.
12) Policies and processes which will be used by staff and service coordinators to communicate with Participants with disabilities, limited English proficiency, or have low literacy levels.
13) Approach to assisting Participants through the MA financial redetermination process.
14) Methods you will use to verify or evaluate the quality of care delivered by out- of-network providers. Describe any potential barriers and the resolution process.
15) Process for establishing caseloads for service coordinators and what caseloads you will target for the population.
16) Experience and approach in coordination among physical health, behavioral health, and LTSS.
17) Strategy for controlling chronic conditions such as high cholesterol, high blood pressure, and diabetes.
18) Past plan performance (including references, poor performance, sanctions, and unsatisfactory resolution of requested corrective action plans).
19) Written and oral presentation of responses to vignettes provided in RFP.
20) Minimum electronic data interchange experience requirements.

D. Quality. Examples of state requirements for bidders:
1) Most recent 3 years of HEDIS results, with higher results and demonstrable trend toward increasing success considered beneficial.
2) National Committee for Quality Assurance (NCQA) accreditation at level of accreditation for Medicaid managed care plans.
3) All physical health and HCBS quality and performance measures that plan currently tracks and plan's performance in these measures, including any LTSS quality measures and plan's performance. Address how you measure utilization, timeliness of service delivery and rebalancing (HCBS vs Nursing Facility). Describe, out of all of the measures you collect, which three would be most meaningful in measuring HCBS quality and performance and why.

E. Network. Examples of state requirements for bidders:
1) Plans to contract with providers groups with a strong track record of providing innovative and high value care to dual eligibles
2) Detail as to how the Plan proposes to develop its network and set up operations capable of meeting the requirements of the program.
3) Strategy for approaching service delivery in rural and urban areas of a zone including LTSS, preventive, and acute care.
4) Plans to monitor the performance of your subcontractors for compliance with all Agreement responsibilities to ensure they are met. Provide sample reports showing actions taken to improve performance and ensure positive results. Describe any sanctions or penalties that apply if a subcontractor fails to perform. Provide a sample performance monitoring reports.

5) Plans to verify that providers and subcontractors submit timely, accurate, complete, and required encounter data elements and the frequency of verification.
6) Plans to create a provider network that meets the network and access requirements. Specifically, include:
   a. The method to be used on an ongoing basis to assess, meet, and maintain network standards for all provider types.
   b. Process for continuous improvement of network.
   c. How plan will include in its network any current willing and qualified HCBS, nursing facility, and LTSS providers that are enrolled Medicaid providers at the time of implementation.
   d. How plan will achieve appointment access standards, including when Participants cannot access care within its provider network and must go to an Out-of-Network provider.
   e. Plans to provide access to necessary covered services when Participants cannot access services within the provider network.
   f. Plans to provide choice of medical, LTSS, and service coordination network providers for Participants.
   g. How plan will collect and address the language, communication, and Participant-specific needs.
   h. Plans to educate provider network about Participants' communication needs and coordinate interpreter services.
   i. How plan will meet accessibility standards within the provider network for Participants who require reasonable accommodations. Specifically addressing physical accessibility and cognitive accessibility.
7) Processes plan has used and will use to correct deficiencies and make improvements in provider network access and accessibility.
   a. Provider incentives or programs used to encourage greater access throughout the network.
   b. How provider network adequacy and access monitoring is integrated in your overall quality improvement programs.
   c. Plans to recruit new providers, and correct deficiencies should they occur.
   d. Methods provider network support staff will use to engage and educate providers.
   e. Circumstances that will result in providers not being approved to participate in the network.
8) Plans to monitor and evaluate PCPs and other provider compliance with availability and scheduling requirements. Plans to maintain PCP-to-Participant ratio requirements.

F. Financial Condition
1) Financial stability and economic capacity to perform the Program requirements.
2) Evidence the Bidder meets all standards for fiscal soundness requirements including the risk-based capital threshold, working capital, and net worth applicable to the MCO.
3) Required financial statements with the proposal submission documents.
4) Evidence the Bidder possesses the current level of capital and surplus to immediately accept all enrollments.