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## DHS Request for Proposals — Factors to Consider

The following discussion document follows the structure of the Minnesota Department of Human Services' (DHS) Request for Proposals (RFP) from health care providers to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees under Alternative Payment Arrangements through the Health Care Delivery Systems (HCDS) Demonstration Projects.<sup>1</sup> The various points or comments raised in the sections below highlight potential questions, concerns or considerations hospitals or health systems might want to consider. MHA attempted to avoid repeating information or instructions contained in the RFP, and instead, focused on areas of decision making or policy implications for those MHA members interested in submitting a response.

It is important for MHA to emphasize that *the information and suggestions that follow are not intended to be legal advice; to be exhaustive of legal, financial or public relations issues facing a potential respondent to the RFP; or to otherwise represent that MHA supports, opposes, encourages or discourages any particular proposal or approach to the RFP.* Instead, MHA hopes that this discussion document will assist our members in making their own independent and informed decisions after obtaining appropriate legal and financial counsel as well as considering any public relations implications for their respective organizations.

### I. Introduction

- While the introduction offers little direction for respondents, it can be a useful source to reference if a proposal offers a direction that differs from the one laid out by the state in the RFP. By explaining how the proposal's alternative approach will better fulfill the goals outlined in the introduction, a respondent could make its approach more palatable to the state.
- The RFP does not clarify whether a respondent must include fee-for-service (FFS) and public program enrollees in managed care in the demonstration project, or Medical Assistance (MA) and MinnesotaCare. Or, instead, whether a proposal could exclude, for example, FFS patients or apply only to MinnesotaCare patients. A potential respondent might want such clarification before finalizing a proposal or negotiating a contract with DHS.
- The RFP states that DHS “may choose to renew any contract awarded under this RFP annually for up to three (3) years.”<sup>2</sup> A respondent might consider asking for further clarification regarding the factors DHS will use to determine whether a contract will be renewed. For example, it is likely that a health care provider would not want the state to decline to renew the contract if the provider's performance indicates that it is about to achieve significant savings in the upcoming year.

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<sup>1</sup> The most recent version of the RFP as of August 3 can be found at [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_162632.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_162632.pdf).

<sup>2</sup> RFP at sec. I.B.

## II. Scope of Work

### Sec. A.1 System Requirements

- Although the RFP includes a general definition of “primary care,” a respondent might consider including its definition or understanding of “the full scope of primary care services” that it will deliver under the demonstration project.
- The RFP can be interpreted as requiring the respondent to deliver all primary care services for its attributed population.<sup>3</sup> However, it is likely that enrollees will receive primary care and preventive services from multiple primary care providers, some of whom are not participating in the HCDS. It might be helpful to clarify that the respondent’s HCDS will provide access to primary and preventive care for its enrollees and that it does not commit to be the sole and exclusive source of such services.
- The RFP indicates that DHS intends to reserve the right to change the terms and conditions of the demonstration project if necessary to obtain CMS approval.<sup>4</sup> MHA understands the state’s need for such flexibility. However, hospitals and health systems should consider whether a similar provision allowing a HCDS to cancel a demonstration project if the terms and conditions change would be appropriate.

### Sec. A.2 Overview of Payment Models and Risk

- The RFP lays out two payment models. Although one of the models might be appropriate for a particular health care provider, one can predict that variations of these models or entirely different methodologies might be better suited for a particular provider, community or enrollee population. The RFP does not state whether other alternatives will be considered. A potential respondent might request clarification on this matter. Regardless, a respondent to an RFP is not required to adhere to the strict requirements set forth by the state, and instead, can propose different ways to accomplish the state’s objective. It is important to emphasize that the state is not obligated to accept alternative approaches.
- The RFP anticipates HCDS receiving a reconciliation payment if they generate savings. MHA has asked DHS to clarify whether a reconciliation payment will be included in the HCDS’ total cost of care in the year in which the payment is received. MHA believes that such payments should not be considered as part of the total cost of care, otherwise an HCDS’ success in one year generates a greater challenge in the following year unrelated to the cost of the care received by enrollees in the second year.
- The RFP encourages respondents to explain how they will involve community organizations in the distribution of shared savings payments. A respondent should ensure that any such distribution arrangement does not conflict with state or federal anti-kickback laws or promote behavior that might be interpreted as anti-competitive or monopolistic.

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<sup>3</sup> See RFP at sec. II.A.1.a.

<sup>4</sup> See RFP at sec. II.A.1, second to last paragraph.

- MHA has asked DHS to clarify if a hospital or health system can limit its demonstration project population to less than 2,000 enrollees and stay in the Virtual HCDS model even though its total number of enrollees served could exceed 2,000 enrollees.
- A respondent that would fall within the Integrated HCDS model might consider clarifying whether the two-way risk sharing model contingent on quality and patient experience measures means that a HCDS that meets quality and patient experience measures will be immune from sharing financial losses, or instead, if DHS intends to use quality and patient experience measures as a contingency for sharing savings with the HCDS but not for determining HCDS liability for downside risk.
- A respondent intending to participate as an Integrated HCDS might want to ask whether downside risk liability will be collected by the state in a one-time reconciliation payment, in withholds of all or a portion of future payments from state public programs, or in installments over a particular period of time.
- The RFP describes some of the data DHS will use to attribute patients to a HCDS.<sup>5</sup> A respondent with the capacity to analyze and confirm such data might request access to it or auditing rights to ensure that the attribution calculation is correct and to better understand the health care utilization patterns of its attributed patients.
- A potential respondent might suggest exceptions or inclusions from the Base Period Total Cost of Care calculation and/or how “catastrophic cases” should be defined in a manner that reflects the respondent’s risk tolerance, care or services capacity, etc.
- The RFP was drafted prior to resolution of the 2011 legislative session, and therefore, the RFP did not anticipate that managed care rates annual growth would be statutorily capped. Accordingly, a proposal might consider clarifying that the expected total cost of care should be calculated based on the manner for calculating managed care cost increases prior to the new statutory caps on rate growth.
- The RFP sets forth varying claim cap levels based on the number of enrollees served by a HCDS.<sup>6</sup> A potential respondent could propose different cap levels with an explanation of the reasoning behind a different amount and/or calculate the cost of any reinsurance it might obtain to protect against losses between the amount of risk it is willing to accept and the state’s claim cap amount.
- DHS intends to impose a 2% threshold before savings or costs are shared with providers.<sup>7</sup> Such a threshold is one approach to shared savings agreements. MHA has encouraged CMS to consider a sliding-scale share savings model that allows for sharing of “first dollar” savings. In such a model, providers receive a small portion of generated savings and their portion of savings increases as the amount of savings they generate increases. Thus, the provider has incentive and reward for any savings it generates. Because of DHS’ intention to require symmetrical models for Integrated HCDS, this first-dollar approach would apply equally to higher than expected costs, and therefore, could serve to increase those providers’

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<sup>5</sup> See, e.g., RFP at sec. II.A.2.c.i, iv, vi, and vii.

<sup>6</sup> See RFP at sec. II.A.2.d.ii.

<sup>7</sup> See RFP at sec. II.A.2.d.iii.

risks. Accordingly, a respondent should carefully analyze the shared savings thresholds in the RFP as well as other models.

### **Sec. II.A.3 Definition of Total Cost of Care (no comments)**

### **Sec. II.A.4 Attribution Methodology**

- DHS anticipates sharing a preliminary population with the HCDS at the beginning of a performance period.<sup>8</sup> The department does not provide much detail regarding the data it plans to share and whether it will be sufficient for the HCDS to identify its preliminary patients and contact them to begin care coordination activities.
- MHA is uncertain whether patient attribution based on emergency department utilization is appropriate given that some patients will receive no other care during the year except for one or two legitimate, appropriate emergency department encounters. It is questionable whether the hospital that provides the emergency care necessary, and perhaps the subsequent inpatient care, should be held accountable for all of those costs when it had no opportunity to identify, communicate with or manage the patient. In particular, MHA suggests that hospitals with higher volumes of trauma patients consider how such a methodology could impact their attributed patient population.

### **Sec. II.A.5 Quality Measures**

- Because DHS has not identified which measures will be used, MHA has no comments or suggestions other than for potential respondents to closely evaluate the measures posted on or before August 30, and then analyze the costs of data collection and reporting.

### **Sec. II.A.6 Role of Managed Care Organizations (MCOs)**

- Each hospital and health system should examine its negotiated payment rates from MCOs and attempt to assess whether such rates will make it easier or harder for the HCDS to meet its savings thresholds. In addition, MHA suggests that members watch for any new MCO contract terms pertaining to reconciliation payments under the demonstration project.

### **Sec. II.A.7 Data Feedback to Providers**

- Potential respondents could offer proposals that include additional data that would help them better manage patient care, or that contain more detail about the specific data expected to be received from DHS.

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<sup>8</sup> See RFP at sec. II.A.4 second paragraph.

## **Sec. II.B. Tasks/Deliverables**

- The enumerated list of deliverables offers a brief outline of issues or assurances that a proposal should address or include. Simply stating that the respondent agrees to the deliverables can result in precluding the respondent's opportunity for further negotiation of those issues. Also, such blanket statements of agreement could negate other alternatives or suggestions offered by the respondent in different sections of its proposal. Therefore, it is important for proposals to explicitly and clearly state which elements of the deliverables are agreed to outright, and which ones are conditionally agreed to subject to the state's acceptance of the proposal's alternatives and/or further negotiations.

## **III. Proposal Format**

- The RFP states that respondents must describe their current state public program enrollee population, including demographic information. Because it can be difficult for providers to identify whether a particular patient is enrolled in a state public program managed care plan or, instead, enrolled in a private sector health plan, it might be useful for respondents to qualify this information in their proposals with a brief explanation of their data limitations.
- The remainder of the RFP contains directions for completing a proposal, indications of how the proposal will be evaluated, required statements the respondent must make and attest to, and what is typically considered "boilerplate" language. Respondents that want to enter a contract with different terms, conditions or attestations should clearly identify and explain those exceptions in the proposal, otherwise they will be deemed to be agreed to by the respondent. MHA strongly encourages members to review this information carefully and ensure that all such conditions are met before submitting a proposal.

Aug. 4, 2011