DEPARTMENT OF HUMAN SERVICES

Legislative Report

Managed Care Procurement

Summary of County Activities

Purchasing and Service Delivery Division

December 1, 2022

For more information contact:

Minnesota Department of Human Services
Purchasing and Service Delivery Division
P.O. Box 64984
St. Paul, MN 55164

DHS.PSD.Procurement@state.mn.us

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.PSD.Procurement@state.mn.us, call 651-431-3039, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $20,000.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Table of Contents

I. Executive Summary

This report responds to the statutory requirement for a summary of county involvement in DHS managed care procurement activities. It also provides the explanation as to the decisions made regarding procurement awards as required by the statute.

II. Legislation

Minnesota Statutes section 256b.69, subdivision 3a, paragraph (h)

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

III. Introduction

In accordance with state and federal requirements governing managed care procurements, DHS conducted competitive statewide procurements for calendar year 2023 to provide health care services through the Seniors and Special Needs BasicCare (SNBC) contracts and for 80 counties in Greater Minnesota to provide health care services through the Families and Children Contracts (PMAP and MinnesotaCare).

Beginning in 2020, DHS and county representatives worked together to establish a new process for conducting managed care procurements. The new process was implemented for the 2022 Seven county metro Twin Cities Area Families and Children RFP. DHS and county representatives worked together to develop the RFP and also scored the proposals together as a team. This process was the template for the Seniors, SNBC and Greater Minnesota Families and Children procurements for contract year 2023.

IV. Procurement Process

Beginning in 2020, DHS and county representatives worked together to establish a new process for conducting managed care procurements. The process arose out of a series of conversations between DHS Medicaid program officers and staff and county representatives organized through the Association of Minnesota Counties (AMC). The new process was implemented for the 2022 Metro Twin Cities Area Families and Children RFP. DHS and county representatives worked together to develop the RFP and also scored the proposals together as a team. This process was the template for the next procurements.

The Seniors and SNBC RFPs were developed over the summer of 2021 and issued in late October 2021. The Families and Children RFP was developed in the fall of 2021 and issued in January 2022. DHS and representatives from each Minnesota Association of County Social Service Administrators (MACSSA) region participated in a workgroup to develop the scored RFP questions, the scoring criteria, and the processes that would be used to evaluate the proposals. The workgroups established priorities regarding health care delivery, improving quality and eliminating disparities, enrollee engagement and communication, county collaboration and support, provider networking and customer service, and payment policy and innovation. In addition to developing the RFP questions, the workgroup determined that scoring would follow a similar process as to what was established for the metro Twin Cities area families and children procurement issued the previous year. The process was designed as follows:

- DHS and counties would jointly score the proposals submitted by the responders.
- Evaluation sessions would be established where groups of counties based on MACSSA regions would come together with DHS to review and score all of the responses for the counties in that group.
- Each county and DHS score would have the same weight except when a Responder was only responding for one county in the group, in which case that county's score would be weighted higher than other counties and DHS.

After the RFPs were issued and responses were received from the various health plan Responders, DHS held all day evaluation sessions with each group of counties to discuss the proposals and the evaluations. Afterwards, counties and DHS staff sent their scores to DHS to compile in order to determine a final score for each Responder in each group. Once the final scores were tabulated, a recommendation form and the scoring sheets were sent to the counties in each group. The counties were given four weeks to send their recommendations and/or county board resolutions indicating their recommendations for which health plans should be awarded contracts.

V. Awards

Once the recommendations were received, DHS evaluated the recommendations as they related to the policy stated in the RFP and made awards based on the following policies for Seniors and SNBC:

- Responders currently serving the programs would be selected for contracting if they met the minimum requirements of the RFP, and
- DHS would not contract with only one Responder in a county unless the Responder: (1) is currently a plan offered in the county, (2) is the highest scoring Responder in this RFP for the county, and (3) is the only plan currently serving the county that meets the minimum requirements of this RFP and passes a Readiness Review, if applicable.

The policy stated in the Families and Children RFP was as follows:

- At least two health plans would be selected in each county, and
- One of the health plans would be a county-based purchasing plan in the counties with county-based purchasing plans, as long as the county-based purchasing plan met the minimum score requirement and did not fail any pass/fail components of the RFP.

In accordance with each RFP and based on the final scores and county recommendations, DHS made final award decisions. Some county recommendations were not aligned with policies outlined in the RFPs and therefore differed from the final awards. After the final decisions were made, letters with the results were sent to the selected Responders and to each county involved in the 2023 procurement. These letters were issued on June 30, 2022.

VI. Mediation

Counties have the right to mediation regarding the selection of participating Responders for their county. The notices of awards sent to the counties outlined the process for requesting mediation. All of the counties that participate in county-based purchasing requested mediation. No other counties submitted a request for mediation. A three-person panel convened in accordance with Minnesota Statutes, section 256B.69, subdivision 3a and made recommendations to the commissioner, who issued her final order on September 12, 2022. The order is included in the Appendix with additional commentary. The county-based purchasing plans sued DHS during the procurement process, and the parties were awaiting a decision at the time the mediation occurred. The mediation panel recommendation reflected consideration of that impending decision from the court.

VIII. Appendix

The following documents are available on the DHS website for reference:

A. 2023 Seniors RFP

B. 2023 SNBC RFP

C. 2023 Greater Minnesota Families and Children RFP

DEPARTMENT OF HUMAN SERVICES

FINAL ORDER OF THE COMMISSIONER OF HUMAN SERVICES

2023 MANAGED CARE HEALTH PLAN SELECTION

In accordance with state and federal requirements, the Department of Human Services (DHS) conducted a competitive procurement to provide prepaid health care to individuals enrolled in Medical Assistance or

MinnesotaCare under the Seniors, Special Needs Basic Care (SNBC), and Families and Children programs. On

June 2, 2022, DHS notified counties of the health plans selected for the Seniors and SNBC programs. On June 30, 2022, DHS notified counties of the health plans selected for the Families and Children program. Thirty-three counties requested to mediate DHS's selections, pursuant to Minnesota Statutes section 256B.69, subdivision 3a.

After receiving the relevant procurement data, a three-person Mediation Panel heard testimony from mediating counties and DHS on August 22 and 23. The panelists were John Klein, designee of the Association of Minnesota Counties; Matt Anderson, designee of the Commissioner of DHS; and Marie Dotseth, selected by Mr. Klein and Mr. Anderson. Following the completion of the mediation proceedings, the Panel submitted the enclosed recommendations for my consideration.

I have carefully considered the Mediation Panel's recommendations, which were informed by two days of testimony and argument by the counties and DHS. As noted in the recommendations, litigation regarding plan selection in the mediating counties is currently pending before the district court. The Panel provided separate recommendations contingent on the district court's order on the pending summary judgement motions. The district court has not ruled on whether DHS is required to award single-plan contracts in the mediating counties.

Because federal deadlines require my decision, I am proceeding with the Panel's recommendation to have more than one plan in almost every county, as described below. I agree with the Panel's recognition of the reasonable policy interests that support providing enrollees with a choice of at least two plans — including enrollee empowerment, privacy, language and cultural considerations, continuity of care, and maintenance of unique Medicare benefits. Offering more than one plan also provides a fallback for enrollees in the event a plan loses economic viability. DHS may revisit these decisions if required by the court's forthcoming order on the pending summary judgment motions and to the extent federal timelines and requirements allow.

My final decisions therefore are as follows:

1. The plan selections in Beltrami, Big Stone, Brown, Chippewa, Clearwater, Cottonwood, Dodge, Douglas, Goodhue, Grant, Hubbard, Jackson, Kanabec, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Nobles, Pipestone, Pope, Redwood, Renville, Sibley, Steele, Stevens, Swift, Traverse, Wabasha, Waseca, and Yellow Medicine Counties for the Seniors, SNBC, and Families and Children procurements are affirmed.

2. The plan selections for MinnesotaCare are affirmed in each of the mediating counties.
3. The plan selections for Itasca County in the Seniors procurement are affirmed.
4. The plan selections for Itasca County in the Families and Children procurement are modified to select IMCare as the single plan for the county.
5. DHS shall consult with Itasca County to confirm the County's recommendations for the SNBC plan selections, and select health plans as prescribed in the Request for Proposal
6. DHS recognizes the default plan is a priority for the mediating counties, and will consider this strongly as part of contract negotiations.

As the Mediation Panel recognizes, there is room for legislative action on managed care procurement, countybased purchasing, and the mediation process. DHS is committed to working closely with counties, the

Legislature, health plans, and county-based purchasers on potential legislation that provides the best results for the people we serve.

I sincerely thank the Mediation Panel for its thoughtful consideration of these issues, and the counties for their time and invaluable role in this important process. I look forward to our continued work together in the procurement of health care for the people we serve.

MINNESOTA DEPARTMENT OF HUMAN SERVICES

JODI HARPSTEAD, COMMISSIONER

Dated: September 12, 2022

August 30, 2022

Commissioner Jodi Harpstead
c/o Alexandra McDonough

Minnesota Department of Human
Services Elmer L. Andersen Human
Services Building 540 Cedar St.

St. Paul, MN 55101

Submitted via email to alexandra.mcdonough@state.mn.us

Dear Commissioner,

The undersigned constitute the three-person mediation panel (hereinafter "the Mediation Panel" or "the Panel") pursuant to Minn. Stat. § 256B.69, subd. 3a(d) and offer the following recommendations with respect to the 33 counties that requested mediation regarding the Minnesota Department of Human Services' procurement of Medical Assistance managed care grant contracts for the Seniors, Special Needs Basic Care (SNBC), and Families and Children programs. Throughout our discussion, when we refer to county-based purchasing (CBP) counties or to a particular CBP's counties (e.g., PrimeWest counties), we are referring to those counties that sought mediation with respect to the procurement process for particular programs in their county.

Context

While the following may be evident to you, the Panel believes it is important to articulate some of our perceptions and understandings for the record.

1. Issues and interpretations of counties' roles in Medicaid managed care have a long, contentious and, at times, confusing history in Minnesota. Many of the issues and disputes raised in the mediation process concern differences of opinion or interpretation of that history, and the significance of historical decisions, legal or regulatory changes, etc.

2. County-based purchasing (CBP) is a creature of state law. It has a long and proud history of innovation and service for people enrolled in Medical Assistance and MinnesotaCare. The CBP model has qualities that can have advantages over other models, especially when it

comes to the integration of health care, social services, housing, transportation, law enforcement, and other county functions, as well as greater understanding of and responsiveness to local needs and priorities.

3. The Minnesota Department of Human Services (DHS), the Association of Minnesota Counties, and the Minnesota Association of County Social Service Administrators, should be commended loudly and publicly for the time, effort, and commitment they devoted to exploring how to improve the procurement process and build stronger collaborations. The current disputes threaten to obscure the progress made, especially with respect to dramatically increasing all counties' contributions to identifying the objectives of managed care procurements, developing the questions to be included in the Requests for Proposals (RFPs), defining how responses would be scored, and perhaps most significantly, the ultimate weight that would be given to counties' scoring of the RFP responses relative to the weight of DHS' scoring.

4. Employees working for counties and for DHS are deeply committed public servants who dedicate themselves to achieving the best possible outcomes for Minnesotans and members of sovereign tribes, especially those people who are or will be enrolled in Medical Assistance or MinnesotaCare. They take their roles and responsibilities seriously and pursue them in good faith. The issues in dispute in no way reflect ill intent, willful disregard of laws or standards, or a lack of effort. Again, they should be loudly and publicly commended for their work and contributions to Minnesota's health coverage programs.

5. Minnesota's state elected officials, DHS, counties, and advocacy groups representing stakeholders in our health coverage programs, have left known disputes and ambiguities about our state law requirements, and their application to county-based purchasing in the larger context of federal laws and regulations, unaddressed for at least seven years. Neither the 1.5 million Minnesotans enrolled in our health coverage programs, the counties and their employees, DHS and its employees, private managed care organizations (MCOs), Minnesota's health care providers, nor Minnesota taxpayers have benefited from this inaction. Regardless of the outcome(s) of the current litigation and procurement, the Panel recommends state statutory changes.

   Despite this lack of clarity and related challenges, county-based purchasing has led to many important innovations in managed care methods with health policy significance and excellent outcomes. As with any structure or system that has been in place for decades, and especially one that has resulted in strained relationships between counties and DHS and disruptions of efficient program administration, there are times when a significant reform or evolution is necessary to reimagine and reposition for the future.

   Minnesota has a tradition of innovative and successful health reforms. Elected officials, DHS, counties, policy makers, and health care stakeholders should consider reforms and innovations that will build on and improve our current system, further integrate public

health coverage programs with social services and community supports at the local level, and share risks and accountability in new ways designed to drive improved health outcomes for enrollees while enhancing stewardship for taxpayer dollars.

Recommendations Contingent on Outcome(s) of Current Litigation

The Panel understands that litigation on almost identical issues is underway. We recognize the limits of our authority to make recommendations vis-à-vis the binding authority of the district court's pending decision which will carry the force of law. Since DHS must comply with the court's ultimate decision, below are two sets of recommendations depending on the outcome of the litigation. In addition, we have provided other recommendations for your consideration that do not depend on the outcome(s) of the court's decision regarding future legislation and policy matters.

If the district court rules that DHS is legally obligated to award single-plan contracts to CBPs, then the Panel recommends the following:

1. Proceed with negotiating and executing contracts under this procurement in accordance with the following recommendations. In other words, we recommend against cancelling the procurement process at this stage.

2. Award contracts to each CBP in its respective counties for PMAP and the Seniors Programs, and do not award contracts to any private MCOs in those counties for those programs.

3. Award contracts to each CBP in its respective counties and one other private MCO in those counties for the MinnesotaCare program, as required under federal law.

4. Award contracts in the PrimeWest counties and SCHA counties for SNBC, and do not award contracts to any private MCOs in those counties for this program.

5. Seek clarification from the Itasca County Board of Commissioners regarding its preferences for plans in SNBC and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts for SNBC.

   Although Itasca County did not respond to the RFP for SNBC, the county did seek mediation for SNBC and raised concerns about DHS' plan selections in its mediation statement. During mediation the Panel discovered what appears to be a simple miscommunication with respect to the County's preferences for this contract.

6. According to representatives participating in the mediation on behalf of the County, Itasca County preferred to have only one Medicaid plan serving SNBC in its county and believed that Medica's RFP response received the highest score. Accordingly, the County expressed its preference for DHS to contract exclusively with Medica.

   However, under DHS' policy regarding contracting with any Medicaid plan already serving the

   SNBC Programs in a county, DHS selected UCare for a contract because UCare already serves SNBC in Itasca County. DHS reasonably interpreted the County's preference on its form to mean that the County wanted DHS to add Medica as another MCO along with UCare for SNBC.

   Accordingly, DHS has proceeded with the selection of both UCare and Medica to serve Itasca County residents enrolled in SNBC.

   Itasca County representatives indicated that if they realized that UCare's proposal received the highest score, the County Board would have expressed its preference for DHS to contract with UCare exclusively. And, because UCare already serves the SNBC Programs in the county and its proposal received the highest score, UCare might be eligible for a single-plan contract under DHS' policy for this procurement. In other words, it is more important to Itasca County for DHS to contract with a single plan to administer SNBC than whether DHS contracts with UCare or Medica.

   In light of this, the Panel recommends that DHS seek clarification from the Itasca County Board regarding its preferences for the plan(s) in SNBC and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts in SNBC.

7. Inform CMS that the State is exercising its authority to enter single-plan contracts after conducting a competitive procurement in accordance with existing federal law exceptions allowing single-plan contracts in rural communities and counties operating a CBP before 1986 and pursuant to the district court's ruling.

If the district court rules that DHS is not legally obligated to award single-plan contracts to CBPs, then the Panel recommends the following:

DHS articulated reasonable policy interests for providing enrollees with a choice of at least two plans including enrollee empowerment, concerns about privacy and local government functions, language and cultural considerations, continuity of care when changing programs, and maintenance of unique Medicare benefits. The CBP counties also articulated reasonable policy interests including higher administrative costs for county agencies and financial impacts that could

jeopardize their respective CBP plan's viability and/or capacity to sustain their distinct model and mission. With enhanced enrollee assistance to support choice of health plans as required by the recently updated federal Medicaid managed care regulations, enrollees should have the opportunity to exercise plan choice especially those for whom the factors highlighted by DHS are paramount, and the actual enrollment impact of the respective policy interests will be learned.

1. Proceed with DHS' plan selections for contracts in the Seniors and MinnesotaCare programs in each of the CBP counties.

2. Proceed with DHS' plan selections for contracts in SNBC in each of the PrimeWest counties and SCHA counties.

3. Seek clarification from the Itasca County Board regarding its preferences for plans in the SNBC eligibility category and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts in SNBC for the reasons stated in #5 above.
4. Award IMCare a single-plan contract for PMAP in Itasca County.

   As described above, DHS and Itasca County articulated reasonable policy interests and concerns, respectively, if two plans are offered. Because IMCare operates exclusively in Itasca County, selecting two plans to serve the small number of enrollees in this county seems likely to result in IMCare losing economic viability. In the recent past, even with single-plan status, the Minnesota Department of Health exercised its regulatory oversight responsibility to require IMCare to develop and adhere to a corrective action plan to ensure it had sufficient capital to cover its medical loss risks.

   Therefore, awarding contracts to two plans in Itasca County seems likely to cause one plan to leave the market during the contract and ultimately result in the same situation DHS is trying to avoid: a single plan administering the PMAP program and two plans administering the

   MinnesotaCare program. Because that outcome seems likely (if not inevitable) if DHS proceeds with contracting with two plans, the Panel recommends entering a single-plan contract with the CBP that already serves this population, rather than putting some enrollees through the upheaval of losing their plan and ending up with a single private MCO that does not have IMCare's years of experience operating in the county.

5. Proceed with DHS' selections of plans for contracts in the PMAP program in the PrimeWest counties and in the SCHA counties.

6. Designate CBPs as the default plan in each program in the CBP counties, except for SNBC in Itasca County. No one can predict with certainty the market dynamics and outcomes of the change to contracting with multiple plans in many of the CBP counties. Granting CBPs the

default plan status mitigates the likelihood that these arrangements will cause plans to leave counties during the contract period.

7. Reexamine processes regarding the Medical Assistance and MinnesotaCare managed care procurements to prevent actual or perceived conflicts of interest with respect to counties actively helping DHS develop and score RFPs and, at the same time, operating CBPs that respond to those same RFPs, and then seek necessary process or statutory changes to protect the integrity of the procurement process.

Recommendations Not Contingent on Outcome(s) of Current Litigation

As stated above, many of the issues disputed in this mediation process have been known and disputed for several years. The Panel recommends that DHS, ideally in collaboration with counties and other stakeholders, pursue the following:

1. Share DHS' decisions on procurement policy issues that are known to be of significant interest to the counties in advance of issuing RFPs so counties have an opportunity to explain their concerns or offer alternatives. While the Panel understands the reasons underlying DHS' decision to pursue contracts with more than one plan in every county for PMAP, and that DHS likely believed that counties knew about DHS' positions regarding plan choice, the value of the relationships between the agency and counties would benefit from allowing more time for counties to provide their feedback and suggestions.

2. While many counties may not have been confused by the group scoring methodology used in this procurement process, it was apparent that some counties were confused about whether plan selection decisions would be based on an individual county's scores for plans in its county or, as DHS intended, that plan selection decisions would be based on the aggregate scores of the respective group of counties. It is impossible to avoid every miscommunication or misunderstanding in a process that is so complex and involves so many components. Nevertheless, this area of confusion should be easy to avoid in future procurements.

3. Seek legislative changes to the mediation process described in Minn. Stat. § 256B.69, subd. 3a(a) to require future mediation panels to submit their recommendations to the Commissioner by a date certain to ensure that DHS has a meaningful opportunity to consider the recommendations, make any changes to its plan selections or contract terms, and meet CMS' deadlines for executed contracts to be delivered for federal approvals. Under the current statutory language, a mediation panel could fail to make recommendations before it is too late for them to be considered.

4. Seek legislation to replace the current CBP model with a clearer, more efficient, and more distinct and innovative model that would more closely embody the Legislature's original intent to create a county-administered alternative to the managed care PMAP program with private MCOs. The new program, referred to here as County Administered Rural Medical Assistance (CARMA), builds on the success of CBPs with the following objectives:

    a. Creating a more meaningful county-administered alternative to managed care as originally intended by the Legislature;

    b. Fostering greater integration of health and social services to better address social determinants of health in rural communities;

    c. Accounting for the smaller numbers of enrollees and of locally available providers, especially for specialty and tertiary care, in rural communities; and

d. Promoting greater accountability for health outcomes, health equity, customer service, community outreach, and costs of care.

Each rural county, as designated under federal law, would have authority to decide whether to participate in either the PMAP program or the CARMA program. A county that chooses the PMAP program would do so in the same or similar manner as counties without CBP plans do today.

If a county chooses to participate in the CARMA program, DHS would not administer the PMAP program or contract with private MCOs in that county. Instead, DHS would contract with the county under a global budget model for all Medical Assistance covered services. Counties would accept financial risk within risk corridors for the total Medical Assistance expenditures for their county residents enrolled in Medical Assistance. Legislators, DHS, and counties should consider whether this calculation of Medical Assistance expenditures should be based on annual spending or whether at least some components of the calculation or other incentives should be based on spending over a longer time horizon, such as three or five years, to encourage counties and their health care providers to incur short-term spending that will produce longer-term savings. CARMA would be distinct from current Medicaid managed care by its use of a global budget that includes all Medicaid-covered benefits; a formal structure for ongoing DHS / county partnership for the development, evaluation and refinement of key outcome measures; and the inclusion of all Medicaid eligible populations, other than those enrollees who have a right to choose to receive services through the fee-for-service program.

As already authorized under state law, counties wishing to operate jointly under the CARMA program could do so through a joint powers agreement, thereby enabling them to benefit from economies of scale, reductions in duplication, etc.

Legislation should provide flexibility for counties participating in the CARMA program and DHS to develop metrics, incentives, risk corridors, accountability standards, and other components that might evolve to address community needs. In addition, the legislation and DHS policy should create oversight, auditing, and other appropriate controls to ensure stewardship of public resources, compliance with federal and state requirements, efficient and effective operations, etc. in the absence of the competitive procurement process and market forces.

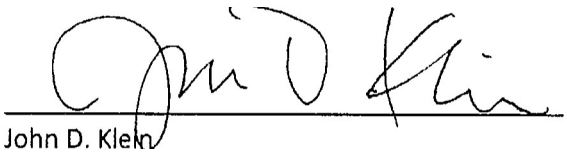
Given the federal government's heightened interest in accountable care organization and global budget models, as well as rural health reforms with strong local buy-in and accountability, the Panel believes that CMS might be more receptive to a waiver request for a non-competitive, county-administered program framed in this manner than its predecessor was in 1999. Depending on the degree of interest and cooperation from CMS,

the Panel suggests exploring a § 1332 waiver to include allowing counties in the CARMA program to administer MinnesotaCare as well, thereby expanding the population under the global budget model, increasing efficiencies and economies of scale, reducing administrative burdens and costs of MinnesotaCare managed plan procurements, and simplifying public health programs and reducing churn for enrollees.

Thank you and the Association of Minnesota Counties for the opportunity to participate in this mediation process and contribute to Minnesota's health coverage programs. We hope our recommendations are helpful as you make these critically important decisions on behalf of the people of

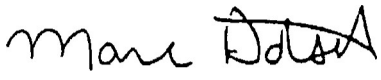
Minnesota.

Respectfully,



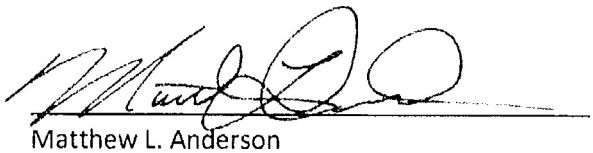
John D. Klein

August 30, 2022



August 30, 2022

Marie Dotseth



Matthew L. Anderson

August 30, 2022