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State Health Access Data Assistance Center

Stakeholder Analysis of Medicaid Competitive Bidding in Minnesota

FINAL REPORT

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Acknowledgements

This report presents the results of a stakeholder analysis of the new competitive bidding process implemented in the seven-county Twin Cities, Minnesota metropolitan area for the 2012 Families and Children Contract for Medicaid (known as Medical Assistance or MA in Minnesota) and MinnesotaCare medical care services.

The project was funded by a grant from the Robert Wood Johnson Foundation under the State Health Reform Assistance Network ("State Network," www.statenetwork.org), a program that provides in-depth technical support to States, including Minnesota, to maximize health insurance coverage gains as they implement key provisions of the Affordable Care Act (ACA) and other health care reform. The State Network is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. The State Health Access Data Assistance Center (SHADAC, www.shadac.org), housed in the School of Public Health at the University of Minnesota-Twin Cities, is one of the organizations providing technical assistance through the Network.

The authors of this report would like to thank the 12 organizations who participated in the stakeholder analysis, including the seven counties in the metropolitan area and the five health plans who bid to serve these counties under the Contract:

Counties	Health Plans
• Anoka • Carver • Dakota • Hennepin • Ramsey • Scott • Washington	• Blue Plus • HealthPartners • Medica Health Plans • Metropolitan Health Plan (MHP) • UCare

A total of 46 individuals representing these organizations participated in in-person stakeholder interviews. We greatly appreciate these individuals' interest in and willingness to contribute to the project and the amount of time and effort they dedicated to prepare for and actively take part in the meetings.

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Introduction

This report presents the results of a stakeholder analysis of the new competitive bidding process implemented in the seven-county Twin Cities, Minnesota metropolitan area for the 2012 Families and Children Contract for Medicaid (known as Medical Assistance or MA in Minnesota) and MinnesotaCare medical care services. While competitive bidding is an approach that has been used by other states around the country to contract with health plans serving public program enrollees, it is new to the State of Minnesota and represents a significant and meaningful change in the manner in which contracting has been handled in Minnesota for over a decade.

The goals of this project were to 1) document the changes made by the State to the contract procurement process for the seven-county metropolitan area, 2) solicit feedback from the seven counties and the five health plans that submitted proposals to serve these populations on the implementation of the competitive bidding process for the Families and Children Contract, and 3) identify common themes and "lessons learned" to inform the State's procurement process in the future.

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This report describes the approach SHADAC used to conduct the project, provides a summary of the Families and Children Contract procurement changes implemented in the metropolitan area, and presents and discusses key themes from interviews with stakeholders about the implementation of the competitive bidding process. We conclude with a set of recommendations for DHS to consider in future procurements in the metropolitan area and throughout the State.

Methods

The project involved two components: 1) documentation of the competitive bidding process implemented by the State and 2) a stakeholder analysis of the changes to the procurement process. For the purposes of this project, stakeholders included county agency staff representing the seven counties within the metropolitan area and representatives from the five health plans that submitted a bid to

[1] The other participating states include Alabama, Colorado, Maryland, Michigan, New Mexico, New York, Oregon, Rhode Island, and Virginia.

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provide health care services to individuals eligible for MA or MinnesotaCare through the 2012 Families and Children Contract. It is important to note that this project was not intended to be a full evaluation of the new competitive bidding process. A comprehensive study would include an evaluation of implementation issues, impacts on program enrollees, and fiscal outcomes.

To complete the first component, SHADAC conducted a document review of materials related to the 2012 procurement and held an in-person meeting with DHS staff to discuss the procurement changes. Prior to the meeting, DHS provided SHADAC project staff with a variety of materials including Request for Proposals (RFP) documentation, Questions and Answers (Q&A) materials, evaluation materials, and stakeholder correspondence. The purpose of the meeting with DHS was to address questions SHADAC had about the design of both the technical and cost bid requirements of the RFP, the timing of the procurement process, proposal scoring and plan selection, and stakeholder engagement.

To complete the second component of the project, SHADAC conducted in-person interviews with staff from all seven counties and the five health plans. Stakeholder organizations included Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties and the following health plans: Blue Plus, HealthPartners, Medica Health Plans, Metropolitan Health Plan, and UCare. A meeting was held with each of the stakeholder organizations for a total of 12 interviews. A main contact person and contact information for each of the stakeholder organizations were provided to SHADAC by DHS. For the counties, these contacts were a director or another administrator or staff member from a Community Services, Human Services or Social Services department. For health plans, the contacts were Government Program administrators or other executives. For three counties, an additional contact had to be subsequently identified due to shifts in staffing at these county agencies.

DHS initiated outreach about the project to the stakeholders by sending an introductory letter (see Appendix A) to each of the 12 contacts in May 2012. The purpose of the letter was to introduce the project, describe the goals of the stakeholder analysis, and invite each organization to participate in the project.

About a week and a half after the initial letter was sent by the State, SHADAC project staff followed up with the key contacts by email and telephone to provide additional information about the project, gauge stakeholder interest in participating, and schedule an in-person meeting at the individual's office location. Prior to the in-person meetings, SHADAC provided the contacts with the discussion guide for the meeting (see Appendix B). Questions in the guide covered four major topics: 1) technical proposal requirements, 2) cost bid requirements, 3) proposal scoring and plan selection, and 4) stakeholder outreach and communication. It is worth noting that the stakeholder interviews addressed a procurement process that had occurred approximately a year earlier. As a result, recall related to some of the questions was difficult for some participants. Further, due to staff turnover and/or reorganizations occurring since procurement, some stakeholder staff who had been involved in the process were not in attendance at the meeting, and some interviewees may not have had experience or familiarity with all components of the procurement process.

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At least two of three SHADAC researchers attended every stakeholder meeting, and the number of interviewees attending on behalf of a stakeholder organization ranged from one to eight. Interviews began on the 12th of June and went through the 9th of August 2012, with each lasting approximately 1.5 hours. Following the completion of the interviews, SHADAC staff prepared and reviewed meeting notes and synthesized results across all interviews to identify common themes among stakeholder feedback.

Summary of Minnesota's Competitive Bidding Pilot

Background on the Families and Children Contract

In 2012, DHS initiated a two-year competitive bidding pilot as part of its Families and Children Contract with managed care organizations (MCOs, hereafter referred to as health plans in this report) to provide prepaid health care to eligible recipients in the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties). Historically, the Families and Children Contract has covered children, pregnant women, parents, and non-citizens who were eligible for MA or MinnesotaCare programs. New for 2012, the contract also covers a recent MA expansion group under the federal Affordable Care Act (ACA), non-disabled adults without children under the age of 65 who prior to March of 2011 would have been eligible for state-only funded MinnesotaCare or General Assistance Medical Care.[2] Thus, the populations covered by the competitive bidding pilot can be summarized as all families, children, and non-disabled adults under 65 without children who are eligible for MA or MinnesotaCare in the metropolitan area.[3] As of April 5, 2011, the total number of MA and MinnesotaCare enrollees in the area covered by the Families and Children Contract was 273,074.[4]

The 2012 Families and Children model contract specified how health plans are to provide enrollees with access to a wide range of health care services.[5] Included were requirements, conditions, and terms related to: eligibility and enrollment; covered benefits; health plan and enrollee communications; marketing and enrollee education; reporting; access standards; transition services; service authorization; quality assessment and performance improvement; denials, terminations and reductions of services; and grievances, appeals and State fair hearings. Significant changes from the prior year's contract language included revisions to the sanction policy for noncompliance; the incorporation of State initiatives such as the health care delivery system demonstration (HCDS) project and health care home coordination; and the addition of performance withhold measures related to hospital admissions and readmissions.[6] All in

[2] While health plans covered this group for a portion of 2011, 2012 is the first full contract year of the Medicaid managed care expansion.

[3] The pilot does not include individuals who are blind, elderly or those with disabilities who are enrolled in Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO) or Special Needs BasicCare (SNBC) programs.

[4] 2012 Families and Children Contract Request for Proposal.

[5] The 2012 Families and Children model contract can be found at: http://www.dhs.state.mn.us/main/dhs16_139710#.

[6] For specific contract language related to these provisions, see Article 5.6 (Remedies or Sanctions for Breach); Article 4.9.3 (Health Care Delivery Systems Demonstration Project); Article 4.8.4 (Evidence Based Childbirth Program); Articles 3.4.2(J) (Health Care Home; Alternative Models) and 4.9.2 (Health Care Home Care Coordination Payment; Variance); and Article 4.6 (Managed Care Withhold).

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all, however, other than the MA eligibility expansion mentioned above, there were few changes to the managed care contract between the State and its health plan partners.

The most fundamental change for the 2012 contract year was certainly to the procurement process itself. Minnesota health plans have a long history of participating in the Families and Children Contract. Under State law, as a condition for participating in State and local government employee and other health insurance programs and as a condition of licensure, health plans in Minnesota must participate in State health care programs including MA and MinnesotaCare. For over a decade, managed care rates for this contract had been set administratively by DHS, based on health plan historical costs, health care trends and benefit changes. The competitive bidding pilot used for 2012 contracts marked a significant change in the procurement process, introducing health plan competition for the first time in the history of Minnesota's Medicaid managed care program. Both technical and cost bid components of the proposals submitted by health plan responders were evaluated and scored on a "best-value basis" along various dimensions of quality, efficiency, and cost. Overall scores were used to determine successful health plan bidders in each county, and certain successful bidders in each county received default enrollment assignments. That is, to the extent an enrollee did not choose a health plan, she/he was assigned to a particular bidder in their county of residence.

Design of Competitive Bidding Pilot and Development of RFP

Traditionally, every five years, DHS's Medicaid managed care procurement process effectively begins with the State's formulation and dissemination of an RFP issued in February seeking qualified bidders. The Department has the authority to renew any contract awarded under the RFP for up to five years. An RFP for the Families and Children Contract in the metropolitan area was due to be issued in 2011, with a contract start date of January 1, 2012.

During our meeting with DHS, the Department indicated that work on the competitive bidding pilot for managed care contracts began almost immediately after Governor Dayton took office in January 2011 and the Department's Commissioner (Lucinda Jesson) and Assistant Commissioner for Health Care (Scott Leitz) began their appointments. As early as mid-February 2011, for example, the Governor's budget recommendations included a competitive price bidding pilot for the metropolitan area among a series of initiatives aimed at reforming the managed care delivery system for Minnesota health care programs.[7] A little over a month later, the Dayton Administration announced that State contracts with health plans would begin to be "subject to competitive bidding to ensure that the State gets the best value for taxpayer dollars."[8] The overall rationale for the change was to seek greater disclosure, accountability, and efficiencies in managed care programs and program spending.

In early March 2011, staff in the Department's Health Care Division began working on the details of a new competitive approach for the metropolitan area and incorporating these changes into the RFP. Key decisions about what would be required as part of the health plan bids as well as how these components

[7] See Governor's FY 2012-13 managed care budget initiative at: http://www.mmb.state.mn.us/doc/budget/narratives/gov11/human-svcs.pdf, page 65.

[8] See Governor's March 25, 2011 press release at: http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=10288.

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would be evaluated had to be made fairly quickly in order to issue an RFP on a timely basis. To help inform decision making, especially with respect to the parameters of the cost bid and quality metrics, the Department engaged Ann Robinow, an independent health care consultant, and Deloitte & Touche, a firm with experience in competitive procurements in other health care markets. State staff also looked at competitive bidding models in other States (e.g., Arizona, New Mexico, and Hawaii) to help inform their conceptual design.

As has been the case in the past, in advance of the start of the procurement process, the Department also reached out to each county in the metropolitan area. DHS provided each county with an RFP template to complete with information about county administration, demographics, service delivery, and providers. Counties were also asked to provide county-specific issues and questions related to service delivery and access; dental care; chemical dependency services; adult and children's mental health; transportation; and public health. Minnesota Statute, § 256B.69, subd. 3a requires DHS to include county input in the process of developing, approving, and issuing RFPs to provide prepaid medical services. DHS is also required to provide counties the opportunity to review health plan proposals based on identification of their specific community needs. Based on this review, county boards are required to make recommendations regarding health plan selection. However, this requirement is consultative in nature; DHS may or may not choose to accept county recommendations. The Department's RFP—published on April 6 and revised on April 25, 2011—required that plans compete on technical elements such as quality measures and access to covered services through provider networks as well as on cost elements. Technical proposals, submitted by health plans by mid-May, made up 50 percent of the final score, and cost bids, submitted in mid-June, made up the remaining 50 percent.[9] As in the past, both State and county professionals evaluated and scored the technical proposals submitted by health plans. A small group of analysts from the Department's Managed Care and Payment Policy Division did the quantitative work necessary to score the cost bid proposals.

The RFP indicated that the State would evaluate the cost bids on a "best-value" basis and select at least two health plans in each metropolitan county.[10] In doing so, the State reserved its right to determine whether two or more health plans would be selected per county after all the proposals were evaluated. Importantly, the RFP also specified that all default enrollee assignments would go to the lowest cost bidder in each county.

A summary and timeline of key procurement activities are provided in Table 1.

[9] A health plan's technical proposal and cost bid would not be evaluated unless the health plan "passed" an initial review of required statements (e.g., Responder Information/Declarations, Affidavit of Noncollusion, Lobbying Certification, etc.)

[10] Federal Medicaid managed care regulations require that states provide enrollees with the choice of two or more health plans in each metropolitan statistical area (MSA).

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Table 1. Key Procurement Activities

Procurement Activity	Brief Description	Date Occurred
RFP Published	DHS document seeking proposals from qualified health plans to provide prepaid health care to eligible MA and MinnesotaCare recipients in metropolitan counties. A revised RFP was issued on 4/25/11.	4/6/11
Bidder's Conference—Technical Proposal	Mandatory meeting for RFP responders; responders were provided opportunity to ask State staff questions about the technical proposal. Oral answers given at the meeting were non-binding.	4/12/11
Questions and Answers—Technical Proposal	Written answers to questions from bidder's conference and any additional questions submitted by responders by 4/14/11 were posted on DHS website.	4/18/11
Bidder's Conference—Cost Bid	Mandatory meeting for RFP responders; responders were provided opportunity to ask State staff questions about the cost bid. Oral answers given at the meeting were non-binding.	4/29/11
Technical Proposals Due	Completed technical proposals covering all elements outlined in the RFP were due to DHS.	5/13/11
Questions and Answers—Cost Bid	Written answers to questions from bidder's conference and any additional questions submitted by responders by 5/20/11 were posted on DHS website.	5/27/11
Cost Bids Due	Completed cost bids covering all elements outlined in the RFP were due to DHS.	6/16/11
Best and Final Offer (BAFO) Letters Sent	Letters sent to top three health plans with highest combined scores in each county, soliciting best and final bids. Health plans had one week to respond.	8/11/11
Notice of Intent to Contract	DHS award letters sent, inviting successful bidders to enter into 2012 contract negotiations to provide health care services in selected counties and informing other bidders that they were not selected.	8/30/11
Start of Contract	Successful health plans began providing access to services for contract year 2012.	1/1/12

Technical Proposal Requirements and Scoring Methodology

As has been the case in the past, health plans responding to the RFP had to submit a technical proposal demonstrating their understanding of the services requested in the RFP and their plan for accomplishing the work. Through an executive summary, a description of the applicant's organization, and a project activities and implementation plan, health plans had the opportunity to respond in detail to many specific questions and present their plans for responding to issues outlined by the State and counties. Both State and county staff then reviewed and scored the technical components. A brief description of the RFP's technical components and the total possible points for each component are provided below in Table 2.[11]

[11] After reviewing the proposals, the members of the evaluation team rated each technical component using the following formula: "excellent" responses received a 1.0 point factor; "very good" responses received a .75 point factor; "good" responses received a .5

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Table 2. Technical Proposal Components

Technical Components	Brief Description	Total Possible Points
Executive Summary	Summary demonstrating the health plan's knowledge of requested services, solutions to problems presented in RFP, and overall project design.	5 points
Description of the Applicant Organization	Health plan description containing information on programs and activities, number of people and geographic area served, staff experience, and accomplishments and prior experience in providing requested services.	5 points
Project Activities and Implementation Plan:		
• **State/County Assurances**	Legally binding certification that health plan will comply with a list of State/County requirements.	5 points
• **Exhibits**	Detailed responses to a series of questions concerning: service and delivery; dental care; chemical dependency services; adult and children's mental health; transportation; public health; and care management/quality.	40 points
• **Quality Assessment and Performance Improvement Program**	Health plan HEDIS 2010 performance measures for Minnesota Health Care Programs (MHCP) and NCQA national Medicaid percentile rankings; optional comparison to HEDIS 2010 performance measures for health plan's commercial HMO products for bonus points.	15 points
• **Plan Design**	Detailed responses to a series of questions about health plan's plan design, methods for ensuring accessibility to covered services, care coordination and management functions, service authorization process, and risk sharing arrangements.	5 points
• **Provider Network**	Report of health plan's contracted providers by county; Managed Care Accessibility Report; geo maps for certain types of providers.	25 points
Total points, Technical Proposal:		**100 points**

Most of the technical requirements of the RFP were identical or similar to those from past procurements for this population. Two technical components were significantly different, however. For the first time within the Quality Assessment and Performance Improvement section, health plans were required to submit Healthcare Effectiveness Data and Information Set (HEDIS) performance measures applicable to the Families and Children Contract (e.g., indicators for childhood immunizations, well-child visits, cervical cancer screenings, etc.). Plans were also asked to submit the national Medicaid percentile ranking for those indicators per the National Committee for Quality Assurance (NCQA). In past procurements of the Families and Children Contract, plans were only required to respond to four general questions about their Quality Assessment and Performance Improvement Programs.

point factor; "fair" responses received a .25 point factor; and "poor" responses received a 0 point factor. Technical scores were determined by multiplying total possible points available for the component by the corresponding point factor.

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Another important change to the technical proposal was in what the State was seeking from the health plans in terms of provider network capacity and adequacy. The RFP noted that it was not necessary to bid full networks and that health plans should consider "high-quality, cost-effectiveness, and capacity for patient engagement, organizational efficiencies, and the ability to meet access standards" in developing the network for the populations covered under the Families and Children Contract. In essence, the Department wanted health plans to rethink or restructure their networks with both access and cost-effectiveness in mind. To provide evidence of network adequacy and capacity for access to services, managed care accessibility reports[12] and geographic maps are required for each county. The State analyzed network adequacy and access as part of the technical proposal evaluation.

Cost Bid Requirements and Scoring Methodology

The new cost bidding portion of the RFP was clearly the most significant change for health plans bidding on the Families and Children Contract in the metropolitan area. Worth 50% of the total score in each county, as well as having important implications for default enrollment, cost bid requirements included a cover letter describing the methodology used in the development of the bid, key historical financial ratios, details on historical administrative expenses, and the cost bids themselves. A description of each of the cost bid components and the total possible points for scored elements are provided below in Table 3.

Table 3. RFP's Cost Bid Components

Cost Bid Requirements	Brief Description	Total Possible Points
Cover Letter	A description of methods and assumptions health plan used in developing rate proposal.	Not Scored
Summary of Key Financial Ratios	Completed Excel template of key expense to revenue ratios for calendar years 2006-2010: medical loss ratio; administrative expense ratio; contribution to reserves. **Only the administrative expense ratio was scored.*	10 points
Summary of Administrative Cost Percentages by Category	Completed Excel template of administrative cost percentages by category (e.g., billing and enrollment, claims processing) for combined Prepaid Medical Assistance Program (PMAP) and MinnesotaCare programs in calendar years 2006-2010.	Not Scored
Cost Bids	Completed Excel bidding templates, by rate cell, for PMAP families, children and adults without children; and MinnesotaCare families, children, and adults without children	90 points
Total Points, Cost Bid:		**100 points**

The first ten possible points on the cost bid were awarded based on a health plan's historical level of administrative expenses as a percent of revenue for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare. Up to one point per year for PMAP and up to one point per year for MinnesotaCare

[12] A managed care accessibility report assesses the health plan's network vis-à-vis geographic standards provided in statute and identifies network gaps.

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were awarded based on administrative expenses for calendar years 2006-2010. Ratios less than or equal to 8.2% garnered one point per program per year, ratios between 8.2% and 10% garnered half a point per program per year, and ratios higher than 10% garnered no points.

To evaluate the rate bids themselves, a weighted average health plan per member per month (PMPM) bid rate for each county was computed across all acceptable rate cells.[13] The lowest average bid in each county received 80 regular points plus 10 bonus points, totaling 90 points. The second lowest bid received regular points proportional to the ratio of that bid to the lowest bid received, plus 5 bonus points. Other bids received regular points proportional to the ratio of their bids to the lowest bid received, but no bonus points. For example, if three bids were submitted for County A, and the average rate for health plan1 was $150 PMPM, the average rate for health plan 2 was $175 PMPM, and the average rate for health plan 3 was $190 PMPM, the three health plans would have received scores as follows:

Table 4. Hypothetical Computation of Cost Bid Scores for a County

	Average PMPM Bid for County	Regular Points Awarded	Bonus Points Awarded	Total Points Awarded
Plan 1	$150	80	10	90
Plan 2	$175	(150/175)*80 = 68.6	5	73.6
Plan 3	$190	(150/190)*80 = 63.2	0	63.2

Health plans received instructions for completing each of the cost bid requirements; Excel templates on which to provide their data; as well as a data book containing managed care enrollment and claims data, risk scores, and health care service utilization data by county.

After initial bids came in and were scored by DHS staff, based on the methodology described above, the State exercised its option to use a "best and final offer" (BAFO) process to solicit final bids in each county from the three health plans with the highest combined scores for that county. While every health plan was offered the opportunity to submit a BAFO in one or more counties, not every health plan was offered the opportunity to submit a BAFO in every county. The correspondence to health plans outlining the BAFO process included information on the low cost bid in each county, as well as actuarially acceptable rate ranges by rate cell. Health plans had one week to provide their BAFOs to the State.

[13] Capitation rates are the monthly prepaid rates paid by the State to the health plan for health care coverage for enrollees. Health plans bid and are paid different rates for different subgroups within the eligible population – these are called rate cells. In this procurement, PMAP rate cells were determined by eligibility category, age, sex, and county; MinnesotaCare rate cells were determined by eligibility category, age, sex, family status, income level, and county.

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Plan Selection and Outcomes of Competitive Bidding

Although the Federal Medicaid regulation only requires a minimum of two health plans within a MSA, the State limited their selection to just the minimum in most counties in the metropolitan area. Based on the methodology outlined above for both the technical and cost bid components, UCare and HealthPartners scored highest and thus were the two successful bidders in all seven counties. To ensure provider capacity, a third plan with the next highest score was selected for Hennepin County (Medica), Ramsey County (Blue Plus), and Dakota County (Blue Plus). This outcome was significant, because in the past, four to five health plans served each county in the seven-county metropolitan area. For the current contract award period, Metropolitan Health Plan no longer administers a Families and Children Contract in the metropolitan area. Table 5 summarizes the change in plan selection for each of the seven counties.

Table 5. Health Plans Serving Metropolitan Counties Pre- and Post-Competitive Bidding in 2012

	Anoka		Carver		Dakota		Hennepin		Ramsey		Scott		Washington	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
HealthPartners	X	X	X	X	X	X	X	X	X	X	X	X	X	X
UCare	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Plus	X		X		X	X			X	X	X		X	
Medica	X		X		X		X	X	X		X		X	
MHP	X		X				X				X			

As a result of the new procurement process, approximately 78,000 enrollees needed to change health plans by January 2012, the beginning of the contract year. This represents an estimated 29% of the total population covered by the Contract.[14] The number and proportion of enrollees requiring a health plan change varied by county, with some counties experiencing more of an impact than others.

Findings from Stakeholder Interviews

The next section presents a synthesis of findings from our stakeholder interviews. As mentioned above, competitive bidding was a significant change in the manner in which MA and MinnesotaCare contracting had been handled in the State for years. Given the magnitude of the change, it is not a surprise that there were a number of adjustments county and health plan stakeholders needed to navigate, and therefore, stakeholders expressed several challenges. Stakeholders also provided areas of positive feedback for DHS. Demonstrated by their participation in the project and the feedback provided, the individuals expressed a great deal of dedication to the program.

We organize and present the findings from our interviews in seven general themes: 1) timeline and planning, 2) clarity in competitive bidding requirements for health plans, 3) focus of technical proposal

[14] As of April 5, 2011, the total number of enrollees covered by the Contract was approximately 273,000. Source: 2012 Families and Children Contract Request for Proposals.

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and requirements, 4) consistency in health plan proposals and evaluations, 5) balancing the evaluation of technical proposals and cost bids, 6) beneficiary enrollment and operational impacts, and 7) stakeholder engagement.

Timeline and Planning

As described earlier, DHS released the RFP for the 2012 Families and Children Contract for the seven-county metropolitan area in early April 2012, with technical proposals and cost bids due from bidding health plans on May 13 and June 16, respectively.

All interviews with stakeholders included discussion about the State's timeline and planning for implementing competitive cost bidding. While one stakeholder acknowledged and complimented the State for setting and meeting a very aggressive goal and timeline, especially in the face of a State shutdown during the summer of 2011, many stakeholders expressed frustration about the procurement timeline.

While several stakeholders were pleased with the State's *original* timeline for the procurement process, indicating that it was clear and adequate, many stakeholders reported that a time crunch developed during the procurement process. Many stakeholders were aware that the State may adopt competitive bidding, but some were surprised by how fast the State implemented the change, indicating that it seemed to be put together very quickly. Several stakeholders remarked that, given how dramatic the changes were, more time was needed for all stages of procurement (county involvement in developing the RFP, technical proposal and cost bid preparation by health plans, technical evaluation by counties, preparation of BAFO responses by health plans, and plan selection) and for the roll out of new contracts in counties. Several stakeholders stated that the timeline was likely "overwhelming" and "a challenge" for all parties involved, including DHS. Several stakeholders commented on the additional timeline complications caused by the State shutdown, calling attention to the fact that the State did not adjust or republish a procurement timeline following the shutdown.

From a health plan perspective, several stakeholders spoke about the amount of time required to respond to the RFP, citing that the RFP had been released later than in previous years, the amount of work required to pull together the information requested and the time required to navigate the complexities associated with network refinements. Several stakeholders said the lack of clear instructions and vague answers by the State in response to questions also contributed to difficulty among some health plans in responding efficiently to the RFP.

Likewise, health plans expressed concern about the time available to complete the cost bid component of the proposal, especially given the newness of this component. Many described the preparation of the bid as a challenging, "all hands on deck" situation requiring resources being diverted from other projects to complete the bid on time, and also rushed within the available timeframe. Concerns reported by the health plans included:

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- the release of cost bid instructions *following* the RFP (preventing health plans from considering the cost bid in their technical proposal response and delaying health plans' preparations of this component of the proposal),
- vague cost bid instructions and unclear responses to questions by DHS as well as the lack of an advance opportunity to have questions answered before bid preparation (as opposed to questions being addressed and instructions being refined while health plans were already engaged in analysis, etc.),
- delays by the State in furnishing the Excel spreadsheet templates for use by the health plans in preparing their cost bids,
- an inadequate amount of time available to complete the complex analyses necessary for health plans to prepare cost bids, and
- an overlap in the timing of state cost bids for the metropolitan area with health plans' Medicare competitive bid, which health plans described as also time- and resource-intensive.

From the county perspective, most stakeholders spoke of the effort it took to internally review and evaluate the technical proposals submitted by health plans, referring to voluminous proposal materials submitted by all the health plans and the need to coordinate across individuals within counties that had multiple reviewers participate.

Counties also expressed concern about the time it took the State to finalize plan selection following evaluation of the proposals. Many said that the timeline at the end became very challenging, taking into consideration the lack of clear information about plan selection, the late addition of a health plan in some counties, the need for county board approvals, the time required to get health plan contracts in place, negotiations between health plans and providers/clinics, and the need to reach out to enrollees about program changes.

Indeed, the time between plan selection and participant enrollment proved to be tricky for stakeholders. Health plans and counties attributed the time crunch to delayed open enrollment letters to enrollees (going out in November instead of September), the time required for the State to negotiate contracts with the successful plans, the late addition of a third health plan in some counties, and the end-of-year holiday season.

Clarity in Competitive Bidding Requirements for Health Plans

As described above, one factor related to health plans' concerns about the procurement timeline pertained to clarity in the proposal requirements. Several health plans remarked on a lack of clarity with regard to the State's implementation of the competitive bidding process. These health plans felt that improved and more frequent communications between the State and stakeholders—upfront and throughout the process—would have helped to explain the State's intent, clarify basic procurement parameters, and ease stakeholder concerns on many fronts. Some health plans believe that better anticipation of program impacts and key stakeholder issues on the State's part would have led to more helpful guidance for ealth plans and a smoother process from beginning to end.

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Among the chief concerns voiced by the health plans participating in our interviews was that the "rules of the road" for this procurement—as outlined initially in the RFP—appeared to be defined and change as the process evolved and as stakeholder questions about the process "got more difficult." For example, some plans stated that key RFP clarifications and changes to technical requirements continued through the month of April 2011, with technical proposals due just two weeks later. Plans reporting having to continually revise their proposals to adjust to their new understanding of the State's requirements, while timelines were extremely tight. On the cost bidding side, the Medical Loss Ratio was provided as an example, stating that it was originally going to be scored but was taken out of the scoring methodology later in the process. Some plans also indicated that they had asked for published actuarial rate ranges early on, and expressed frustration about the State communicating that they would not release them in advance of the cost bidding deadline and then releasing them unexpectedly during the BAFO process. Another plan expressed frustration with the State's allocation of default enrollment to a plan who was not the highest score bidder in a county, a decision that they believed contracted the RFP.

Some stakeholders we interviewed seemed much more comfortable with this ambiguity than others, assuming that DHS was "figuring things out" as it went due to sheer necessity. "It was a learning experience for everyone," was a common refrain among these health plan stakeholders. They noted having trouble communicating with the State when the State government shut down just after cost bids were due from health plans in mid- June. In fact, most health plans conceded that the difficulties they experienced getting their information needs met were at least in part due to the State government shutdown. "A perfect storm of issues" was how one health plan executive described the competitive procurement and events leading up to health plan selection in the metropolitan area.

On a positive note, many plans commented that the State did a great job providing health plans with several opportunities to ask questions through two bidders' conferences and multiple Q&A documents. Many appreciated that the State's answers to bidders' questions were published at the same time for everyone. A few plans acknowledged that the State's answers to their questions weren't always definitive, but these plans seemed to have an expectation that the State, as purchaser, would have an interest in waiting to make pivotal decisions after receiving all health plan proposals.

Other plans expressed a high level of frustration with the time and effort they spent elaborating their many questions about the process, particularly the parameters of the cost bid, only to have the State answer many of their most significant questions vaguely or not at all. Many health plans were critical of the number of times in Q&A documents that DHS responded to a question about a key assumption with a comment like "the State has no further detail at this time" or "DHS reserves its right to consider all its options and make decisions in the best interests of the State." Still others described facing an "unprecedented amount of unknowns" that could yield material swings in the financial viability of the contract and a feeling of "total discomfort" about business risks, particularly in formulating cost bids.

Through our interviews, we discovered that there was an uneven understanding of basic procurement parameters across health plans. Confusion over what could and could not be assumed in putting together their submissions appears to have been common during the process. Some of this confusion

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should be expected given the fact that the introduction of competitive bidding was a significant change to a health plan procurement process that had not been altered for over a decade. However, it is conceivable that in addition to easing stakeholder concerns with the process, providing more clarity around the following issues would have resulted in better technical proposals and cost bids from health plans (a win-win for both the State and health plans). Some of the key areas of confusion described are outlined below.

- **Possibility for reduction in health plans.** While some plans suggested they clearly understood that the State might reduce the number of health plans in each county from the very beginning of the process, others described operating under the assumption that it would likely be "business as usual." The RFP and subsequent Q&A documents provided said that the State had to contract with a minimum of two plans in each county, but most plans recognized this as a federal requirement, not an indication of a significant change in direction for the program. One plan thought all qualified bidders would be invited to participate but at the lowest cost bid in each county, or that all qualified bidders would be invited to participate but that the lowest cost bidder in each county would receive the default enrollment assignment. A few stakeholders expressed their total surprise that a plan could be completely excluded from the seven-county metropolitan area.

- **How long the contract period was and when rates would be renegotiated.** A few plans expressed confusion over how long the contract period would be, when rates will be adjusted, and when they could expect the contract to be re-procured. Is this a one-year contract? A two-year pilot (as established by the 2011 legislation)? What will happen next? How often will procurement result in changes in health plans participating in the program and therefore plan transitions among enrollees?

- **Whether DHS preferred narrow provider networks to broader networks and how DHS planned to analyze and score network capacity.** While most plans understood that the State was opening the door to narrower provider networks, not all plans understood the State's *preference* was for narrower provider networks. Some plans were frustrated by what they called the State's mixed message of advocating broad access but narrow networks. One plan communicated a disconnect between the positive feedback they had received about their network by the State in the past and the evaluation of their network during this procurement. Despite the many questions submitted by plans on the topic of provider networks, plans did not seem to clearly understand what metrics the State would use to evaluate provider networks. Traditional time and geographic standards? Availability standards (i.e., whether providers in a network were willing to take on new patients)? Standards that favored access to specialty providers such as mental health providers and dental providers? And when did these significant changes to networks have to be accomplished?

- **What cost bids represented and how these bids would ultimately translate into payment.** Most plans described a fundamental lack of clarity when it came to formulating their cost bids. Key questions like whether they were bidding on an "average risk" profile in each

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county or on their "existing risk" profile caused plans great unease. Given that risk adjustment could be a significant portion of total payments, most plans underscored their confusion over how and when risk adjustment would be accomplished, and how it would relate to the bids being submitted. On a related note, plans questioned how possible legislative changes such as ratable reductions, benefit changes, and withholds would be treated. Most of these questions were asked multiple times at bidders' conferences and within Q&A documents, but some plans conveyed continued frustration with the lack of specificity in DHS' answers or felt that DHS staff simply did not understand the technical questions being asked.

- **How the technical proposal would be scored and how the evaluation would be completed.** While the RFP provided health plans with the overall scores possible for each technical area (e.g., 40 points for the County Exhibits in Appendix J), some health plans wanted a more detailed understanding of how the many questions and responses in each section would be scored and weighed. Certain plans also indicated a lack of comfort with the process State and county staff would use to evaluate their proposals. Several plans said they were interested in feedback from the State and counties on their proposals at a much more detailed level than they received. They indicated a desire to use this feedback to inform program development and improvements in the future.

- **BAFO process and the meaning of BAFO letters.** A health plan only received a BAFO letter for a county if it had one of the three highest combined technical and cost bid scores for that county. The number of BAFO letters received and the content of the BAFO letters confused many health plans. It was not clear why a BAFO letter was received or not received by a health plan. Some plans thought that if they hadn't received a BAFO letter for a county, they were successful in that county (which was not the case). The fact that some BAFO letters included published actuarial ranges and others did not added to the confusion. Some plans questioned how they were supposed to respond if they had a bid within the published range or if they were already identified as the low cost bidder.

- **The rules of an appeals process.** One health plan expressed concern about a lack of guidance in the RFP about the appeals process available to bidding health plans in response to the procurement outcomes. More information about the rules and timing of this process was requested.

Focus of Technical Proposal and Requirements

With the exception of a few key differences described earlier in this report, most of the technical responses required of health plans as part of this RFP were identical or similar to those from past procurements for this population. Through an executive summary, a description of the bidder's organization, a project activities and implementation plan, and responses to a comprehensive set of questions, health plans had the opportunity to present their plans and respond to issues outlined by the State and counties.

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Many counties and health plans indicated a desire for more streamlined technical requirements. From a health plan perspective, there were simply too many questions to address each one thoroughly. Several health plans expressed the need for clearer and more focused State program goals to inform a less expansive, but more cohesive set of technical requirements. From a county perspective, the amount of information submitted with health plan proposals was overwhelming, making the scoring process very challenging. According to one county, the RFP was so comprehensive that the review process "got diluted" and became "almost meaningless."

The project activities and implementation plan—and in particular, addressing the county specific issues contained in Appendix H and all the questions developed by the State and counties in Appendix J—was particularly vexing for health plans. As mentioned earlier in the report, information and questions provided by each county on service and delivery, dental care, chemical dependency services, adult and children's mental health, transportation, public health and the like were included in the RFP. Health plans bidding on multiple counties had to address multiple sets of county specific issues and answer a significant number of questions in their responses. Most counties certainly appreciated the opportunity to tailor questions toward their own health care priorities, and one county remarked that their input was integral to the process because counties are closer to enrollees and service delivery issues. Still, most stakeholders (counties and health plans alike) called attention to the repetition and redundancy of issues health plans had to address. Several stakeholders noted that the county-specific questions were very similar, with just slight differences in content and format. These nuances meant that health plans often had to address the same issue seven times in slightly different ways.

Several health plans and counties recommended that collaborative work be done across counties to develop a streamlined set of standards in advance of any future procurement. There were differing opinions as to whether this could be done at the metropolitan level, or whether clusters of "like" counties could develop a smaller, thoughtful set of key issue areas. A few counties noted that doing so would make more sense for another reason: service delivery borders are not clean, and Medicaid enrollees from one county might be seeing physicians in several other metropolitan counties. While there appeared to be general enthusiasm for this type of collaboration among counties, some stakeholders emphasized the advanced planning and time it would take to do this type of work.

Consistency in Health Plan Proposals and Evaluations

As described in the Summary of Minnesota's Competitive Bidding Pilot section of this report, technical proposals, submitted by health plans in mid-May, made up 50 percent of the final score, and cost bids, submitted in mid-June, made up the remaining 50 percent. As in the past, a State and county professionals evaluated and scored the technical proposals submitted by health plans. A small group of analysts from the DHS's Managed Care and Payment Policy Division did the quantitative work necessary to evaluate health plan cost bid proposals.

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While most stakeholders agreed that the State's overall scoring system looked reasonable on paper as planned, some health plans and counties expressed concerns about whether health plan technical proposals and cost bids had been assessed consistently in practice.

Technical Proposal Evaluation

Health plans and counties alike questioned how technical proposals that were so comprehensive, covering so many dimensions of care at such a detailed level, could be consistently evaluated and scored by multiple, disparate teams of reviewers from different levels of State and county government. A comment heard several times from health plan executives was, "we turned in so much data and information, how was anyone going to read all of this?" Several counties commented that it was very difficult to assess and make comparisons between health plans because there was an overwhelming amount of information associated with each technical proposal component.

All counties would have welcomed more instructions from the State as to how to best evaluate and apply DHS' scoring methodology to health plan technical proposals. Some counties were unsure of the reference point and worried that anecdotal information about the plans would seep into the evaluations. Others thought it was appropriate to base their evaluations on everything known about health plans. Because of tight timelines and the need to provide scores to the State quickly, certain key questions about the evaluation process were raised:

- Were counties supposed to evaluate health plans based strictly on their technical responses or could they also include their knowledge about working with the plans?
- What if health plan responses conflicted with their knowledge of plans?
- Did health plan responses reflect what they planned to do in the future or what they already do? And how could counties be sure?
- Were there any other reference points or outcome data that could help to ground county evaluation processes?
- What if certain health plan responses seemed more thoughtful because they were written better than others? Should better writing equate to more points?

In the end, counties chose to handle their evaluations in a variety of ways. Some stuck to evaluating RFP responses only, some incorporated their knowledge of health plan performance based on experience, and one focused on past experience. Equally varied was the approach each county took to staffing the evaluation. Some counties engaged a broad group of experts in each substantive area of the proposal and other counties appointed one person to do the evaluation and scoring (with, in some cases, that person reaching out and consulting with others within their organization).

Providing counties with a consistent basis for scoring, a preferred approach for staffing and performing the evaluation, and more time to complete the evaluation would be a great start to improving the

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process at the county level. A forum for counties to "cross-walk" their technical scores with the scores of State staff evaluating the same components was also recommended. Additionally, several counties would welcome additional space in their evaluations for more qualitative feedback and/or opportunities to discuss health plan performance and their recommendations with the State and/or other counties.

Cost Bid Evaluation

On the cost bid side, concerns were voiced primarily by health plans as counties were not involved in this part of the process. As mentioned earlier in this report, many health plans were confused about what their cost bid was supposed to represent. Several health plans felt they lacked the detailed instructions needed to make key assumptions and then have confidence that their cost bids would be comparable to those of their competitors. Some health plans illustrated this point by highlighting the "Bidding Information and Instructions" document provided by the State and comparing it to the much more detailed guidance provided by CMS as part of Medicare Advantage bidding.

Several plans indicated that without definitive answers to their detailed questions about bidding assumptions through the Q&A documents, they had to make their own assumptions and lay these assumptions out in writing for DHS. In addition to providing capitation rate bids by rate cells, all plans also submitted a cover letter describing the methods and assumptions used in developing their rate proposal. Many of these assumptions related to how the health plan assumed their bid would translate into final payment, how risk adjustment would occur, or how legislative changes would ultimately be handled. Some health plans relied heavily upon their own data—but this involved implicit assumptions that populations served would stay the same—and some relied on the databook provided by DHS for countywide averages. Others described a process using their own data but "normalizing" their risk scores so that their bids would be comparable to others. All in all, with these differing approaches in mind, many health plans questioned whether comparing bids submitted by health plans was like comparing "apples to oranges." A number of health plans questioned whether the process had been fully vetted and whether the process had resulted in a level or uneven playing field for all parties involved.

Balancing the Evaluation of Technical Proposals and Cost Bids

Most stakeholders seemed cognizant of the State's desire for greater accountability of managed care spending and agreed that a balanced approach to evaluating quality, efficiency, and cost-effectiveness made sense. Most stakeholders agreed that the scoring methodology outlined in the RFP for technical proposals and cost bids appeared to be, on paper, balanced. However, several stakeholders voiced their opinions that as the process unfolded and plans were selected, they came to believe that DHS just chose the lowest cost bidders in each county. Certain health plans and counties speculated that there was little deviation on the technical rating between the health plans, and thus cost must have been the driving force behind ultimate plan selection. A few counties felt that the State completely disregarded their evaluation of technical components and preferred plans, and that cost concerns trumped all.

While the scope of SHADAC's analysis did not include an in-depth data analysis of the scoring methodology used as part of the competitive bidding procurement, a cursory review of points awarded for technical proposals and cost bids does suggest that the variability in cost bid scores was much

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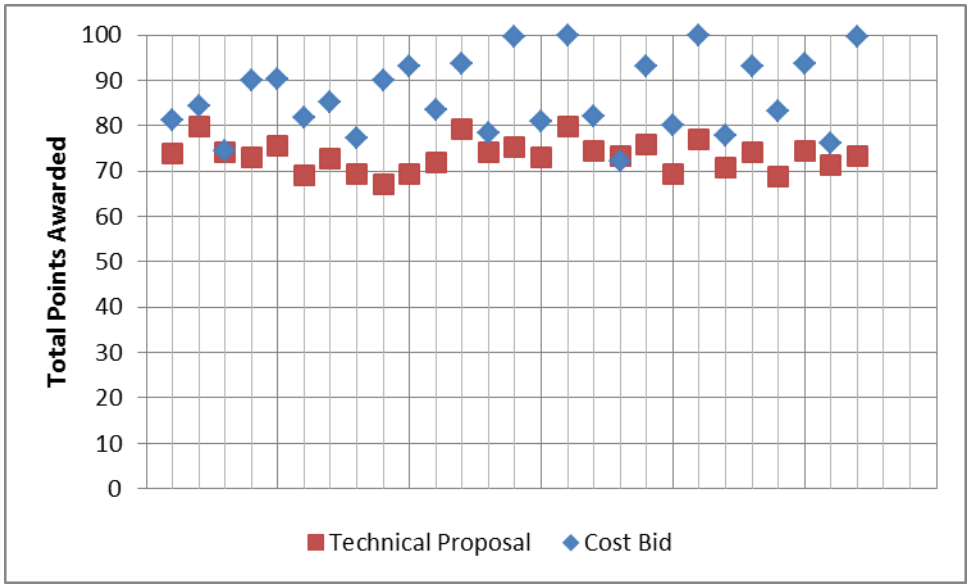
greater than the variability in technical proposal scores (see Figure 1). Although the technical proposal and cost bid each represented 50% of a health plan's total score, the relative lack of variation among technical scores meant that cost bid scores played more of a role in differentiating health plans.

Figure 1. Distribution of Total Points Awarded for Technical Proposals and Cost Bids*



*Each data point above represents total points awarded for either a technical proposal or cost bid for one health plan in one county.

This result may not be particularly surprising, given the contents of the technical proposal and their origin. As Stated earlier, many technical requirements that were part of this RFP were identical or similar to those from past procurements. Also, in the past, as happened here, both State and county staff reviewed and scored technical components. The significant difference for this procurement was that technical scores were used and combined with scores from the cost bids to rank and ultimately select health plans. The scoring in the past had only been used to ensure that plans met certain benchmarks and were qualified to participate in the program.

If more balance is sought toward the joint goals of quality, accessibility, and cost-effectiveness, several stakeholders (both health plans and counties alike) felt that future procurements should refocus the scored components of the technical proposal on a narrower set of key parameters, provide instructions and/or baseline data to technical evaluators to ensure a sound basis for evaluation, and streamline the process to ensure consistency across evaluators.

Beneficiary Enrollment and Operational Impacts

Because of the switch from four or five to two to three contracted health plans in each county, a number of MA and MinnesotaCare enrollees needed to change health plans in 2012. While our

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stakeholder discussion guide focused on procurement, nearly all stakeholders spoke about the transition and enrollment of beneficiaries and related member operations. Several stakeholders felt that DHS was disconnected from transition and operations issues as well as from the experience of enrollees – saying that the new procurement process had not been patient-centered enough – and several stakeholders expressed concern about the degree of State planning and sophistication of the State's infrastructure/systems to support changes "downstream." As discussed below, both counties and health plans described an intense period from the fall of 2011 to March 2012, between plan selection and beneficiary enrollment.

One factor contributing to stakeholder difficulties in planning for the transition pertained to the State's program enrollment estimates. Several of the estimates were reported to be significantly off, making it difficult for health plans to anticipate and prepare for changes in enrollment.

Another key aspect of the transition concerned the letters sent to enrollees by the State in September of 2011 notifying enrollees that their health plan may change. Several counties and health plans described this correspondence as confusing and not patient-centered, citing that the letters lacked adequate information about the forthcoming changes and did not provide relevant contact information to enrollees who had questions. "The letters produced a lot of fear" among enrollees and stress and "administrative pain" for counties. It was understood that the computer system generating these letters did not easily accommodate changes to the letter, which frustrated several stakeholders. Several counties and health plans stated that the confusion caused by the letters put counties "in a difficult position." Staff at one county indicated that they did not know the letter was going to be sent. Because negotiations between the state and health plans were still going on and because successful health plans were still negotiating with clinics and providers, counties did not know what plans were being selected so they could not address enrollee questions and clarify for enrollees what to expect. The fact that an additional plan was being added late in some counties also added to customer service difficulties.

Some counties experienced relatively few member enrollee transitions, whereas others experienced a high number or proportion of members shifting to a new plan. According to stakeholders, these changes were a significant undertaking for these counties. For health plans adding members, it took significant "infrastructure" (e.g., staff, time) and, for counties, it involved a great deal of effort, referring to significant overtime and resources. More collaboration between the State and counties and health plans (both successful and unsuccessful) was recommended to ensure a smoother process in the future.

It is worth noting that stakeholders identified several positive factors facilitating the enrollment transition and process. Multiple stakeholders (including both health plans and counties) complimented health plans for their level of enrollee outreach during this stage. These compliments were directed not only to the successful health plans taking on new enrollees but also the health plans transferring members to new plans. Also mentioned were health plans' allowance for enrollees to use an out of network provider during the first 90 or 120 days of the contract year and the State's grace period permitting enrollees to switch health plans if desired in the first 60 days. While enrollment was a challenging process for counties, one county felt very favorably about its collaborative relationship with its State enrollment contact during this time. (In the past, counties have entered enrollees' program

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forms into the enrollment system. For this procurement, all of the plan choice forms came back to the State, and in turn, the State entered these forms.)

Stakeholder Engagement

As described earlier in this report, the State used several mechanisms to engage counties in the procurement process (e.g., in the development of the RFP and evaluation of technical proposals) and to reach out to bidding health plans (e.g., bidders' conferences and Q&A documents). Much of the conversation with the health plans about stakeholder engagement seemed to focus greatly on communications by and with DHS and, as discussed above, the desire for more clarity in the procurement approach and requirements. In this section, we emphasize the involvement of county stakeholders in the procurement process but also touch on other aspects of engagement described by the health plans.

While several counties applauded DHS for reaching out to counties early in the process, a recurring sentiment was that the State's engagement of counties was not continuous throughout the entire procurement process, with gaps in engagement occurring during the cost bid and BAFO stages of procurement and during the time when the State was scoring and selecting the plans. Most counties described being involved and receiving instructions about the process in a very "piece meal" fashion: there were short periods of intense communication and activity followed by long periods with no involvement or information coming from the State (an "information vacuum," as one interviewee described it). Several health plans also communicated interest in having the expertise of health plans and counties be leveraged more in the development and implementation of the new procurement process. A couple health plans mentioned that that they provided input and/or research on competitive bidding when they got wind that the State was seriously considering competitive bidding but was not sure if the State had used the information. One health plan recommended that DHS more proactively utilize existing health plan and county knowledge about network and provider capacity and patient access to improve the program in the future.

Several counties expressed gratitude for being able to comment on and contribute to the technical questions included in the RFP, and one county expressed interest in even more county engagement/collaboration in the development of this RFP content. Some counties were skeptical whether their input in this stage was used by the State. As mentioned earlier, more cross-county collaboration and coordination were recommended to strengthen counties' contribution to and the focus of the technical component of the RFP. Several health plans echoed this sentiment, indicating that more coordination across counties would have helped to streamline the RFP.

Several counties also communicated a similar sentiment related to scoring of the technical proposals from health plans. Some counties felt they did a tremendous amount of work to evaluate health plan technical proposals in a short amount of time—some creating fairly in-depth evaluation processes and engaging a broad array of staff—but then had no assurances that their comments actually mattered in ultimate plan selection and whether their feedback was received by the health plans. At the time technical evaluations were being completed, some individuals expressed feeling that the evaluations were

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very important and that they should be taken very seriously; after plans were selected, these same individuals felt their input was insignificant in terms of the overall process. Additional opportunities to meet or conference with the State and other counties to discuss technical scoring guidelines and review the results of technical scoring were recommended. As mentioned earlier in this report, several health plans said they would welcome more information about their proposal evaluations by the State and counties to inform plan improvements in the future.

All counties communicated a lack of involvement during the cost bid stage of the procurement process and during final plan selection. While some felt that being separate from the cost bid stage was appropriate and therefore not of concern, several counties expressed disappointment about a lack of involvement in the final scoring and selection of health plans. Counties conveyed feelings of being uninformed about final scoring results and unclear about how these scores led to final plan selection across and within counties by DHS. Several counties expressed that they would have appreciated more information as to why certain plans received contracts and others did not. In some counties, the final health plan selection did not correspond with the county's technical review of the plans, leaving these counties feeling as though their feedback and input was not taken into account. More opportunity to explain and discuss a county's ratings of health plans with the State was requested. One county questioned why counties needed to go to their Boards for approval, when counties were not really players in terms of the negotiations with the health plans.

While most counties did not have a desire to be involved in the cost bidding evaluation, many would like to have been informed about the results of that evaluation ahead of the notice to health plans. In general, many counties wished they would have had a better understanding of how the cost bidding portion of the competitive procurement related to the technical evaluation and how it influenced health plan selection. Finally, many counties expressed a desire for clearer communications from the State once health plans were selected. According to some, there were instances at the end of the process when DHS didn't proactively communicate with counties and/or health plans, which led to a certain level of misinformation and confusion all around. A couple counties reported hearing about plan selection "through the grapevine" prior to being officially informed. Finally, enrollee transition (discussed in greater detail above) is another phase about which both counties and health plans expressed a void in engagement by the State. Several stakeholders recommended that counties' and health plans' expertise be leveraged particularly in reaching out to enrollees. For example, some counties and health plans expressed concern about the initial letters that were sent to enrollees by the State and the lack of opportunity to contribute to those letters to reduce enrollee concerns and confusion about program changes. As one county said, "there is value in talking about how to communicate" to enrollees.

All in all, several counties and health plans expressed an interest in more engagement throughout the procurement process. A couple of counties emphasized an interest in greater collaboration and coordination among the seven counties in the procurement process as well. One county recommended a group consisting of one representative from each county to interface with the State throughout the procurement process to facilitate better information sharing in the process but also to provide an ongoing and consistent forum for county input on and expertise in the process.

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Several stakeholders also expressed appreciation for this stakeholder analysis project and the fact that it was being conducted by an outside, objective entity. One recommendation was to bring stakeholders into a meeting with DHS to help interpret results of this report and to determine improvements for future procurement cycles.

Recommendations for Future Procurements

Through conducting this stakeholder analysis, we witnessed a universal commitment among State and county officials, health plan executives and their respective staff to improving Medicaid and MinnesotaCare programs for enrollees and increasing the value of services provided for by taxpayers. In general, our interviews revealed a great deal of support among stakeholders for competitive bidding as a strategy that could help to support these goals. Still, competitive bidding is a major and meaningful change to the way contracting has been handled in Minnesota for years, and it was implemented on a very aggressive timeline. Given the significance of the change, it is not surprising that several "lessons learned" emerged from our discussions with counties and health plans. We offer the following recommendations for DHS as it contemplates future procurements under a competitive bidding model:

- **Better anticipate stakeholder information needs and provide more clarity in RFP guidance and instructions.** Continue the practice of holding bidders' conferences, allowing bidders' questions at specified intervals, and publishing answers to bidders' questions at the same time. Utilize the Q&As from the 2012 competitive bid procurement process and key stakeholder concerns to help focus Departmental decision-making in advance of the next procurement process, make clarifications within the RFP itself, and refine communications with health plans. Provide specific answers whenever possible and appropriate from a State purchasing perspective. Help to ensure the consistency of health plan submissions by providing more specific guidance on proposal parameters and cost bidding assumptions.

- **Refocus the scored components of the technical proposal on a less expansive, more cohesive set of requirements that align with key State and county goals.** Streamline the process for health plans to prepare proposals and counties to evaluate proposals, and perhaps more importantly, attain a better balance between technical and cost components of the evaluation. Help to facilitate collaborative work among counties necessary to develop a more focused set of metropolitan- or regional –level technical standards in advance of any future procurement.

- **Provide counties with a consistent basis for evaluating and scoring health plan technical proposals.** Under competitive bidding, counties play an even more significant role in the evaluation and scoring process that ultimately leads to health plan selection. As such, they should be provided with a consistent basis for scoring, preferred approaches for staffing and performing evaluations, adequate time to complete this work, and more communication and engagement in the process. A forum for counties to "cross-walk" their technical scores and to share their qualitative assessments with State staff evaluating the same components would also be an improvement to the process.

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- **Leverage DHS project management capabilities and assign accountability for the procurement process from beginning to end.** Under competitive bidding, member transitions are a likely outcome of future procurement processes. After RFP responses are evaluated and health plans are selected, the difficult work of coordinating operations among multiple stakeholders (e.g., counties, health plans, providers) and ensuring smooth transitions and care coordination for enrollees begins. Better use of project management resources within DHS throughout the procurement and enrollment process will connect the planning and evaluation process with downstream impacts on State information systems, enrollment, and operations.

- **Treat the procurement process as one opportunity to engage county and health plan stakeholders in a meaningful discussion about how to improve program outcomes and achieve better value for taxpayers.** With each new procurement process, the State, counties and health plans devote significant resources—both human capital and financial—to designing the RFP, developing proposals, and evaluating responses. The culmination of all of this work should not only inform health plan selection for the current procurement cycle, but should influence overall program improvement efforts. Providing direct feedback on evaluations and scores to health plans and counties and facilitating opportunities to leverage county and health plan expertise to inform program design, RFPs, and management (such as this stakeholder analysis) are ways to increase stakeholder engagement in these efforts.

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Appendix A: DHS Letter to Stakeholders

Date

Dear [Health Plan or County Representative],

As you know, in January 2012, the State entered into contracts with selected health plans to serve Medicaid and MinnesotaCare populations in the seven-county metropolitan area based on a competitive bidding selection process. While competitive bidding is an approach that has been used in other states around the country to contract with health plans serving public program enrollees, it is new to Minnesota. We recognize that it is a significant and meaningful change to the way contracting has been handled in Minnesota for decades.

It is in this context that we would like to seek feedback from the county directors in the seven counties and the health plans that bid to serve these counties to inform future competitive bidding processes and procurements. Specifically, we are interested in your feedback on how the competitive bidding process for the Families and Children Contract was implemented; how technical and cost bidding components were designed; how health plan proposals and bids were evaluated; and how health plans were selected. Our hope is to identify common themes among health plan and county stakeholders and to develop "lessons learned" for the program.

We are fortunate to have technical assistance funding through the Robert Wood Johnson Foundation (RWJF) to help us in this endeavor. To carry out an objective analysis, we have engaged two senior researchers from the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota's School of Public Health, Donna Spencer and Kristin Dybdal. We recently met with the SHADAC team to provide them with an overview of the competitive bidding process from the State's perspective.

The research team will develop instrument guides and begin interviewing health plan and county representatives as the next step in the evaluation process. We anticipate that they will contact you in the next couple of weeks to schedule interviews with you (and/or others from your organization that you deem appropriate) during the last half of May and early June. They will provide you with information about the interview well in advance of these meetings. We hope to have a final report from SHADAC compiling their findings by the end of August.

Thank you in advance for participating in this process and for your insights as we collectively seek to increase quality and improve efficiencies in the State's managed care programs.

Sincerely,

Scott Leitz, Assistant Commissioner for Health Care

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Appendix B: Stakeholder Analysis Discussion Guide

DHS Competitive Bidding Stakeholder Analysis
Stakeholder Discussion Guide

Thank you for participating in the stakeholder analysis of the 2012 Families and Children Contract competitive bidding process for the seven-county metro area. The goal of this project is to solicit feedback from the seven counties and health plans bidding to serve Medicaid and MinnesotaCare populations in these counties; to identify common themes; and use these "lessons learned" to inform the competitive bidding process and procurements in the future.

Technical Proposal Requirements

1. From your perspective, what technical proposal requirements were both new to this procurement and significantly different from past practice?

2. Did you feel you had adequate time to respond to these changes? [N/A to counties]

3. Were the new technical requirements presented in the RFP addressed in subsequent bidders' conference and Question and Answer (Q&A) process, clear? [N/A to counties]

4. Did you understand the rationale for these changes?

5. How well do the technical requirements of this RFP align with your county's priorities for the managed care program? What suggestions do you have for how to improve the technical requirements, either in clarity or content? [Counties only]

6. What other feedback, either positive or negative, would you like to provide the State with regard to the technical proposal requirements or the technical phase of the competitive bidding process?

    a. What suggestions do you have for improvement? [N/A to counties, redundant]

Cost Bid Requirements

7. Were the new cost bid requirements presented in the RFP addressed in subsequent bidders' conference and Question and Answer (Q&A) process, clear? [N/A to counties]

8. Do you feel you had adequate time to provide a competitive cost bid? [N/A to counties]

9. Do you feel you had adequate instructions to provide a competitive cost bid? [N/A to counties]

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10. Do you feel you had access to the right data to provide a competitive cost bid? [N/A to counties]

11. What feedback, either positive or negative, would you like to provide the State with regard to the cost bid requirements or the cost bid phase of the competitive bidding process? When answering this question, please keep in mind the following:

    a. History of key expense ratios (e.g., administrative cost ratio)
    b. Initial cost bid and templates
    c. Best and final offer (BAFO) process
    d. Risk adjustment
    e. Cost bid instructions, Excel templates, and data book

Proposal Scoring and Plan Selection

12. Based on the information provided by the State in the RFP, bidders' conferences, and Q&A process, do you believe that your [health plan] proposals were evaluated objectively and fairly?

13. Given your understanding of the RFP and scoring methodology, did any outcomes of this process come as a complete surprise?

14. What feedback, either positive or negative, would you like to provide the State with regard to the scoring methodology and how plans were ultimately selected? When answering this question, please keep in mind the following:

    a. Technical proposal scoring
    b. Cost bid scoring
    c. Number of plans in each county
    d. Default assignments for enrollees

15. If you participated in the process as a technical proposal evaluator, what was your role? Would you recommend any changes to the evaluation process itself? [Counties only]

Stakeholder Outreach and Communication (to extent not covered already)

16. Please describe how you were engaged during the competitive bidding process. When answering this question, please think about the following:

    a. Development of procurement timeline

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b. Design of technical or cost bidding requirements
c. Bidders' conferences and Question and Answer (Q&A) process
d. Proposal evaluation
e. Plan selection and notification/award letters
f. Other

17. Were you able to anticipate most process milestones, deliverables, and requirements through the RFP, bidders' conferences, and Q&A process? [N/A to counties]

    a. Were your questions adequately answered?
    b. Did anything about this process come as a surprise?

18. From your perspective, were the changes to the procurement timeline significant? How did they impact internal operations?

19. In general, how satisfied were you with the DHS' level of outreach and communications during this process?

20. In terms of outreach and communications, what was handled well? What suggestions do you have for improvement?

Other Feedback

21. What were the key "lessons learned" for your health plan/county from the new procurement requirements and process?

22. Is there anything else about the competitive bidding process you would like to share at this time?

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