



Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900

phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

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Submitted electronically to ross.owen@state.mn.us

Ross Owen
Health Care Administration
Minnesota Department of Human Services
St. Paul, MN 55155-0984

RE: Questions for Health Care Delivery System Demonstration Project Responders' Conference

Dear Mr. Owen:

On behalf of the 146 hospitals and 17 health system members of the Minnesota Hospital Association (MHA), we appreciate the opportunity to provide the following questions regarding the Alternative Payment Arrangements through the Health Care Delivery Systems (HCDS) Demonstration Project Request for Proposals (RFP). We respectfully ask that the Department of Human Services (DHS) respond to them as best you can during the discussion at the upcoming responders' conference.

Definitions

- What is the definition for Primary Care Providers?
 - Does this include General Practice, Family Practice, Internal Medicine, Geriatrics, OB?
 - Are Nurse Practitioners or Physician Assistants included in the definition?
- What is the definition of a “major accusation” as used in the second full paragraph on page 17 of the RFP? Does DHS have a dollar threshold or other guidance for potential responders to gauge whether a particular accusation is considered “major” or the level of certainty required to determine that it could “affect your financial stability”?

Payment Model – Shared Savings

- The RFP describes alternative payment models that a respondent might consider based on the size of its patient population and its degree of integration. Will DHS accept proposals that put forward other payment models that blend together or differ from those suggested in the RFP? For example, if a respondent submits a proposal that does not include downside risk for the respondent but does explain how savings will be generated for the state, will DHS reject the proposal because it fails to adhere to the two models described in the RFP?
- What factors will DHS include in its risk adjustment process? Can a respondent propose factors, such as socio-economic or primary language, as part of its proposal?
- Does DHS anticipate that it will share savings on a “first dollar” basis if the respondent meets the 2% minimum threshold, or instead, does DHS intend to retain the initial 2% of savings and share only in the savings that exceed 2%?

- Can an organization elect to participate in model 1 even if it has more than 2,000 enrollees?
- If a respondent receives a reconciliation payment for its portion of the savings achieved in the previous year, will the amount of that payment be included in the respondent's total cost of care calculation in the year in which it was paid? In other words, will the shared savings earned by a respondent count against the respondent in the subsequent year as an additional cost?
- When does DHS expect to provide the trend factor analysis described in section 2.C.iv of the RFP?
- Can a certified health care home participate in the demonstration project? If so, will the care coordination fees received by the health care home be counted as part of its patients' total cost of care?

Total Cost of Care Performance Measurement Specifications and Requirements

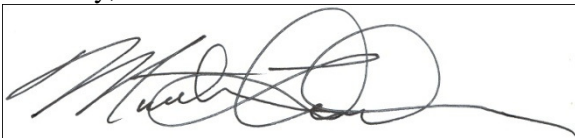
- Is DHS willing to accept proposals that vary from the RFP's claims cap levels? While it is understandable that a smaller organization with a smaller population would have a smaller claims cap to mitigate its risk, but organizations serving larger populations have a greater chance of treating patients with large claims and face a dramatically higher claims cap under the RFP. Will DHS consider reducing the claims cap so that no organization takes on claims that exceed \$250,000 for a single patient?

Participation Scope

- Can a health system with multiple hospitals and/or clinics limit the scope its proposal to
 - (a) a specific geographic market (i.e., a particular county, metropolitan statistical area),
 - (b) population demographic (i.e., state public program enrollees between ages 21 and 45),
 - (c) enrollment status (i.e., MinnesotaCare only, fee-for-service only or PMAP only), or
 - (d) disease condition (i.e., state public program enrollees with diabetes)?Or, instead, must a respondent agree to serve its *entire* Medicaid patient population at all of its facilities under the conditions of the demonstration project?

If you have any questions or concerns about the above questions, please feel free to contact me at your convenience.

Sincerely,



Matthew L. Anderson
Vice President of Regulatory & Strategic Affairs
Minnesota Hospital Association
2550 University Avenue West
Suite 350-South
St. Paul, MN 55114
(651) 659-1421