

Medicaid Managed Care Procurements: A Toolkit for State Medicaid Agencies

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This toolkit is designed to assist states to procure Medicaid managed care entities (MCEs) to offer covered services to their enrollees, and to maximize the benefit of these organizations. To do so, states must begin with developing a procurement process that is focused on improving performance in specific areas valued by the state by identifying priority needs of the state agency, its enrollees and other stakeholders and utilizing a variety of performance improvement tools, incentives, and disincentives to improve value.

States frequently issue procurements with contract terms of at least five years if optional contract extensions are included. This means that a Medicaid managed care procurement does not happen often—perhaps once or twice a decade—and state staff responsible for a procurement may not have been involved in a prior procurement of this nature or size.

States typically need at least a year from procurement planning to implementation but getting started earlier is better (see Table 1). States with brand-new, or larger Medicaid managed care procurements will likely need more time.

Table 1: **General Medicaid Managed Care Procurement Timeline**

Procurement Phase	Suggested Timeframe
Phase 1: Strategic Procurement Planning	• 6-12 months in advance of procurement release
Phase 2: Solicitation Development	
Phase 3: Bid Review and Selection	• 3-6 months
Phase 4: Contract Execution, Readiness Review, and Implementation	• 6-9 months
Phase 5: Contract Management	• Ongoing for the contract performance period

In general, a successful procurement process is facilitated by:

- > **Leadership:** Creating a clear vision that is shared across Medicaid staff and with stakeholders, including enrollees and their representatives, providers, and potential bidders.
- > **A Clear Pathway:** Defining in unambiguous and measurable terms what the state expects of its MCEs in the scope of work (SOW).
- > **Trust:** Developing a collaborative relationship between the state Medicaid managed care program and MCEs, leading to a strong partnership to improve care for Medicaid enrollees.

State agencies need to create and utilize detailed purchasing specifications, working collaboratively with stakeholders to achieve objective, measurable improvements in performance.

This toolkit is designed to guide Medicaid agencies through key action steps and considerations in the major phases of the procurement cycle: 1) strategic procurement planning, 2) solicitation development, 3) bid review and selection, 4) contract execution, readiness review and implementation, and 5) contract management.

Phase I. Strategic Procurement Planning

Tip: Take the time to define your strategic objectives and vision for the managed care procurement before you get caught up in line-by-line editing of the managed care SOW. Think big!

Many states procure large, multi-year Medicaid managed care contracts for most enrollees and covered services. Solid strategic planning and early engagement across involved state departments and agencies will help to create a clear sense of direction and timeline for the managed care procurement. States should consider the following action steps during Phase I of the procurement cycle (see Table 2):

Table 2: Strategic Procurement Planning Action Steps and Considerations

Strategic Procurement Planning Action Step	Considerations
Identify and notify the procurement team	<ul style="list-style-type: none"> Consider team members who may be external to the Medicaid agency, including staff from sister agencies who have responsibilities (or delegated authority) for managing Medicaid programs.
Develop a procurement timeframe	<ul style="list-style-type: none"> When considering the procurement target release date, be realistic and consider holidays and contractual or statutory deadlines. Allow at least 30-60 days for bidders to develop and submit a proposal to a competitive bid. Consider potential for protests and impact on the timeline. Start with the target implementation date and work backwards to allow some cushion for potential (often inevitable) delays.
Develop a clear vision and strategy for the procurement	<ul style="list-style-type: none"> Clearly articulate the state’s vision and procurement strategy so that potential bidders understand the state’s priorities. The vision should be linked to achievable and measurable scope of work requirements within the procurement. Make sure the scope of changes in the vision and strategy are considered when developing or adjusting the procurement timeline.
Solicit public input on procurement process and policies	<ul style="list-style-type: none"> Engage stakeholders early and use a variety of methods to ensure meaningful stakeholder feedback on the state’s intended managed care procurement objectives and approaches. Pay attention to procurement rules which limit the state’s ability to discuss the procurement outside of defined public processes.

Identify and Notify the Medicaid Managed Care Procurement Team and Key Senior Executives That Will Plan for and Execute the Procurement

It is never too early to start planning for your next procurement (or substantive contract amendment)—both operationally and strategically. To both meet state procurement goals and ensure compliance with federal Medicaid managed care regulations, early and sufficient procurement planning cannot be overstated. Procurement processes will often take as long as a state allows, particularly if there is no external deadline forcing completion of the procurement by a certain date. Generally, start procurement planning at least one year before the targeted procurement release date and ideally at least two years prior to the expiration of existing managed care contracts.

Developing a Medicaid managed care procurement is an iterative process. To start, it is essential to identify a project sponsor and lead, as well as individual team members who will be responsible for guiding an agency's managed care procurement process and making progress through each phase. Depending on how your state is organized and how it conducts procurements, it may be particularly important to define the role of the Medicaid agency (and the managed care department within the Medicaid agency) along with other state agencies or departments including procurement and legal staff. In developing the procurement team, each state should consider the subject matter expertise and resources needed to support its managed care initiatives and accomplish key goals, both during the procurement and in managing the selected contractors. States should consider whether other agencies need to be involved in procurement discussions, such as state departments of insurance, behavioral health, public health and social services.

At a minimum, key members of the procurement team should include:

- › **Executive Sponsor** for the procurement (typically the executive team member responsible for the managed care program);
- › **Project Lead** (since the procurement sets the direction for the managed care program, the Lead should be the director of the managed care program if possible);
- › **Representatives** from the managed care department that can be dedicated to procurement activities and support drafting of the procurement documents;
- › **Legal**, contracts and finance representatives; and
- › **The procurement evaluation committee**, made up of individual team members who are responsible for reviewing bidder proposals and recommending awardees.

The procurement evaluation committee should be as small as possible given the size and scope of the procurement (e.g., in many statewide procurements, three or five members may be sufficient, but larger states with regional procurements may require a larger team) while being as inclusive as you need in obtaining input from Medicaid agency staff and staff from other agencies, as appropriate. At a minimum, the team should include senior Medicaid managed care staff and other reviewers with appropriate expertise. Subject Matter Experts (SMEs) who support the procurement evaluation committee may include, for example, health information technology, financial, clinical or population health staff, depending on the makeup of the committee and the questions asked in the request for procurement. The procurement evaluation committee should also be supported by a procurement specialist and a facilitator to help ensure the integrity of the procurement process, consistent with state laws and policies.

States should add a project manager to the procurement team to help keep the many procurement tasks on track with the procurement timeline. To the extent feasible, draw on prior procurements and other states' managed care procurements for ideas and best practices in terms of both substance and procurement processes. If available, consulting resources can be helpful to assist with elements of the procurement process including sharing best practices or trends in recent managed care procurements. All involved staff and their agencies should have a clear and shared understanding of the procurement timing, including recognizing and addressing potential conflicts with other state initiatives.

Develop a Proposed Procurement Timeframe

Be realistic about the time necessary for large Medicaid managed care procurements. Timelines should assume about 3-6 months from the release of the procurement to the announcement of MCE awards and take into consideration all procurement phases and tasks outlined in this toolkit. This timeline could be shorter or longer depending on the complexity of the procurement, number of expected bidders, state resource constraints, etc. It is important to allow sufficient time for bidders to provide thoughtful, organized bids and to clearly articulate how the bidders will approach delivering services. Similarly, state staff need sufficient time to develop a comprehensive, integrated procurement and review and evaluate bidder proposals.

Early in the process, Medicaid agency staff should review roles, assumptions and timing of the procurement and obtain commitments for specific staff participation from involved agencies and departments. Operationally, senior leaders should support the procurement lead in identifying and “reserving” participation from the procurement evaluation committee and specific SMEs and others to support the procurement development, including:

- > **Individuals to be involved in review of draft procurement documents;**
- > **Individuals needed to sign off on final procurement documents**, including but not limited to legal staff, procurement staff, and senior executives;
- > **Individuals designated as procurement evaluation committee members** responsible for determining awardees;
- > **Legal** and/or procurement staff responsible for ensuring that the procurement process and team members follow all applicable state laws and departmental policies regarding managed care procurements; and
- > **Individuals to be involved in the proposal review team(s) as SMEs** offering advice to the procurement evaluation committee.

Senior department leaders should do all they can to prioritize the managed care procurement throughout the process and support staff working on the procurement. Staff should not be expected to maintain all other responsibilities while participating in a managed care procurement development and/or evaluation process.

Have a Clear Vision of What You Want to Achieve With Your Medicaid Managed Care Procurement



States often feel they do not have enough time to develop and revise Medicaid managed care procurement documents to accurately reflect the state’s vision for managed care. Before drafting procurement documents, think strategically about what the state wants to achieve with the procurement. A scan of 53 Medicaid managed care procurements across 28 states released between September 2016 and August 2021 identified state priorities relating to improving quality or health outcomes, increasing the use of value-based payment models, addressing fragmentation in the delivery of care, and addressing social determinants of health, and health equity.¹

A re-procurement process is an important and rare opportunity to leverage state purchasing power to improve the value that MCEs provide to the state and its enrollees. Because managed care procurements only occur every few years, the state needs to be strategic in its approach.

Below is an example of a Medicaid managed care vision statement from the Ohio Department of Medicaid (ODM).

Example: Ohio Medicaid Managed Care Vision Statement (2020)

ODM has designed Ohio's Medicaid managed care program to achieve the following goals:

- > Focus on the individual;
- > Improve individual and population wellness and health outcomes;
- > Create a personalized care experience;
- > Support providers in continuously improving care;
- > Improve care for children and adults with complex needs; and
- > Increase program transparency and accountability.

Ohio's Medicaid managed care program will advance many of these goals through ODM's population health approach, which is designed to address health inequities and disparities and achieve optimal outcomes for the holistic well-being of individuals receiving Medicaid.

ODM envisions a Medicaid managed care program where ODM, the MCOs, the OhioRISE Plan (responsible for providing behavioral health services to children with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple child-serving systems), and the Single Pharmacy Benefit Manager (responsible for providing and managing pharmacy benefits for all individuals), coordinate and collaborate to achieve healthcare excellence through a seamless service delivery system for individuals, providers, and system partners.

Managed care design decisions need to be considered in the state's overall value context. Translating your state's vision statement for Medicaid managed care programs and procurements into actionable, measurable goals and objectives is critical to obtain the best value from your MCEs. The executive sponsor of the procurement and other team leaders should discuss and seek consensus on specific value objectives for the procurement to provide staff drafting the procurement documents with clear direction for improving the SOW, procurement questions, and evaluation criteria.

States should consider which purchasing decisions are most likely to positively affect the care and health status of managed care enrollees. Keep the legislative, budgetary, and managed care context in mind when contemplating questions such as:

1. What does the state want to achieve through its managed care program next year? In three years?
2. Is the state trying to improve access to and/or coordination of certain types of care?
3. Is the state focused on improving care to specific enrollees or in certain regions?
4. Does the state seek to align the procurement with delivery system or payment reforms or other innovations?
5. Is the state looking to include new services or populations in the managed care procurement?
6. Is the state hoping to generate Medicaid savings or improve budget predictability?
7. Are there new or updated Medicaid managed care federal regulations the state should consider in its approach? Is additional federal authority needed?
8. Does the state intend to better integrate care and services for enrollees being served by other state agencies or programs (e.g., public health, justice system, early intervention programs, housing assistance)? For which populations and services?

9. Is the state bound by legislative language, court decisions, and/or specific policy objectives relative to this procurement?
10. How does the state intend to leverage MCEs to address social determinants of health and health equity?

Solicit Broad Public Input on Procurement Process and Policies, and Use This Input to Refine the Procurement Prior to its Release

Engaging stakeholders early on in the procurement process helps to build trust, refine policy approaches, and gain buy-in to key managed care policies and requirements envisioned in the procurement. Stakeholder engagement is essential and should not be overlooked given the long-term nature of MCE contracts, the need to assess state procurement objectives, and the impact these comprehensive contracts have on enrollees and providers. States should seek broad input, share stakeholder feedback publicly,² and use the feedback received from stakeholders to refine the procurement. States should consider engaging the following types of stakeholders during the planning phase of the procurement:

- > **Current enrollees** and their representatives;
- > **Healthcare providers** and provider associations;
- > **Community-based organizations**, including providers of social services; and
- > **Potential bidders.**

In addition, in some states, it will also be important to engage legislators to obtain buy-in for the state's managed care vision. Depending on the stakeholder type, states may apply different strategies for seeking input. Some states, for example, release requests for information, draft procurements, or policy whitepapers to convey the procurement vision and policy direction and then use these same documents to receive input through listening sessions, statewide townhall meetings and/or focus groups.³ Ohio's 2020 procurement vision, highlighted in Phase I, was developed in part from stakeholder feedback received from 17 community-level listening sessions and two public requests for information.⁴

States should consider how to meaningfully engage Medicaid enrollees who likely differ in their level of understanding and experience with Medicaid programs, may be less familiar with how to engage in a public procurement process, and are less inclined to review lengthy, technical procurement documents. Consumer advocates suggest soliciting feedback at the community level to yield more meaningful feedback, through listening sessions and focus groups.

It is also important to include an education component in the engagement process. Stakeholders need to understand your intentions and why it is relevant to them before they can offer input. Think about how to make the engagement as inclusive as possible and consider any potential barriers to participation, such as the event location and time, technology set up, or language barriers. For example, you might want to offer multiple events across the state to limit the amount of travel required of participants, offer alternate meeting times that accommodate different schedules, use closed captioning functions on virtual platforms, make call-in options available for stakeholders that don't have access to the internet or transportation, use plain language in procurement materials, make procurement information available in different languages, and make translator services available. Partner with consumer advocacy and other community organizations who are experienced in this type of engagement.

States' engagement with stakeholders should not end once the procurement process is over—it should extend into the implementation phase of the managed care program and continue throughout the contract term, albeit in different formats and forums.

Phase II. Solicitation Development

Tip: To develop integrated procurement documents, the vision statement should clearly link to measurable scope of work requirements. Procurement questions and evaluation criteria should reflect the value and priorities the state seeks and link to the state’s purchasing specifications.

Competitive Medicaid managed care procurements should include a publicly advertised procurement process, including a SOW or model contract,⁵ and a specification-driven assessment of bids based on pre-determined questions and criteria. Most states limit the number of Medicaid MCEs by implementing a competitive procurement with awards to a specific number of plans, based on highest overall scores. Some states accept any willing and qualified bidders.

States should consider the following action steps during solicitation development (see Table 3):

Table 3: Solicitation Development Action Steps and Considerations

Solicitation Development Action Step	Considerations
Identify and develop key components of an integrated procurement	<ul style="list-style-type: none"> Do not underestimate the time it takes to develop procurement documents. Include SMEs in the process but limit the number of people editing procurement documents. Begin as soon as the procurement vision and key policy decisions are made; continue through procurement release.
Develop evaluation criteria, scoring rubric, and review tools	<ul style="list-style-type: none"> Evaluation criteria and scoring should reflect the state’s procurement vision, goals and objectives.
Release the procurement	<ul style="list-style-type: none"> Where feasible, release all procurement-related information at the same time, including financial-related information and the complete procurement library.
Hold bidders conference (optional)	<ul style="list-style-type: none"> Typically held within 7-10 days after procurement is released, a bidders’ conference allows the state to personally communicate its strategic vision and objectives to potential bidders and directly hear questions from bidders.
Receive non-binding letters of intent to bid (optional)	<ul style="list-style-type: none"> Typically expected 1-2 weeks after the procurement is released. Requiring non-binding letters of intent to bid will provide the state with an estimate of bids and assist in planning for bid review and selection.

Identify and Develop Key Components of an Integrated Procurement

Once a state has defined its Medicaid managed care vision statement for what it wants to purchase and related procurement goals and objectives, it is time to focus on the key components of an integrated procurement, including:

- > **Drafting** a high-level summary of the SOW;
- > **Establishing** comprehensive and detailed purchasing specifications that are specific and measurable (such as network adequacy requirements, quality benchmarks, encounter data requirements, call response times, etc.), including incentives and penalties based on performance;

- > **Defining** processes and timelines in the SOW for how the MCE and the state will seek to improve “performance,” including regularly negotiating performance goals and working with contractors to meet established goals; and
- > **Prioritizing** items for procurement submission requirements based on SOW requirements that will enable the state to identify meaningful differences across bidder proposals and likely indicators of future performance consistent with the state’s vision for its Medicaid managed care program.

In developing a SOW, identify priority needs of the agency and its enrollees before, during, and after the procurement process. The SOW included as part of the procurement is the roadmap for your managed care expectations, your assessment of proposals, your future contract requirements, and your management of MCEs.

It is important to make sure you translate managed care policies and design elements into enforceable contract language; however, it is easy to get lost in the weeds of Medicaid managed care contract language and federal regulations when developing or revising a SOW. While it is important to include all aspects of an MCE’s responsibility within the SOW, the state should focus on developing a SOW which improves purchasing specifications and overall value in priority areas defined by the state. The SOW should include formal aspects of the relationship between the state and the MCE and include both state and contractor responsibilities. For example, Louisiana’s Medicaid managed care model contract and North Dakota’s current contract include both MCE and state responsibilities.⁶

SOWs should clearly delineate both state and MCE responsibilities, including:

- > **Which Medicaid enrollees** are being enrolled in MCEs—both mandatory and voluntary—and how enrollment information will be communicated to the MCEs;
- > **Which services** the MCE is responsible for providing and/or coordinating;
- > **Network adequacy** and accessibility requirements by provider type/covered service;
- > **How the MCE will be paid** by the state;
- > **Parameters the MCE is expected to use** in paying its providers;
- > **Requirement for the MCE to monitor** quality performance, including measures to report, performance target expectations, and financial and non-financial consequences/rewards based on performance;
- > **Requirement for the MCE to adopt** a population health approach;
- > **Systems and data sharing requirements**; and
- > **MCE reporting requirements**, including those related to clinical performance, network adequacy, and priority areas reflecting the value the state is seeking from MCEs and the managed care program overall.

Overall, the SOW should align MCE requirements with the state’s value expectations. For example, the following excerpt from the TennCare managed care contract includes quality management and quality improvement (QM/QI) program requirements which are linked to specific performance improvement reporting requirements and performance targets associated with financial and non-financial incentives and penalties for contracted MCEs.

Example: Select TennCare QM/QI Managed Care Organization (MCO) Scope of Work Requirements⁷

At a minimum, the Contractor's QM/QI program shall:

- › Address physical health, behavioral health, and long-term care services;
- › Be accountable to the Contractor's board of directors and executive management;
- › Have substantial involvement of a designated physician and designated behavioral health practitioner;
- › Make all information about its QM/QI program available to providers and members;
- › Collect information on providers' actions to improve patient safety and make performance data available to providers and members;
- › Use the results of QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members;
- › Take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified;
- › Conduct special focus studies as requested by TennCare;
- › Participate in workgroups and agree to establish and implement policies and procedures, including billing and reimbursement, that are agreed to and/or described by TennCare in order to address specific quality concerns;
- › Collect data on race and ethnicity. As part of the QM/QI program description, the Contractor shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected;
- › Include QM/QI activities to improve healthcare disparities identified through data collection; and
- › Incorporate all applicable reporting and monitoring requirements and activities.

Identify High-Level Goals, and Then Specific Agency Objectives Related to the Value of the Services Being Purchased on Behalf of State Medicaid Enrollees

In developing objectives for your state's Medicaid managed care program, consider state priorities and available data, particularly if you are re-procuring managed care contracts:

- › In what areas are MCEs or providers performing farthest from best practice or defined desired performance?
- › Are there MCE or region-specific opportunities for improvement?
- › To what extent can MCEs/providers influence improvement in different areas?
- › Can the state use the procurement to address specific Medicaid program issues or expectations raised by providers, enrollees, and other stakeholders? Which ones?
- › Does the inclusion or exclusion of certain services or populations in the managed care approach affect other state or local health agencies that are purchasing or providing services to Medicaid enrollees?
- › Which managed care program improvements are priorities for the state?

Once senior leaders have reached consensus on priorities, it is essential to articulate specific, measurable Medicaid agency objectives—first for the managed care procurement team and then for selected MCEs and the Medicaid managed care program going forward.

Consistent with the Tennessee MCO QM/QI program example above, TennCare identifies high-level managed care program goals, objectives, and measures in its Medicaid managed care Quality Strategy as outlined in Table 4.⁸ As part of managed care program oversight, TennCare's Quality Strategy clearly specifies the statewide managed care performance goals, as well as the measures and the data sources to be used to assess performance toward the goal.

Table 4: **Excerpt from the TennCare Quality Assessment and Performance Improvement Strategy**

Goal 2: Provide high-quality, cost-effective care to enrollees

Objective 2.4: By 2024 statewide HEDIS rates for the following child and adolescent immunization measures will improve to the 75th percentile.

- › Childhood Immunization Status (CIS) Combo 10
- › Immunizations for Adolescents (IMA) Combo 2
 - › 2020 Baseline:
 - CIS Combo 10: 35.66%
 - IMA Combo 2: 32.49%
 - › 2021 Goals:
 - CIS Combo 10: 39.17% (66.67th Percentile)
 - IMA Combo 2: 34.43% (50th Percentile)

Improving value for state Medicaid agencies and enrollees might mean examining ways for MCEs to improve care for populations with special healthcare needs and new requirements or initiatives aimed at:

- › Increasing care coordination across MCEs, providers, and different settings;
- › Enhancing the use of and impact of patient centered medical homes;
- › Better integrating medical and behavioral health services;
- › Improving population health, such as enhanced coordination with vendors that manage carved-out benefits such as behavioral health, transportation, dental and pharmacy;
- › Addressing social determinants of health and reducing disparities; and
- › Implementing alternative payment models (APMs) with provider entities to incentivize and reward performance in priority areas.

CMS and many states are focused on increasing managed care plan use of APMs with their providers to improve the value of care delivered to Medicaid enrollees. States use a variety of models and approaches to meet this objective, including encouraging or requiring MCE use of APMs, or requiring use of specific models.⁹ To enable monitoring of whether MCEs are meeting these objectives, SOWs must include specific language requiring MCEs to report on their progress using APMs. In addition to APM reporting requirements, some states, such as Louisiana for example, impose a financial penalty on contractors that do not meet APM requirements.¹⁰

Make a Stronger Business Case for MCE and Provider Performance Improvement

States should establish clear MCE performance incentives in targeted areas. In addition, it is important to create meaningful consequences—both positive and negative—for performance and follow through. Consider having a menu of different types and levels of incentives and sanctions in the SOW and utilizing a variety of financial and nonfinancial tools to incentivize improved performance in priority areas. Examples of nonfinancial incentives for performance include public release of information, performance profiling and transparency with MCEs and stakeholders.

Develop a Select Number of Carefully Worded, Data-Driven Procurement Questions

One of the most important pieces of procurement development is developing questions to ask bidders and the related reports or sample documents to review. Responses to procurement questions are used to evaluate bidders' qualifications, and in the case of a competitive bidding process, to help the state compare bidders' potential to perform in high value areas.

Spend time identifying the exact scope and wording of procurement questions. If the submission questions do not clearly and consistently reflect the state's goals and objectives or how the state determines "value," the state will miss opportunities to differentiate bidders likely to achieve the agency's core objectives.

Typically, asking bidders to respond to about 10-15 carefully identified and worded questions (some of which may include sub-questions) should be sufficient to assess bidder qualifications. Procurement questions, sometimes in the form of "case scenarios," should be linked to contract specifications in the SOW and help distinguish the qualifications, proposed innovations and overall responses of bidders to support more effective evaluation of bids. Resist the temptation to ask bidders to respond to too many procurement questions. Sometimes more questions mean more work for bidders and reviewers but no added value for the procurement or contract management process. Avoid broad, descriptive questions asking bidders to describe processes that are likely to be lengthy to read, with similar boilerplate responses across bidders. Where possible, questions should be data driven so that responses can be objectively scored across bidders. Design questions that ask for a bidder's proposed approach to do or achieve "X" within "Y" timeframe for your state's Medicaid enrollees, including specifying expected results or requesting examples of past initiatives. Later, use bidder responses to these questions in managing future contracted Medicaid plans.

Do not ask a question about every scope of work component. Consider:

- › How will the submission question help the state to distinguish relative value for the state offered by potential bidders?
- › Does the procurement question help to identify a bidder's likely future performance under this contract?
- › How will the procurement question be evaluated?

On the next page is a sample data-driven question from Nevada's Medicaid managed care procurement related to quality improvement and clinical initiatives.¹¹

Nevada MCO RFP (2021):

The State intends to implement a required performance improvement project (PIP) to address maternal and infant health disparities within the African American population. Describe how the Vendor plans to approach this PIP, including the Vendor’s partnerships with key Providers and key community agencies serving this population, the model of care the Vendor proposes to support this population and improve maternal and infant health outcomes, the specific quality measures the Vendor will utilize to evaluate the performance of the PIP design, and the Vendor’s reporting capability to report upon the measures selected. In addition, provide at least one example of how the Vendor has addressed maternal and infant health disparities for African Americans or other high-risk maternal health membership within a Medicaid population, the measurable improvements achieved, and how the Vendor has maintained the improvements over time.

Require bidders to follow consistent numbering and format for responding to procurement questions. The more consistent the presentation of the information, the easier it will be for reviewers to assess differences across bidders without wading through pages of text or attachments. Specify page limits in the response instructions, overall and/or for specific questions. Consider limiting the number/types of attachments that will be reviewed as part of the bid.

After the procurement questions are drafted, think about how each section will be evaluated and scored as discussed in Phase III of this Toolkit. Many states use a numeric-based scoring rubric, while some, like Massachusetts, use a ratings-based scale based on ratings such as “Excellent, Very Good, Good, Fair, Poor and Non-Responsive.” Texas considers “Best Value Evaluation Criteria” in the evaluation of bidder responses to technical questions and oral presentations (see Table 5).¹²

Table 5: Texas Best Value Evaluation Criteria

Texas Best Value Evaluation Criteria
Delivers person-centered service coordination that connects Member needs to effective care.
Ensures members have timely access to the services they need.
Encourages providers to participate in the Medicaid program.
Ensures a sustainable Medicaid program by incentivizing value in the service delivery model and optimizing resources.
Uses data, technology, and reporting to facilitate and demonstrate strong performance and oversight.

Revisit and revise the questions as needed once the scoring allocations, criteria, and review process are finalized, and before the procurement is released. It is important that the submission questions are developed in a manner that allows responses to be fairly and effectively evaluated using the state’s proposed evaluation approach.

Additional Documentation to be Released With Procurements

Release procurement libraries as part of your procurement to provide potential bidders with information on the history of the Medicaid and managed care program in the state, data books that describe populations to be covered, distribution of eligible enrollees geographically, potential enrollee service history, and utilization. These documents are particularly important to potential new bidders or when bidders must submit cost proposals as part of their procurement responses. Even if bidders are not required to submit a cost proposal, data book(s) should provide sufficient, recent utilization and expenditure information to allow potential contractors to assess their ability to manage the contract successfully under the managed care rates established by the state. Depending on the size and complexity of the procurements, states may want to consider holding multiple bidders’ conferences with one or more focused solely on

the financial aspects of the program and related procurement documents, particularly when there are new managed care programs, services and/or populations.

Do not underestimate the time that it will take to collect the appropriate materials and data to be included in the procurement library. Begin thinking about and planning for the procurement library as other procurement documents are developed so all procurement documents can be released at the same time.

Often bidders will raise specific questions about materials shared, including financial and utilization data. Be prepared to answer questions regarding the procurement library in a bidder's conference and during the bid question and answer period. Typically, states will clarify that only written responses to questions or resulting amendments to procurement documents are binding.

Develop Evaluation Criteria, a Scoring Rubric, and Review Tools Reflecting the Value the State Seeks From its Contracted MCEs

Before procurement documents are posted, consider how reviewers will evaluate bidder responses to specific questions. Consider your stated procurement objectives and goals and make sure your evaluation criteria and scoring reflect these priorities. As you draft evaluation criteria, circle back to the model contract and make sure that expectations related to submission questions are clearly reflected in the SOW. If there is a procurement question that does not align with any SOW requirement, either the submission question is not appropriate, or the SOW needs to be modified before the procurement responses are due.

Managed care procurement documents should inform bidders—at a high level—of evaluation criteria, and general information on how proposals will be evaluated and scored. States vary in the level of detail they share with bidders regarding their evaluation approach. Some, like Florida, provided detailed information about how each question will be evaluated (see below). Others, like Massachusetts, provide information on the scoring process overall, but do not provide specific information by question.

Florida Patient Centered Medical Home Questions and Evaluation Criteria¹³

Respondent will describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures.

Score: Section worth a maximum of 25 raw points with the first component being worth 10 points and each of the remaining components (2-4) being worth a maximum of 5 points each.

Evaluation Criteria:

1. Extent to which the Respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
 - › Enhanced access;
 - › Coordinated and/or integrated care; and
 - › Achievement of improved quality outcomes.
2. Extent to which the Respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH as their PCP.
3. Extent to which the Respondent's description of recognizing PCMHs addresses methodologies and processes to improve child health outcomes for enrollees assigned to a PCMH as their PCP.
4. Extent to which the Respondent's description of recognizing PCMHs that focus on improving enrollee/family satisfaction.

In developing procurement documents, the state must determine whether, and to what extent, the procurement will require cost proposals from bidders. While requiring bidders to compete on price may lead to some reduction in overall costs, states can typically achieve similar results through setting rates within the lower end of the federally required actuarially sound range. Given the tradeoff between the complexity of the evaluation process where cost proposals are included and limited potential to drive down costs significantly, states may want to limit cost proposals to administrative costs only or decide to set both medical and administrative costs. Where states do request cost proposals, we recommend they only review cost proposals from bidders that meet certain minimum technical evaluation scores.

As part of the procurement development, identify key evaluation criteria, any mandatory pass/fail requirements, the maximum value or number of points a proposal can earn, and the order of importance of various subsections that will be scored.

- › **For applications** where bidders need to meet minimum requirements, be specific about the minimum criteria for bid awards.
- › **For competitive bids**, make sure the number of possible points in each scored section and overall is sufficient to enable the review panel to have meaningful differences in scoring across bids reflective of the quality of the responses.

If using a numeric-based scoring rubric, the total number of points available and the scoring weights assigned to questions are critically important. Avoid allocating too many or too few points to one question or section. An overly weighted question can make the results of reviewing other questions meaningless in selecting winning bidders. If a question does not need to be allocated many points, then the question may not need to be asked.

Do not have too few points overall—or too many questions where bidders are likely to score similarly. It is harder to defend competitive award decisions where the difference between bidders is very small.

To the right is California’s point distribution for the technical components of its competitive Medicaid managed care procurement.¹⁴ Note that more than half the total score is weighted towards the managed care goals the state prioritized for the procurement, which are described upfront in the request for proposal.

Rating Category	Section	No. of Evaluation Questions	Rating Category Weighted Max. Score as % of Total (rounded to hundredths for display)	
A	A-III-2.2 Quality Improvement and Health Equity Transformation Program (QIHETP)	14		
A	A-III-3.1 Network Provider Agreements, Subcontractor and Downstream Subcontractor Agreements, and Contractor’s Oversight Duties	3		
A	A-III-5.2 Network and Access to Care	9		
A	A-III-5.5 Mental Health and Substance Use Disorder Benefits	13		
A	A-III-4.3 Population Health Management and Coordination of Care	17		
A	A-III-5.6 MOUs with Third Parties	5		
A	A-III-4.5 Community Supports	9		
A	A-III-4.4 Enhanced Care Management (ECM)	4		
A	Rating Category A Total	74		53.01%
B	County-specific Requirements	13		
B	A-III-5.3 Scope of Services	26		
B	A-III-3.3 Provider Compensation Arrangements	3		
B	A-III-1.1 Organization and Administration of the Plan	4		
B	A-III-1.3 Program Integrity and Compliance Program	4		
B	A-III-2.3 Utilization Management	13		
B	RFP Main, Voluntary Letter of Support [See NOTE]	1		
B	Rating Category B Total	64	30.07%	
C	A-III-5.1 Member Services	2		
C	A-III-2.1 Management Information System	5		
C	A-III-4.6 Member Grievance and Appeals System	5		
C	A-III-3.2 Provider Relations	11		
C	A-III-6.0 Emergency Preparedness and Response	2		
C	A-III-5.4 Community Based Adult Services (CBAS)	2		
C	A-III-4.1 Marketing	2		
C	Rating Category C Total	29		15.10%
D	A-III-1.2 Financial Information	8		
D	RFP Main, Proposing Firm’s Capability	2		
D	RFP Main, Executive Summary	2		
D	Rating Category D Total	12	1.82%	
n/a	A-I-1.0 Definitions	0		
n/a	A-I-2.0 Acronyms	0		
n/a	A-II-1.0 Operational Readiness Deliverables and Requirements	0		
n/a	A-III-4.2 Enrollments and Disenrollments	0		
n/a	A-III-7.0 Operations Deliverables and Requirements	0		
Proposal Total			100%	

States should create evaluator trainings and bid review tools that help reviewers differentiate bids with concrete commitments from vague but well-written responses. Given the nature of and impact of protests on Medicaid managed care procurements, it's important to engage your legal and procurement specialists in the development of bid review tools, processes, and procedures.

Proposals typically are hundreds of pages and can be quite difficult to review. To make the process easier for the procurement evaluation committee, create tools that provide clarity for consistent scoring of each scored subsection. In general, reviewers should consider:

1. Has the bidder demonstrated that it has successful, relevant experience with this aspect of the required SOW?
2. Has the bidder demonstrated that it is willing and likely to successfully provide the required SOW for this particular state/region/population/service?
3. Relative to the SOW and expected value standards, what did the bidder promise to do, by when, how often/how much and with what commitment of resource?

Give the procurement evaluation committee—and the state—the opportunity to contract with the strongest organizations, promote competition, and react optimally to proposals received. When permissible by state procurement rules, review tools and processes should allow for some flexibility (e.g., including multiple topics and questions for each subcategory) for the procurement evaluation committee to allocate ratings or points related to specific submission materials in a manner that reflects their perception of the value each bidder offers to the state.

Phase III. Bid Review and Selection

Tip: *To minimize the probability of a protest occurring or being successful, it is essential the state follow its own established protocols during the bid review and selection process.*

There are many tedious tasks involved in bid review and selection that require significant state staff time, however, it is the exciting part of the process where the state gets to identify and select those bidders whose values best align with those of the state. It is time to put the evaluation criteria and review tools developed in the prior phase to use!

States should consider the following action steps during bid review and selection (see Table 6):

Table 6: Bid Review and Selection Action Steps and Considerations

Bid Review and Selection Action Step	Considerations
Receive questions from potential bidders	<ul style="list-style-type: none"> • Questions are typically due within two weeks of procurement release. Be prepared to receive many questions from bidders that may be time consuming to answer.
Respond to questions from potential bidders and modify procurement documents or timeline if needed	<ul style="list-style-type: none"> • Provide responses to bidder questions in a timely manner, often within 1-2 weeks following receipt of the questions, to ensure bidders have sufficient time to adjust their proposals. Some states release answers incrementally to get information to bidders more quickly.
Provide evaluation team with adequate time to review bids	<ul style="list-style-type: none"> • Allow the procurement evaluation committee sufficient time to thoroughly review bids independently prior to reviewing as a group to ensure a fair and comprehensive review and documentation.
Apply a systematic and fair bid review process	<ul style="list-style-type: none"> • Using consistent, objective procurement evaluation methods is necessary for the integrity of the procurement process.
Hold oral presentations (optional)	<ul style="list-style-type: none"> • Presenters should be limited to proposed leadership and key personnel. Consultants should not be allowed to attend. This gives the state an opportunity to interact directly with the team that would be responsible for delivering the contracted services.
Recommend successful bidders	<ul style="list-style-type: none"> • Allow the evaluation team time to finalize summary documents justifying their decisions, check the math, and present selections to state leadership. Develop a memo that supports the recommendations of the procurement evaluation committee.
Announce award recommendations	<ul style="list-style-type: none"> • Be mindful of all of the necessary approvals prior to announcing award recommendations, some of which may be outside of the Medicaid agency.
Anticipate a protest period	<ul style="list-style-type: none"> • Plan for a protest, which can take months (or sometimes years) to resolve depending on your state’s procurement laws. Develop a strategy to mitigate protest outcomes, and plan for your next steps should it happen.

Identify and Effectively Utilize Procurement Evaluation Committees With Appropriate Expertise

The specific members and size of your procurement evaluation committee should be discussed early on with involved state agencies and department leaders as noted in Phase I:

- › **Identify an odd number** of qualified voting members to participate in the bid review, preferably no more than five voting members. Teams larger than this may be less efficient.
- › **If the procurement is for an existing Medicaid managed care program(s)**, at least one senior manager overseeing the current MCEs should be included as a voting member.
- › **If there is a price component** to the bid or if bidder's financial data is being reviewed, individuals with financial expertise should review the financial components of the bid.
- › **Consider whether staff** from another state agency, such as the behavioral health department or public health department, should participate in the review.

Not every member of the review team needs to be a voting member of the procurement evaluation committee. The committee should be supported by SMEs who provide targeted reviews of individual sections of the proposals and present their summary analysis and scoring recommendations. SMEs are particularly helpful for reviewing certain proposal sections, such as submissions related to clinical quality (e.g., HEDIS measures and performance) and financial stability.

The responsibilities of the SMEs differ from that of the procurement evaluation committee members:

- › **SMEs may not be required** to review all bid submissions;
- › **SMEs are advisers**, not voting members, though they may recommend scores;
- › **SMEs should report** their review findings to the procurement evaluation committee in writing or in person; and
- › **SMEs may be invited** to attend procurement evaluation committee meetings, respond to questions, and/or to provide oral presentation to the committee.

The state should confirm that procurement evaluation committee participants and SMEs have no conflicts of interests or close personal relationships with any bidders. All participants should be trained related to fair procurement processes and the need for confidentiality.

Apply a Systematic and Fair Bid Review Process

Make sure all SMEs responsible for reviewing select portions of bids and procurement evaluation committee members are trained on the review tools to ensure a systematic approach to scoring. Seek consensus on scoring, rather than averaging individual scores that may vary widely.

The procurement evaluation committee must strictly adhere to a clear and logical bid review process to help protect the state agency against challenges from bidders that are not selected. All bids meeting submission standards and mandatory requirements should be treated in the same manner and be given equal consideration. Build steps into the review process to protect against potential bias in the evaluation, and to ensure comprehensive documentation in support of the procurement evaluation committee's recommendation.

Ensure that scoring is applied consistently across proposals. To do this, it is helpful to have a facilitator for the procurement evaluation committee meetings who is focused on maintaining the fairness and consistency of the review process. Prior to procurement evaluation committee meetings, each reviewer should independently read and comment on each proposal using the review tool as a guide.

Procurement evaluation committee members should receive consistent instructions and guidelines, such as:

- › Review all proposals and all elements of the response fully and thoroughly (even if a SME is also available and scoring);
- › Evaluate content—not style—of proposals;
- › Focus on evaluation criteria set out in the procurement documents;
- › Examine bidder performance data to identify gaps relative to standards and objectives specified in the model contract;
- › Although information may not be in the correct location in the procurement materials, make sure it is taken into account when reviewing a bidder's response to a standard question;
- › Follow the prescribed procedures for documenting the strengths and weaknesses, or deficiencies, of each bidder's proposal; and
- › Request SME input if necessary to understand a bidder's response.

Lastly, establish procedures for procurement evaluation committee meetings, including modifications for virtual participation.

Phase IV. Contract Execution, Readiness Review and Implementation

Tip: Start planning for readiness review and implementation activities prior to bidder selection and MCE contract award(s) so you can quickly shift your attention to ensuring a successful managed care program go-live.

Contract execution, readiness reviews and implementation activities are the next steps in the procurement process. States will quickly shift their attention and resources from procurement activities to ensuring operational readiness, to ensure a smooth transition to new managed care programs, MCEs, populations, or services.

States should consider the following action steps during Phase IV (see Table 7):

Table 7: Contract Execution, Readiness Review, and Implementation Action Steps and Considerations

Contract Execution, Readiness Review and Implementation Action Steps	Considerations
Execute MCE contract(s)	<ul style="list-style-type: none"> Incorporate a bidder’s proposal commitments into formal MCE contract documents as a way to hold MCEs accountable for the promises made in their proposals.
Prepare for readiness reviews	<ul style="list-style-type: none"> Develop timelines and a checklist based on items identified in the model contract. The scope and intensity of readiness review will differ whether it is an incumbent contractor versus a new vendor. See <i>Appendix A</i> for Louisiana’s readiness review requirements.
Conduct readiness reviews	<ul style="list-style-type: none"> Reviews must be conducted at least 90 days before the operational effective date; readiness review results must be submitted to CMS for approval of any associated MCE contract. Carefully review MCEs’ submissions to ensure all MCEs will be ready for go-live.
Go-live! (operational effective date, or program start date)	<ul style="list-style-type: none"> Do not underestimate the need for staff training at the state, MCE, and provider levels to achieve desired results. In addition, where there is a change in MCEs, it is essential to provide appropriate notice and information to enrollees to select a new MCE.
Document procurement lessons learned	<ul style="list-style-type: none"> Document procurement lessons learned in a systematic way so they can be resurfaced in future procurements, particularly when there is turnover in state staff.

Use Readiness Review Requirements From Procurement Documents to Pivot to Implementation

Readiness reviews are required under federal law when a state newly implements a managed care program, contracts with a new MCE, or expands an MCE contract to cover new eligibility groups or new benefits. Readiness reviews are an important step to ensuring selected bidders will be ready to deliver managed care services and benefits on the operational effective date.

The state’s SOW or model contract developed in Phase II should include requirements for readiness reviews. Utilize these requirements to develop a readiness review timeline that can be quickly shared with successful bidders.

See *Appendix A* for an example of readiness review requirements from Louisiana’s 2021 model contract.¹⁵

Phase V. Contract Management

Tip: Think of the MCO contract management process as an extension of the procurement process—because it is!

Managed care procurements can mean significant and ongoing changes for a state Medicaid agency and its contracted plans. As part of your routine MCE contract management process, create a schedule and expectations for reviewing documentation and meeting with individual MCEs to determine whether they are implementing improvements as promised, according to the timelines and parameters required under the contract and/or proposed by the MCE.

Leverage the Procurement Process to Prioritize Performance Improvement

Use information obtained in the procurement to prioritize performance improvement efforts for the initial MCE contract year(s). Similarly, use MCE proposals as the foundation for ongoing MCE contract management priorities. Bidders are trying to win your business and will promise to do things in their proposals, more so than once they have been awarded a contract. Create mechanisms in your contract management approach to hold successful bidders to those promises. Establish a system and a timeline for revisiting MCE performance to specified activities and timelines identified in their bids. For example, a state that asks bidders to commit to increasing APMs in the procurement could ask MCEs to prepare and present changes they have made in their APMs six months after the operational start date of the new contracts.

Appropriate Leadership to Support Proactive Contract Management

Holding vendors accountable is more than just creating good contracts, incentives, and penalties. To effectively manage MCE contracts, Medicaid staff responsible for oversight of contracts need to be able to engage MCE leadership on equal footing. The state Medicaid managed care program director should be a senior department leader with oversight over skilled contract management staff. Medicaid agencies can utilize the following steps to implement contract management strategies with MCEs.

Establish MCE Contract Management Teams and New Internal Accountability

To effectively oversee and manage MCEs, engage more staff and partners in different ways. Many Medicaid agency staff can and should have a role to play in MCE contract management. They should:

- › **Consider new accountability structures** for state staff and re-focusing of staff resources to manage contracted MCEs;
- › **Identify skill sets** and/or individuals that could play a larger role in the state's oversight and engagement of contracted MCEs;
- › **Sponsor MCE meetings** and work groups to foster collaboration and performance improvement; and
- › **Encourage interagency collaborations** in monitoring and managing MCEs.

Some states have developed MCE contract management teams in a matrix management approach with members from across the agency, including staff with expertise in contracting, quality, clinical, finance, managed care, behavioral health, pharmacy, and/or data analytics. All senior managers and teams should both be empowered and held accountable for assigned MCEs achieving annual performance improvement goals. Consider tying annual state agency

goals, and potentially individual staff performance measurement, to MCE performance on contractual improvement goals. Medicaid MCE work groups can be staffed and led by agency employees with specific expertise inside or outside Medicaid managed care departments (e.g., quality, information technology, pharmacy, behavioral health and maternal and child health). Work groups enable states to leverage MCE and other state staff expertise to improve performance of the managed care program. Work groups make use of the state's power as a convener of plans and stakeholders to address common challenges and solve problems.

Develop Structure for Ongoing Quality Conversations and Meetings

States should establish regular processes that focus on MCE performance to pre-established objectives and targets in high priority clinical and service areas. 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.

Establish regular, substantive in-person meetings on MCE performance and provide substantial internal and external transparency on MCE-level performance regarding the extent to which each MCE is meeting expected performance levels for quality, efficiency, or other priority measures (e.g., using the dashboards to support the discussions). In advance of these meetings, states should identify the specific MCE performance areas to be discussed, the process and timeline for reviewing performance in the future, and specific performance goals. In Arizona and Tennessee, for example, senior Medicaid managed care staff regularly meet with senior leaders at each plan individually and in small groups to discuss strategic and performance expectations, challenges, and trends in performance. Staff from these states emphasized the importance of having structured performance-focused meetings (not during rate meetings) with MCE C-suite executives and state Medicaid leadership on at least a semi-annual basis.¹⁶

Conclusion

Implementing a statewide, competitive procurement for Medicaid managed care is one of the most important things state purchasers do to improve value for enrollees and taxpayers. Doing so requires significant and ongoing focus on performance improvement in each phase of the procurement cycle: 1) strategic procurement planning, 2) solicitation development, 3) bid review and selection, 4) contract execution, readiness review and implementation, and 5) contract management.

Throughout the process, both the state and MCEs must remain focused on the big picture: improving the health of populations that have been economically/socially marginalized while being sensitive to the prudent use of taxpayers' dollars. States should use the procurement process to identify areas where variability in MCE and provider practice exists and where gaps between current practices and knowledge can be closed during the contract period. States should consider annual or bi-annual performance improvement goals, including Medicaid managed care baseline, mid-cycle, and final evaluation periods to track improvement gains at the plan and program level. Initially, and over time, states should seek additional value—such as improvements in population health, health equity, quality, and safety as well as improvements in Medicaid managed care processes and efficiencies.

States must effectively collaborate—both internally and externally—to define and continually add value to Medicaid managed care programs on behalf of enrollees and taxpayers. Think creatively about how to staff and support your Medicaid managed care program and procurement process. In reviewing bids, focus on identifying MCE partners likely to meet your value expectations. Work with the successful MCEs to create and implement incentives and supports to reward high-value providers. Finally, do not overlook opportunities to coordinate your Medicaid purchasing and oversight efforts with other purchasers, such as aligning performance measures to reduce the noise for plans and providers.

Appendix A: Louisiana's Model Contract Readiness Review Requirements

PART 2: CONTRACTOR RESPONSIBILITIES

2.1 Contract Transition & Readiness

2.1.1 Transition Phase

2.1.1.1 The Contractor shall submit to LDH or its designee as part of Readiness Review, for its review and approval, a Transition Work Plan that demonstrates how it will accomplish required tasks set forth in this Contract before the Operational Start Date and provide documentation of the following:

2.1.1.1.1 Project management structure;

2.1.1.1.2 Communication protocols between LDH and the Contractor;

2.1.1.1.3 Contacts for readiness activities;

2.1.1.1.4 Schedule for key activities and milestones; and

2.1.1.1.5 Process for ensuring continuity of care for Enrollees during the transition with a focus on health and safety.

2.1.1.2 The Contractor shall provide monthly status reports that track implementation progress against the schedule in the Transition Work Plan, as approved by LDH in writing, for six (6) months following the Operational Start Date.

2.1.2 Readiness Review

2.1.2.1 LDH or its designee will conduct a comprehensive Readiness Review of the Contractor prior to the Operational Start Date in accordance with 42 C.F.R. §438.66(d). LDH will provide the Contractor with the Readiness Review schedule. The Contractor agrees to provide all materials required to complete the Readiness Review by the dates established by LDH. The review may include an evaluation of all deliverables as defined in the Contract. A portion of the Readiness Review will be performed onsite at the Contractor's administrative office. The Contractor shall be responsible for all travel costs incurred by LDH, or its designee's, staff participating in onsite Readiness Reviews. The results of the Readiness Review will be submitted to CMS by LDH for CMS to make a determination that the contract or associated contract amendment is approved under 42 C.F.R. §438.3(a).

2.1.2.2 The Contractor must disclose any changes to proposed key staff, subcontractors, or value added benefits identified in the proposal for LDH approval.

2.1.2.3 The Contractor must have successfully met all Readiness Review requirements established by LDH no later than sixty (60) Calendar Days prior to the Operational Start Date or by the dates established by LDH in writing when applicable.

2.1.2.4 If the Contractor does not fully meet the Readiness Review prior to the Operational Start Date, LDH may impose a Monetary Penalty for each Calendar Day beyond the Operational Start Date that the Contractor is not operational.

2.1.2.5 The Contractor is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) Calendar Days after written notification of any such deficiency by LDH or its designee. If the Contractor documents to LDH's satisfaction that the deficiency has been corrected within ten (10) Calendar Days of such deficiency notification by LDH or its designee, no Corrective Action Plan is required.

2.1.2.6 System Readiness

2.1.2.6.1 The Contractor will define and test modifications to the Contractor's system(s) required to support the business functions of the Contract. The Contractor will produce data extracts and receive data transfers and transmissions. The Contractor must be able to demonstrate the ability to produce encounter files.

2.1.2.6.2 If any errors or deficiencies are evident, the Contractor will develop resolution procedures to address the problem identified. The Contractor will provide LDH or its designee with test data files for systems and interface testing for all external interfaces.

2.1.2.7 The Contractor shall participate in additional Readiness Reviews when providing or arranging for the provision of MCO Covered Services to new eligibility groups in accordance with 42 C.F.R. §438.66(d)(1) as directed by LDH.

PART 3: STATE RESPONSIBILITIES

3.1.5 Readiness Review

3.1.5.1 LDH or its designee will assess the performance of the selected MCOs prior to and after the begin date for operations in accordance with 42 C.F.R. §438.66(d). LDH expects to complete the Readiness Review at least three (3) months prior to the Operational Start Date. Each Readiness Review for entities that did not contract with LDH as an MCO immediately prior to the Contract effective date shall be performed via a desk review of documents and on-site at the Contractor's Louisiana administrative offices and shall include an assessment of the Contractor's ability and capability to perform satisfactorily in the areas noted below as set forth in 42 C.F.R. §438.66(d)(4). All selected MCOs must participate in a comprehensive Readiness Review if required by LDH; however, LDH retains the discretion to conduct a more limited Readiness Review for existing MCO contractors. LDH or its designee may conduct additional Readiness Reviews of the Contractor prior to enrolling additional populations in managed care or prior to adding or deleting covered services from Attachment C, MCO Covered Services.

3.1.5.2 The scope of the Contractor's Readiness Review may include, but is not limited to, a review of the following elements against the requirements provided in this Contract and the MCO Manual:

3.1.5.2.1 Administrative staffing and resources, including key personnel;

3.1.5.2.2 Delegation and oversight of Contractor responsibilities, including capabilities of material subcontractors;

3.1.5.2.3 Enrollee and provider communications, including Enrollee services capability;

3.1.5.2.4 Grievance and Appeals;

3.1.5.2.5 Enrollee services and outreach, including marketing materials;

3.1.5.2.6 Provider network management plans and model Network Provider Agreements, including any provider performance incentives;

3.1.5.2.7 Program integrity and compliance, including Fraud, Waste, and Abuse;

3.1.5.2.8 Service delivery, including care management capabilities, quality management and quality improvement, and utilization review;

3.1.5.2.9 Financial management, including financial reporting and monitoring and financial solvency; and

3.1.5.2.10 Systems management, including claims management, encounter data and Enrollee information management, and, at the request of LDH, a walkthrough of any information systems, interfacing and reporting capabilities, and validity testing of encounter data, including IT testing and security assurances.

3.1.5.3 LDH shall not enroll Potential Enrollees into the MCO until LDH determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review, except as provided below.

3.1.5.4 LDH shall identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion:

3.1.5.4.1 Allow the Contractor to propose a plan to remedy all deficiencies prior to the Contract Operational Start Date;

3.1.5.4.2 Postpone the Contract Operational Start Date for any MCO that fails to satisfy all Readiness Review requirements; or

3.1.5.4.3 Enroll Enrollees into the MCO as of the Contract Operational Start Date provided the Contractor and LDH agree on a Corrective Action Plan to remedy any deficiencies.

3.1.5.5 If, for any reason, the Contractor does not fully satisfy LDH that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and LDH does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then LDH may terminate the Contract and shall be entitled to recover damages from the Contractor.

3.1.5.6 LDH shall submit the results of the Readiness Review to CMS in order for CMS to make a determination that the Contract or associated Contract amendment is approved under 42 C.F.R. §438.3(a).

ENDNOTES

- ¹ Bailit Health conducted a national scan in Fall 2021 as part of a project for the Medicaid and CHIP Payment and Access Commission. The scan included procurements released between September 2016 and August 2021.
- ² North Carolina published a summary of input from written comments and public listening sessions held throughout the state: https://files.nc.gov/ncdhhs/PublicCommentsSummary_Medicaid_April-May_2017.pdf.
- ³ Leading up to North Carolina's 2018 Medicaid managed care procurement, the state released approximately 13 proposed managed care policy concept papers, which typically included a public comment period, covering a range of topics: <https://www.ncdhhs.gov/divisions/aging-and-adultservices/nc-emergency-solutions-grant/policy-papers>.
Louisiana released a whitepaper in advance of its 2019 Medicaid managed care procurement summarizing the state's future managed care vision and policy considerations and held public forums across the state to seek input: https://ldh.la.gov/assets/HealthyLa/LDH_MCO_RFP_WP.pdf.
Texas invites potential Medicaid managed care bidders to pre-solicitation meetings to introduce their company's capabilities and service delivery benefits, provide thoughts and/or recommendations on the HHSC procurement process; and provide input and/or recommendations on future contracts: <https://www.hhs.texas.gov/news/2020/11/hhsc-schedule-star-health-pre-solicitation-vendor-meetings>.
- ⁴ Ohio's Medicaid managed care procurement vision and the stakeholder process is described here: <https://managedcare.medicare.ohio.gov/managed-care/managed-care-procurement>.
- ⁵ In this document, we use the term scope of work (SOW).
- ⁶ For an example of state responsibilities included in a SOW, see Part 3 of the Louisiana Medicaid Managed Care 2021 model contract: https://ldh.la.gov/assets/medicaid/RFP_Documents/MCO/RFP2021/Attachments/AttachmentAModelContract.pdf.
- ⁷ Tennessee's Medicaid Managed Care Contract can be accessed here: <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>.
- ⁸ Tennessee's Medicaid Managed Care quality strategy can be accessed here: <https://www.tn.gov/content/dam/tn/tenncare/documents/qualitystrategy.pdf>.
- ⁹ "Medicaid Managed Care Contracts as Instruments of Payment Reform." Catalyst for Payment Reform, December 2019. https://www.catalyze.org/wpcontent/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf.
- ¹⁰ Louisiana's Medicaid managed care executed contracts can be accessed here (refer to Section 5.4 Withhold of Capitated Payments): <https://ldh.la.gov/page/1763>.
- ¹¹ Nevada's 2021 Medicaid Managed Care RFP can be accessed here: <https://nevadaepro.com/bso/external/bidDetail.sdo?bidId=40DHHS-S1457&parentUrl=activeBids>.
- ¹² Information regarding Texas' proposed Medicaid Managed Care STAR and CHIP Best Value Criteria can be accessed here: <https://www.hhs.texas.gov/news/2022/04/request-public-comment-best-valuecriteria-star-chip-managed-care-procurement>. The criteria, as used in the 2022 STAR+PLUS RFP, can be accessed here: <https://www.txsmartbuy.com/esbddetails/view/HHS0011062>.
- ¹³ Additional examples of Florida Medicaid managed care procurement evaluation criteria can be found in the 2018 Intent to Negotiate: <https://www.floridahealth.gov/programs-and-services/childrenshealth/cms-plan/cms-plan-invitation-to-negotiate/itn-response-materials.html>.
- ¹⁴ California's 2022 Medi-Cal Managed Care Plan procurement can be accessed here (follow instructions to "View Event Package" and download RFP; refer to RFP Attachment 11): https://caleprocure.ca.gov/pages/Events-BS3/eventdetails.aspx?Page=AUC_RESP_INQ_DTL&Action=U&AUC_ID=20-10029&AUC_ROUND=1&BIDDER_ID=BID0000001&BIDDER_LOC=1&BIDDER_SETID=STATE&BIDDER_TYPE=B&BUSINESS_UNIT=4260.
- ¹⁵ Louisiana's 2021 Medicaid Managed Care RFP and Model Contract can be accessed here: <https://ldh.la.gov/page/4199>.
- ¹⁶ Arizona and Tennessee report that senior Medicaid managed care staff regularly meet with senior leaders at each plan individually and in small groups to discuss strategic and performance expectations, challenges, and trends in performance.

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT BAILIT HEALTH

This toolkit was prepared by Beth Waldman, Mary Beth Dyer, and Erin Campbell. 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.bailithealth.com.