Managed care procurement process

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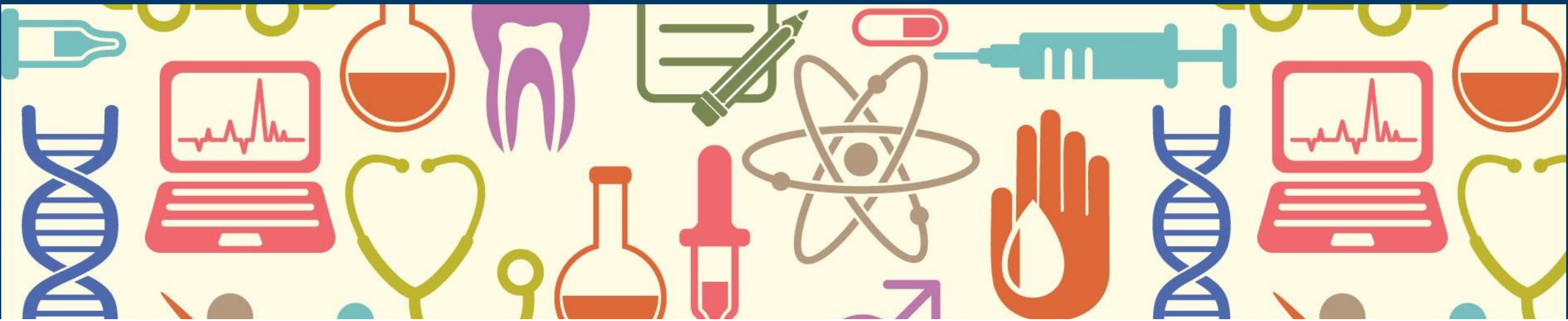
DEPARTMENT OF HUMAN SERVICES

Topics to cover today

- History of managed care in Minnesota
- Federal history of managed care
- Minnesota's managed care reforms
- Competitive bidding process
- Revised federal managed care regulations
- Future considerations



History of managed care in Minnesota

Minnesota: a leader in managed care

Minnesota was one of the first states to receive a federal waiver to implement a mandatory managed care program for its Medicaid enrollees.

- 1985: DHS began using managed care organizations (MCOs) on a prepaid capitated basis in three counties through the Prepaid Medical Assistance Program (PMAP).
- 1995: Minnesota received a federal waiver to require most Medicaid and all MinnesotaCare enrollees to receive health care services through MCOs. PMAP expanded statewide during the next decade.
- 1997: Minnesota Legislature allowed county-based purchasing to contract as MCOs with DHS for Medicaid services.
- Today about 80 percent of the nearly 1.2 million enrollees are served by MCOs while the remainder use the fee-for-service delivery system and all LTSS for people with disabilities in managed care are administered by DHS.

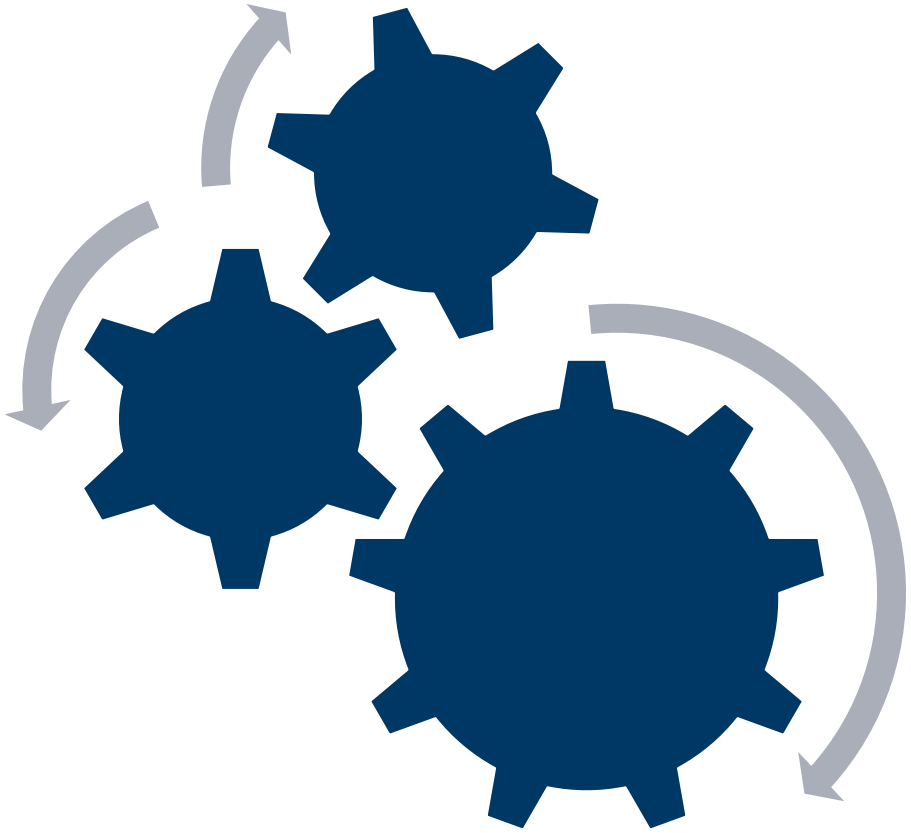
History of managed care: Elderly, people with disabilities

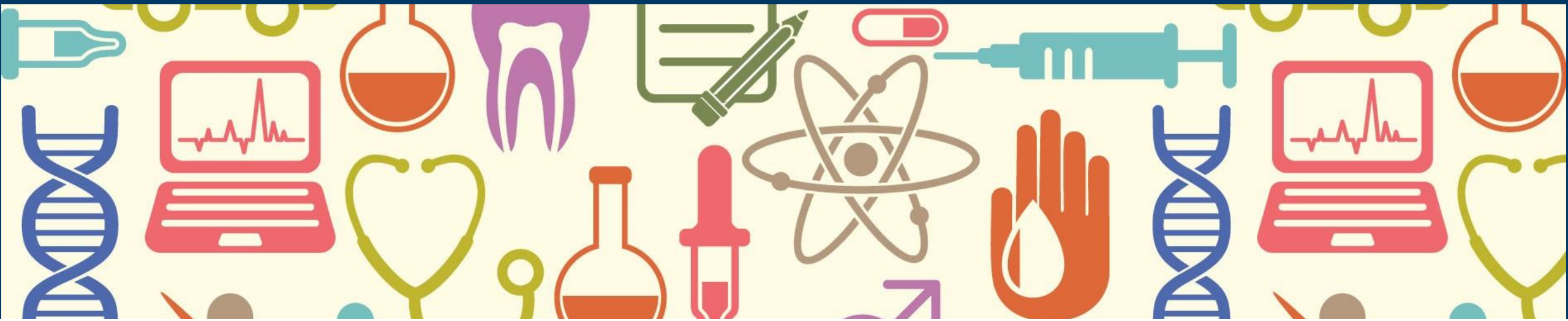
- **Managed care for seniors:** Managed care has been mandatory for seniors since the 1980s, and the state transitioned the seniors' program to a waiver in 2006.
  - **Minnesota Senior Care Plus (MSC+)**: Program for dually eligible (Medicare and Medicaid) seniors, where the Medicare and Medicaid benefits are managed separately.
  - **Minnesota Senior Health Options (MSHO)**: Program established in state law in the early 1990s that integrates Medicare and Medicaid programs for dually eligible seniors to better coordinate care and reduce conflicting financial incentives. Enrollment is voluntary.

- **Special Needs BasicCare (SNBC)**: In 2006, Minnesota passed a law for an integrated Medicare and Medicaid managed care program for people ages 18-64 with disabilities and later required people with disabilities receiving Medicaid be assigned an SNBC health plan unless they opt out.

Procurement cycle history

- Every county was procured once every five years
- Procurements included counties that were not necessarily geographically connected or sharing similar provider-service areas
- All plans that met minimum requirements were awarded contracts
  - Too many plans in some counties – difficult for counties and providers to manage (exception: county-based purchasing counties)
  - Did not promote efficiency





Federal history of managed care

Federal history of Medicaid managed care

Minnesota's managed care program preceded federal law and operated under a Medicaid § 1115 waiver for years.

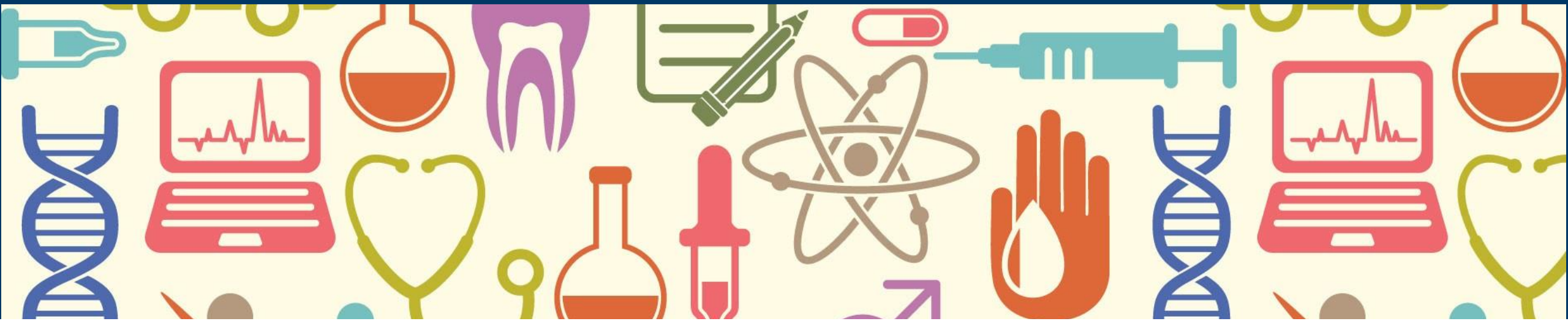
- 1997 Balanced Budget Act: allowed states to mandate people into managed care without federal waiver authority, added consumer protections, required choice of at least two health plans except in rural areas, and added more specific requirements regarding capitation payments.
- 2000: The Centers for Medicare & Medicaid Services (CMS) clarified that competitive procurement and choice of health plans would not be waived (impacted CBPs).
- 2002: CMS promulgated regulations, including rate setting based on actuarial principles. Prior regulations had only limited capitation rates to no more than what would otherwise have been paid under fee for service. Over time, most of Minnesota's managed care authority transitioned from a waiver to state plan.
- 2016: CMS promulgated regulations that were considered a "rewrite" of the original managed care regulations. This included new provisions around rate setting, beneficiary support and counseling, network adequacy, provider enrollment, and directed and pass-through payments.

2008 OLA financial audit of health care programs

Office of the Legislative Auditor's recommendations for managed care:

- Detailed **financial reporting**
- Provider **payments captured and protected** as non-public
- Administrative expenses: **changes to allocation, oversight and allowable costs** for rate setting
- County-based purchasing plans
  - **Reserves required**
  - **Expenditures limited** to health care services

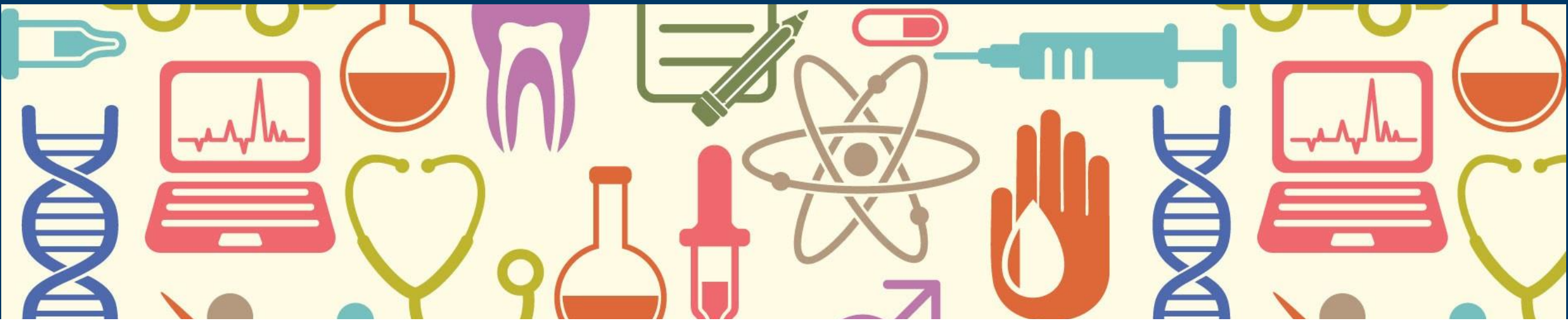
Concerns about level of rate increases and plan profits



Minnesota's managed care reforms

Managed care reforms

- Competitive bidding
- 1% cap on MCO operating margins in 2011
- Governor Dayton's executive order on managed care
- Legislative trend limits
- Enhanced financial reporting and encounter data monitoring
- Administrative cost limitations
- Changes to rate-setting development and procurement/evaluation



Competitive bidding process

2011: Movement to value and performance

- In 2011 the Dayton administration and the Legislature moved to a more competitive process for awarding managed care contracts to:
  - Ensure state (and taxpayers) get the best value for more than $4 billion spent on managed care
  - Add competition on performance related to quality, operations and cost – previously health plans awarded contracts for meeting basic technical components only
  - Address concerns about health plan profits

Competitive bidding begins

- The first competitive bid was in 2011 for the 2012 contract year in the seven-county metro area.
  - The biggest change was addition of a price component; the technical component remained similar to previous years
  - 50% of score technical, 50% price
  - Plans awarded contracts based on competitiveness; some lost service area in metro
  - Evaluation conducted by U of M included counties, state and plans
  - Resulted in $1 billion in total savings in combination with other health plan reforms passed or implemented in 2011

Financial and rate-setting reforms

2013 legislative changes

- Unallowable administrative expenses
  - Charitable contributions
  - Compensation in excess of $200,000
  - Marketing
  - Penalties
- Quarterly financial reporting
  - Required additional detail by population and program

Additional legislative changes made in 2015 following audit by OLA

Changes to capitated rate setting

Rate setting pre-2011	Rate setting 2011-present
Base for calculation: average of three years of all plans' medical claims and administrative costs	Base for calculation: most recent and complete 12-month period; introduction of competitively bid rates
Trend based on aggregate and national trend in Medicare and Medicaid	Trend considers current year and specific to experience. Price and utilization trends are separate. National trends are used as a benchmark.
Data used for rate setting provided in aggregate categories (hospital, physician, Rx, dental). Audited financial data used as reference.	Financial reporting in detail by service, provider, type of payment (FFS or capitated), etc. Financial data reconciled to audited financials and encounter data. Rates set using encounter claim data. Plans required to explain and verify discrepancies.
Administrative costs were generally trended forward with review of allowable costs	Administrative costs are reviewed by category; several limitations exist on what can be included (i.e., compensation, charitable donations, marketing)

Rate setting: state-set vs. bid

State-set rates: The Medicaid agency sets an average for the population. This rate can vary by demographics, geographic location, and institutional vs. community setting. Each plan is paid the ***same rate*** adjusted for the same person multiplied by plan-specific health risk status (risk adjustment).

- DHS develops state-set rates for SNBC and seniors.
- DHS develops state-set rates for PMAP and MinnesotaCare for years following competitive price bids.
  - Example: 2016-2017 used bid rates, and 2018-2019 used state-set rates

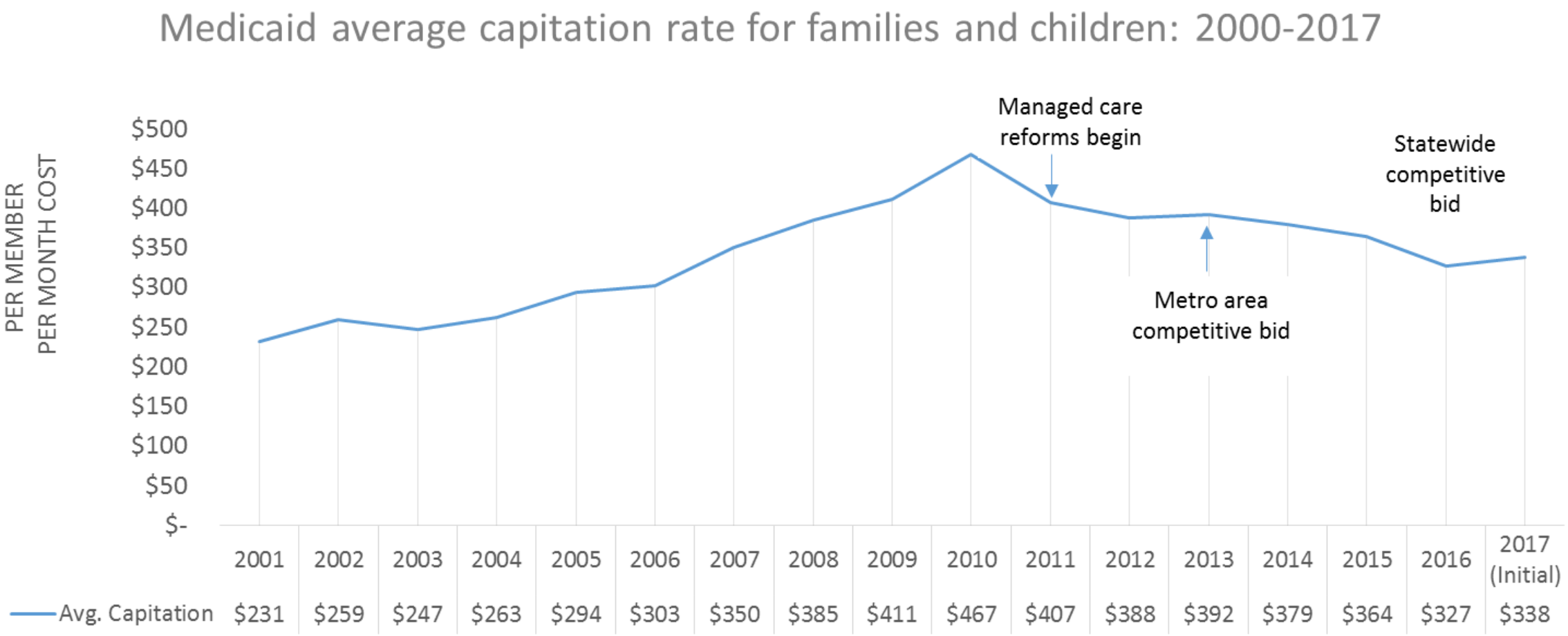
Bid rates: DHS provides data specific to county, service category and population for plans to bid an average rate for each region.

- Amount DHS pays can ***vary*** by plan but is determined using standard criteria and must fall within a range.
- Bid rates are also risk adjusted.

Competitive bidding expands

- Competitive bidding expanded in 2013 for the 2014 contract year to 27 counties (Greater Minnesota).
  - Legislature expanded competitive bidding in 2013 and passed statewide 87-county competitive bidding requirement for 2016
  - Improvements were made to technical components of RFP with the addition of performance on health care reform efforts (25% of technical score)
  - 60% of score technical, 40% price (changes to weight of plan administrative costs)
  - Plan bids came in closer together.

The result of reforms and oversight



Statewide competitive bid

- Statewide competitive bidding took place in 2015 for the 2016 contract year.
  - Legislative requirement for statewide bid included organizing all 87 counties into regions and coordination of Medicaid and MinnesotaCare
  - Community and partner engagement began in 2014
    - Counties (organized by Minnesota Association of County Social Service Administrators regions)
    - Public comment process
  - Continued improvements in technical component and scoring
  - Changes to price scoring were made to reflect major differences in budget impact to the state and more appropriately incorporate administrative cost differences
  - 55% of score technical, 45% price

Statewide bid results

- Plan performance very competitive on technical component (quality, network, operations, county and state questions) and price components
- Plans that scored well on price also scored well on technical component.
- In CBP counties, all plans did not have to compete based on price.
- If a plan did not score well on price, they still had opportunities to be the second or third plan option based on technical score alone.
- Total program savings: $445 million for CY2016 only
- County mediation process: 28 counties total
- Major plan shifts resulting in 415,000 enrollees changing plans

Transparency in PMAP procurement process

- Communication before issuance of RFP: meetings with MCOs, counties, MACSSA
- Communication after RFP issued: responders conference on technical and price components
- Responses submitted are nonpublic under Minnesota statutes Chapter 13 until final contracts are executed
- Responses scored by counties, DHS and MDH staff
- Determination if best-and-final-offer process necessary
- County mediation (if exercised)
- Contracts awarded

PMAP 2016 scoring overview

100-point scale

- Price: **45** points
- County questions: **15** points
- State questions: **10** points
- Technical aspects:
  - Network scored by Minnesota Department of Health staff: **10** points
  - Network scored by county: **5** points
  - Health care reform initiatives: **10** points
  - Quality of care and services: **5** points

Best and final offer

- Responders are instructed to submit their most competitive bid at the outset.
- DHS only considers a best-and-final-offer process with select plans when the initial bids received are too close to differentiate among plans or the majority of price bids come in above the level desired by the state:
  - Rewards plans that submit their most competitive bid at the outset
  - Mitigates negative impacts to the competiveness of future bids
  - Addresses concerns about plans submitting best and final offers that are significantly lower than their original bid, causing potential concerns about financial sustainability or ability to carry out service delivery plan

How contracts are awarded

- Factors considered:
  - Best value: plans with the highest scores, meaning overall combined score on technical aspects (quality, reform, service, delivery, network) and price.
  - Compliance with Basic Health Plan: MinnesotaCare requires a minimum of two MCOs in all counties
  - Alignment between programs and geographic regions
  - An attempt was made to select at least one of each counties' Board Recommendations
- Awards ensured plan choice in every region for both programs (two in Greater Minnesota and three in metro) and capacity in the region while also streamlining plans for administrative efficiency for the state, counties and providers
  - The exception: CBPs given single-plan status in certain counties for Medicaid
- The top scoring plan received default enrollment in 2016

County mediation process

- Counties can request the recommendation of a mediation panel
- Three-member panel hears and considers testimony
  - A member selected by DHS and counties; third member mutually selected
- A nonbinding recommendation is made to the commissioner

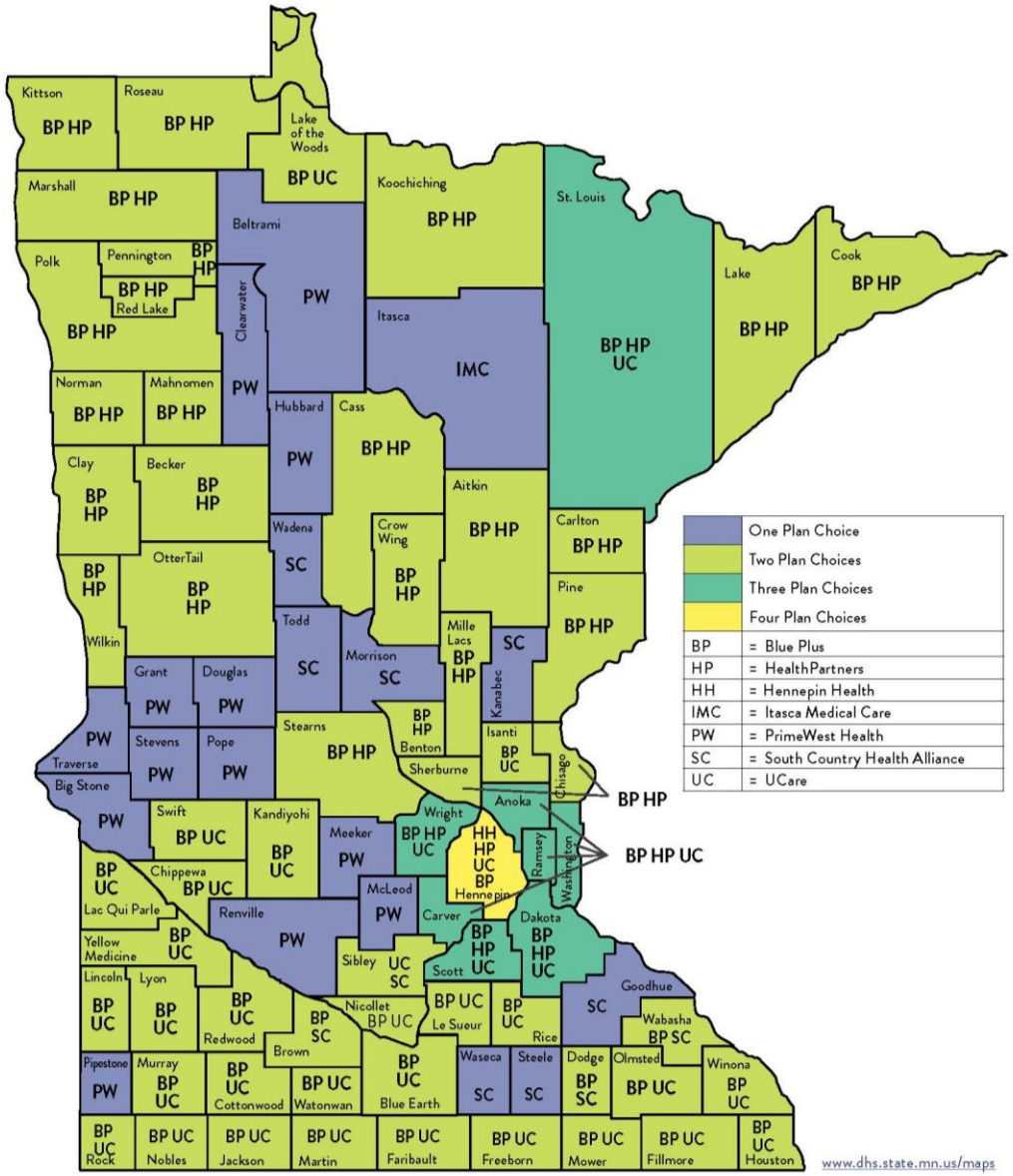
A competitive bidding comparison

Before competitive bidding	After competitive bidding
Contract rates raised annually based on trends in medical and administrative costs.	Savings of $445 million
Contracts awarded based on minimum requirements	Contracts evaluated on a comprehensive set of measures covering the breadth of MCO administrative and service delivery functions
RFP scoring weighted toward technical abilities of managed care organizations	RFP technical scoring methodology weighted more toward enrollee access, quality and service delivery
RFPs by smaller groups of counties limits the alignment of incentives and innovations that benefit from economies of scale, and result in uneven experiences for enrollees and providers in the same region of the state.	RFPs by region provide more comprehensive county coverage, promote consistency in enrollee and provider experience
No scoring guidelines to help scorers maintain consistency when reviewing RFPs	Universal set of objective scoring criteria created to establish a fairer basis for RFP comparison
Each county developed and scored their own questions, making it hard to effectively evaluate MCO processes and procedures across enrollees, regions and provider systems.	Counties develop RFP questions focused on specific issues of interest in region, and county scoring is a significant factor in plan selection.

Lessons learned from 2016 procurement process

- DHS “used a reasonable and inclusive process to develop its request for proposals, evaluation criteria, and score proposals” (OLA special audit November 2015)
- Will continue to look for improvements, engage county partners
- Statewide (all 87 counties) at once logistically challenging for DHS, counties and enrollees
- Timing between competitive procurements important

PMAP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Clearwater PW
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Three Plan Choices
Four Plan Choices
BP = Blue Plus
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IMC = Itasca Medical Care
PW = PrimeWest Health
SC = South Country Health Alliance
UC = UCare
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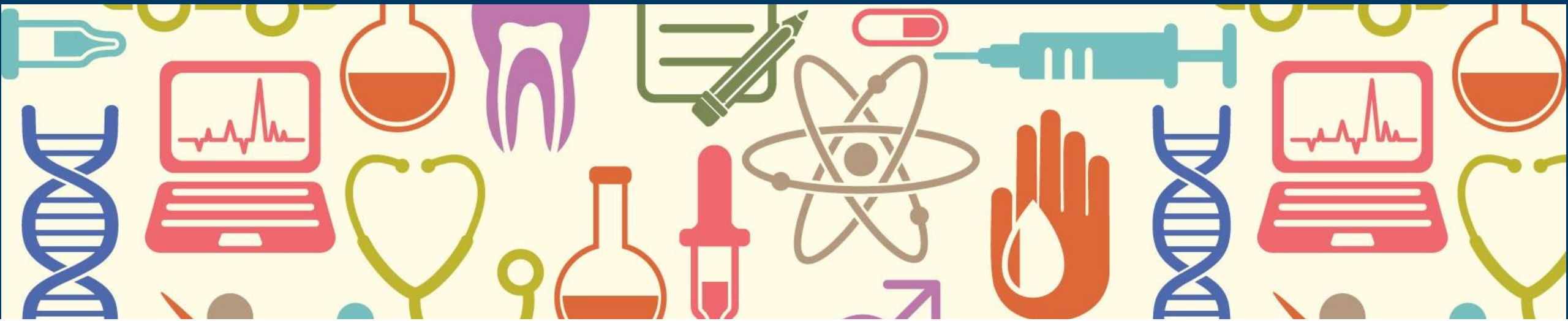


Revised federal managed care regulations

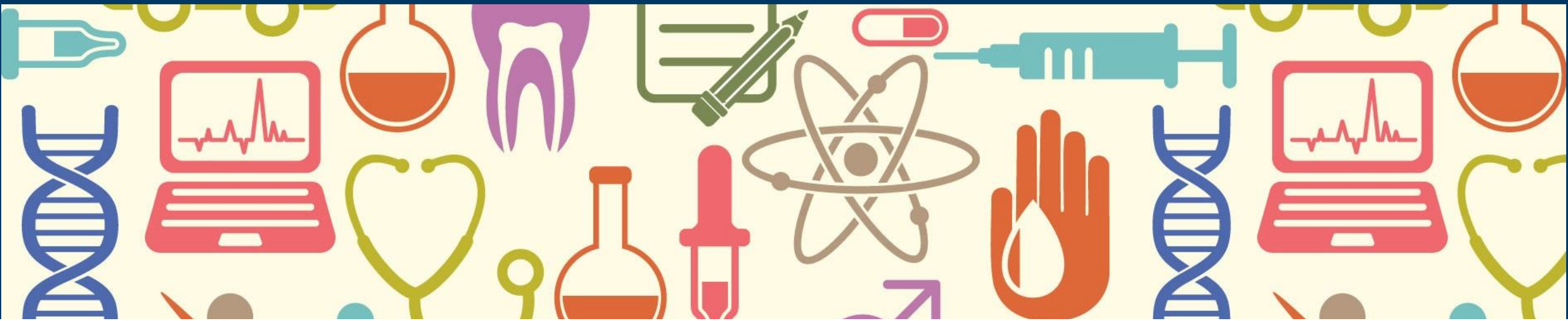
Revised federal managed care regulations

CMS issued a comprehensive revision of requirements governing managed care in May 2016. The new requirements:

- Reiterate the need for competitive procurement and scoring that is free from conflicts.
- Promote quality of care
- Strengthen efforts to reform delivery
- Enhance policies related to program integrity
- Ensure appropriate enrollee protections, including screening of all MCO network providers and neutral resources that help enrollees understand what to consider when choosing a health plan
- Help ensure accountability in capitation payment rates (directed payments, pass-through payments, limitations to IMDs used as “in lieu of services” and required medical loss ratio)

Directed payments and pass-through payments

- Pass-through payments are made outside of capitation payments and discontinued under new CMS rules
- Directed payments are made inside the capitation payments and direct an MCO to pay a specified amount to certain providers. These payments are scrutinized by CMS and allowed only under certain conditions:
  - Financial review for reasonableness of the rate and actuarial soundness
  - Review for meaningfulness and appropriateness within the context of the state's comprehensive quality strategy



Future considerations

Future considerations

- DHS must reprocure PMAP and MinnesotaCare contracts statewide by 2021 under state law
- Eligibility of for-profit health plans to respond
- Incorporating Integrated Health Partnerships into the procurement process
- Impact of strengthened conflict-of-interest federal regulations on RFP scoring and review process.

Future considerations

- High rates of enrollee default (no active selection)
- Determination of how outcomes fit into technical, quality and price scores
- How to evaluate new entrants (and all responders)
- Holding responders accountable for activities, programs and contracting to be implemented during the life cycle of the contract

Thank you