Success Begins with Selection: Tips on Assessing Bidders' Past Performance for States Procuring Integrated Care Plans

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Many state Medicaid agencies that operate integrated care programs for dually eligible individuals using Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs) employ procurement processes to select the plans that will be responsible for covering Medicaid benefits within those programs. For these states, the past Medicare and Medicaid performance of bidding organizations are both relevant to the organizations' potential to successfully operate an integrated care plan. However, while many states have experience evaluating the past performance of Medicaid managed care plans, few have experience evaluating a bidding organization's past MA and/or D-SNP performance to understand if the organization is qualified to operate a D-SNP, its experience delivering high-quality integrated care to dually eligible individuals, and its ability to help the state meet its integrated care goals.

This tip sheet, which adds to the Integrated Care Resource Center (ICRC)'s existing tools on D-SNP contracting, is designed to help states that are planning procurements related to their integrated care programs for dually eligible individuals. Specifically, this tip sheet aims to help these states: (1) understand the relationship between state efforts to procure Medicaid managed care plans for these programs and the state's D-SNP contracting strategy; (2) consider options for incorporating Medicare resources into integrated care program procurements; and (3) identify and use Medicare resources to inform state selection of Medicaid managed care plans that will cover Medicaid benefits for D-SNP enrollees.[1] To that end, it describes five steps that states can take when developing Medicaid managed care procurements for integrated care programs:

1. Develop scoring criteria that consider bidding organizations' past Medicare and Medicaid performance;
2. Evaluate bidding organizations' Medicare performance using available Medicare data and resources;

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3. Consider bidding organizations' ability to offer integrated coverage of Medicare and Medicaid benefits;
4. Establish contingency provisions for selected organizations that are ultimately unable to meet integrated care program requirements; and
5. Assess the impact of sanctions issued by the Centers for Medicare & Medicaid Services (CMS) on bidding organizations' ability to participate in the state's integrated care program.

1 Develop Scoring Criteria That Consider Bidding Organizations' Past Medicare and Medicaid Performance

Most states with Medicaid managed care programs use competitive procurement to select managed care plans. In addition to assessing bidders' ability to comply with federal Medicaid managed care regulations (see 42 C.F.R. § 438), states award contracts to bidders with higher scores (that is, more points) on a broad range of qualifications and metrics. These metrics include, for example, financial solvency and medical loss ratio performance, access to covered benefits, quality of services, encounter data reporting, program integrity safeguards, and experience serving eligible populations. When developing scoring criteria for integrated care program procurements, states should also consider: (1) the qualifications and past performance of the bidding organizations' affiliated MA plans and D-SNPs (or, if needed, affiliated MA plans and D-SNPs under a different named legal entity that is part of the same parent company), in addition to the past performance of the organizations' Medicaid managed care plans, and (2) bidding organizations' past experience serving dually eligible populations within the state/local region. For example, thoughtful scoring criteria can:

- Assign maximum points to organizations with strong Medicare and Medicaid past performance and local capacity/experience;
- Assign fewer points to organizations with poor Medicare and/or Medicaid past performance and no prior local capacity/experience;
- Allow organizations without local capacity or experience to score comparably or better than local organizations that have poor past performance if they can demonstrate their ability to serve the state's dually eligible population and help the state meet its integrated care goals;
- Avoid awarding contracts to organizations that are sanctioned by CMS if the sanction will prevent the organization from performing the duties required within the state's integrated care program, as would occur, for example, if an organization received a sanction prohibiting it from enrolling new beneficiaries. (See section 5 of this tool for more information about CMS sanctions.)

Sections two and three below describe how states can incorporate this information into their procurement decisions.

2 Evaluate Bidding Organizations' Past Medicare Performance Using Available Medicare Data and Resources

In the past, some states have relied primarily on narrative responses from bidders to understand how each bidder would approach implementation of the state's managed care requirements. Although narrative responses can provide helpful supporting details, states should gather Medicare performance data and

resources for each plan and use those data and resources to make more informed procurement award decisions. **Appendix A** describes how states can gather these data and resources from CMS, bidding organizations, or both.

States can use a variety of resources to assess bidding organizations' past Medicare performance. Examples of these resources include:

- **Special Needs Plan (SNP)-specific Healthcare Effectiveness Data and Information Set (HEDIS) measures**, which measure the plan-level performance of MA Special Needs Plans, including D-SNPs, on 13 individual and composite quality measures, such as colorectal cancer screening, care for older adults, and follow-up after hospitalization for mental illness;
- **Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures**, which are designed to assess patient experience in a variety of specific health care settings;
- The **Medicare Health Outcomes Survey (HOS)**, a survey of MA plan enrollees about their physical, mental, and functional health; and
- **Medicare Star Ratings**, which are designed to help consumers compare the quality of MA and Part D prescription drug plans.

Medicare resources should supplement, not supplant Medicaid resources in states' Medicaid managed care requests for proposals (RFPs). States should still rely on Medicaid resources to evaluate bidding organization's past Medicaid performance and experience, particularly for Medicaid-covered benefits like long-term services and supports and behavioral health.

Summary results from CMS audits of MA plans and CMS corrective action plans (CAPs) for MA sponsors found noncompliant with CMS requirements are also publicly available for use by states. While states can potentially use these resources to identify bidders with negative performance findings, as part of their procurement process states should consider requesting that bidders provide complete CMS audit reports and CAPs for their organizations for a determined time period to better inform their evaluations of bidders' qualifications.

For information on how to access and use these resources, see ICRC's guide to CMS data resources and ICRC's tip sheet on incorporating D-SNPs into Medicaid quality oversight activities.[2] Additionally, **Appendix A** contains information on these and other Medicare resources available to monitor and evaluate D-SNP quality and performance.

For example, states interested in improving behavioral health outcomes in their integrated programs can review bidding organizations' SNP HEDIS measure results to assess their past performance on behavioral health measures. Specifically, states can review performance on the SNP HEDIS measures "Antidepressant Medication Management" and "Follow-Up After Hospitalization for Mental Illness" when assessing bidding organization's past performance providing behavioral health services.

When selecting Medicare resources to evaluate the qualifications and past D-SNP/MA plan performance of organizations bidding for Medicaid managed care contracts, states should understand that some Medicare resources, such as MA star ratings, are reported only at the MA contract level. An MA plan or D-SNP is often only one of several plans incorporated into a single MA contract, which dilutes states' ability to leverage contract-level resources for assessing plan performance. To address this issue, states can request that bidding organizations submit, to the extent possible, disaggregated information, such as HEDIS

performance measure scores, at the plan level for plans within their relevant MA contracts.[3] States that require at least some D-SNPs to operate with exclusively aligned enrollment can also require D-SNPs to operate within state-specific, D-SNP-only MA contracts with CMS,[4] which allows the state to gather information specific to the D-SNPs within each state. **Appendix A** includes the level (e.g., plan, contract, and sponsor) at which D-SNP data is reported for each Medicare resource.

If a bidding organization will be required to establish a new D-SNP in response to the state's RFP, there will not be any D-SNP-specific Medicare past performance resources available for that specific D-SNP. However, the state can request information regarding the bidding organization's performance for other MA plans in the state, as well as information for D-SNPs that the organization has operated in other states, such as neighboring states, similar states, and/or in states that already operate integrated care programs that are similar to what the state is aiming to achieve.

3 Consider Bidding Organizations' Ability to Offer Integrated Coverage of Medicare and Medicaid Benefits

In addition to evaluating bidding organizations' past Medicare and Medicaid performance, states should also assess the organizations' past experience covering Medicare and Medicaid benefits for dually eligible populations. Relevant past experience may include experience operating a Medicaid managed care plan, MA plan, D-SNP, and/or Medicare-Medicaid Plan (MMP) for dually eligible individuals within the state, nearby states, and/or similar states.

States should also assess the adequacy of bidding organizations' Medicare and Medicaid provider networks. CMS conducts triennial D-SNP network adequacy reviews, and states can require that bidding organizations submit the CMS network adequacy review results to them as part of the state's procurement process.[5] There are several methods available to states to assess a bidding organization's Medicaid provider networks, particularly for long-term services and supports (LTSS) and behavioral health services given the need for those services among dually eligible individuals. This includes reviewing External Quality Review (EQR) network adequacy validation results and Managed Care Program Annual Reports (MCPAR) of states in which a bidding organization operates a Medicaid managed care plan.[6,7] If bidding organizations would need to establish new D-SNP contracts with CMS for the state's integrated care program, the state may add contingency language (see section 4) to its RFP and its D-SNP State Medicaid Agency Contract (SMAC) regarding step(s) to be taken if the organization's D-SNP does not meet CMS network adequacy requirements.

4 Establish Contingency Provisions for Selected Organizations That Are Unable to Meet Integrated Care Program Requirements.

Even with thoroughly developed RFPs and detailed procurement plans, unexpected challenges can arise in which bidding organizations fail to meet critical integrated program requirements. For example, because MA and Medicaid procurement cycles are often not aligned, a state may select a bidding organization under the state's Medicaid procurement that goes into effect on (for example) July 1, 2024, before the January 1, 2025 date when the organization's newly established D-SNP contract with CMS is due to go into

effect. If the organization fails to meet the CMS network adequacy criteria as part of its overall MA application and is therefore unable to obtain the MA contract to offer a D-SNP from CMS, the state is left without integrated care for that organization's Medicaid managed care enrollees. To protect themselves from such scenarios, states should establish and include in their RFPs contingency provisions for situations when bidding organizations become unable to meet the state's integrated program requirements. Examples of potential contingency strategies include:

- If a selected bidding organization cannot meet all the state's program requirements by a particular date, the selection is canceled.
- If a selected bidding organization cannot meet all program requirements by a particular date, the organization has one year to meet the requirements.
- If a selected bidding organization can only meet program requirements in some but not all service areas covered by the integrated program, the selected bidder's service area will be reduced to the area in which it meets those requirements.

5 Assess the Impact of CMS Sanctions on Bidding Organizations' Ability to Participate in the State's Integrated Care Program

CMS can issue sanctions for noncompliance with a variety of MA requirements, and these sanctions can affect organizations' ability to operate D-SNPs in integrated care programs. For example, failure to comply with CMS' medical loss ratio requirements (see 42 C.F.R. § 422, Subpart X) can result in sanctions including a prohibition on new enrollment (see 42 C.F.R. § 422.2410).

States should avoid awarding an integrated care program contract to a bidding organization that is currently under sanction, as CMS sanctions can prevent organizations from holding MA contracts with CMS, which thereby inhibits the organization from meeting the state's integrated program goals. To that end, states can build scoring criteria that reflect CMS compliance and enforcement information and review this information as part of the procurement process. In addition, states can withdraw an award if a CMS sanction prevents the bidding organization from establishing a D-SNP in the state.

To obtain information about current CMS sanctions, states can require bidding organizations to disclose in their bids whether any of the organization's D-SNPs or MA plans are under a sanction based on CMS enforcement actions. To obtain information on potential sanctions, states can require bidding organizations to submit with their bids copies of all ongoing CMS compliance or enforcement actions, such as notices of non-compliance, warning letters, corrective action plan requests, civil monetary penalties, and/or terminations concerning the organizations' existing or pending MA contracts.

Putting It All Together

States can use a variety of resources to evaluate bidding organizations' past Medicare and Medicaid performance when procuring plans for integrated care programs for dually eligible individuals. By taking the five steps described in this tool – (1) developing scoring criteria that incorporate bidders' past Medicare and Medicaid performance; (2) leveraging the Medicare resources mentioned in section 2 and Appendix A to assess bidding organizations' past Medicare performance; (3) considering organizations' ability to offer integrated Medicare and Medicaid benefits; (4) establishing contingency provisions for selected organizations that are ultimately unable to meet the state's integrated care program requirements; and (5) assessing the role of CMS sanctions in organizations' ability to participate in the state's integrated care

program – states can design procurement processes that will help them select organizations with the breadth and depth of experience and expertise needed to deliver high-quality integrated care to dually eligible populations.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] In some cases, states may contract directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees, in which case the D-SNPs will serve as the Medicaid managed care plans. For more information on this method of contracting, see: https://integratedcareresourcecenter.com/sites/default/files/Managed%20Care%20Authorities%20Tip%20Sheet%205-15-23.pdf. The information contained in this tip sheet is applicable to procurements under those arrangement as well.

[2] In addition to these resources, states will have access beginning in 2027 to the CMS Health Equity Index (HEI). The HEI will summarize contract-level performance among enrollees with social risk factors (SRF) across multiple, existing star ratings measures in a single score. SRFs included in the HEI are: (1) low-income subsidy status; (2) dually eligible status; and (3) disability status. Although CMS will make the HEI available at the contract level, states that require D-SNPs to operate within state-specific, D-SNP-only contracts can gather HEI data specifically for the D-SNP(s) in their state.

[3] Note that this may or may not be possible for all plans/measures, as some plans may not have sufficient enrollment size to calculate plan-level measure scores.

[4] This option is available through the authority described at 42 C.F.R. § 422.107(e).

[5] More information on CMS network adequacy reviews can be found at: https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance06132022.pdf.

[6] Under 42 C.F.R. § 438.66(e), states must submit their MCPARs to CMS no later than 180 days after each contract year and post their MCPARs on their websites.

[7] More information on assessing Medicaid network adequacy can be found in the following documents: Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability; Managed Long-Term Services and Supports Access Monitoring Toolkit (medicaid.gov); and Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit.

Appendix A: Medicare Resources Available to States to Monitor D-SNP Performance and Quality Improvement

Medicare Resource	Description of Resource	Frequency of Data Reporting	Sources from Which the State Can Obtain Resource	Level at Which Data Are Reported (Plan, Contract, Sponsor)
CAHPS Measures[a]	CAHPS measures contain information collected via surveys about enrollees' experiences with their MA plans. CAHPS measures also contribute to Medicare star ratings.	Annual	From bidding organization on request through procurement bidding process	Contract
CAPs[b]	Corrective Action Plans (CAPs) are issued by CMS to MA sponsors to address persistent and/or serious performance issues.	Varies by MA sponsor; CAPs are issued on an ad hoc basis	• CMS (CAP request letters) • From bidding organization on request through the procurement bidding process (complete CAP report)	Sponsor
CCIPs[c]	As part of MA quality improvement programs, all MA plans (including D-SNPs) implement Chronic Care Improvement Programs (CCIPs), which promote improved health outcomes for enrollees with chronic conditions.	Varies by plan; MA organizations must report CCIP information to CMS as requested	From bidding organization on request through procurement bidding process	Plan
HEDIS Measures Reported by MA Contracts[d]	HEDIS measures are a set of standardized quality measures calculated using data submitted by MA contracts, on topics such as effectiveness of care, access, and utilization. HEDIS data also contribute to Medicare Star Ratings.	Annual	• CMS website • From bidding organization on request through the procurement bidding process	Contract
HEDIS Measures Reported by SNPs[e]	SNP-specific HEDIS measures are a set of standardized quality measures that are calculated specifically for MA Special Needs Plans, including D-SNPs. These measures identify each SNP's performance scores on measures such as follow-up after hospitalization for mental illness and plan all-cause readmissions.	Annual	• CMS website • From bidding organization on request through the procurement bidding process	Plan

Medicare Resource	Description of Resource	Frequency of Data Reporting	Sources from Which the State Can Obtain Resource	Level at Which Data Are Reported (Plan, Contract, Sponsor)
Medicare HOS[f]	The Medicare HOS is a physical and mental health survey of enrollees in MA plans. HOS data also contribute to Medicare Star Ratings and HEDIS measures.	Annual	• CMS website • From bidding organization on request through the procurement bidding process	Contract/Plan
Medicare Star Ratings[g]	Medicare Star Ratings provide performance scores for MA contracts based on outcome, patient experience, access, and process measures.[h]	Annual	• CMS website • From bidding organization on request through the procurement bidding process	Contract
Past Performance[i]	CMS can issue 'intent to deny' and 'application denial' notices for a MA contract application due to past performance issues, such as having summary Medicare star ratings of 2.5 or less in the two most recent star ratings periods.	Varies by contract	From bidder on request through the procurement bidding process	Contract
Program Audit Results[j]	CMS conducts audits of MA parent organizations' performance on core program requirements, such as compliance program effectiveness, organization determinations, appeals, and grievances, and Special Needs Plan Models of Care.	Varies by MA sponsor; program audits are conducted by CMS periodically	From bidder on request through procurement bidding process	Sponsor

[a] More information on CAHPS survey data is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MCAHPS.
[b] More information on Medicare CAPs is available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDComplianceActions.
[c] More information on Medicare CCIPs is available at: https://www.cms.gov/medicare/health-plans/medicare-advantage-quality-improvement-program/5ccip.
[d] More information on HEDIS measures is available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-hedis-public-use-files and https://resdac.org/cms-data/files/hedis-rif.
[e] SNP-specific HEDIS public use files are available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/SNP-HEDIS-Public-Use-Files.
[f] More information on the Medicare HOS is available at: https://www.cms.gov/research-statistics-data-and-systems/research/hos.
[g] More information on Medicare star ratings and associated SNP-specific Star Rating measures is available at: https://www.integratedcareresourcecenter.com/resource/how-states-can-use-medicare-advantage-star-ratings-assess-d-snp-quality-and-performance. Star Ratings performance data are available at: https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data. Note that states will have access beginning in 2027 to the CMS Health Equity Index (HEI), which will summarize contract-level performance among enrollees with social risk factors (SRF) across multiple, existing star ratings measures in a single score. SRFs included in the HEI are: (1) low-income subsidy status; (2) dually eligible status; and (3) disability status. Although CMS will make the HEI available at the contract level, states that require D-SNPs to operate within state-specific, D-SNP-only contracts can gather HEI data specifically for the D-SNP(s) in their state.

[h] Process measures include, for example, cancer screenings and annual flu vaccines.
[i] More information on past performance is available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-K/section-422.502.
[j] More information on Medicare audits is available at: https://www.cms.gov/medicare/audits-compliance/part-c-d/program-audits.