Bidding Information and Instructions

This document provides bidding information and a set of instructions for completing the Cost Bid requirements outlined in Section III.A.3 of the RFP. The Cost Bid component is a separate component that is required for the submission of an acceptable RFP proposal.

A complete response to the bidding component of this RFP must include the following documents:

- A cover letter describing methods and assumptions used in developing the rate proposal. The purpose of this document is to assist the State evaluators to understand the proposed rates.
- A completed Excel template (Attachment I) summarizing key financial ratios for the past 5 years.
- A completed Excel template (Attachment II) requiring detailed information on administrative expenses for the past 5 years.
- A completed Excel template (Attachment III), the PMAP bidding form.
- A completed Excel template (Attachment IV), the MinnesotaCare bidding form.
- Attestation/certification by a qualified actuary that the proposed rates are actuarially sound.

Failure to provide all six of these documents may result in disqualification.

To assist Responders in developing bids, a data book is posted on the DHS website. The data book contains historical enrollment, cost and utilization data for the seven counties included in this procurement.

Responders are advised to submit their most accurate and competitive bids on these templates. The Department of Human Services (DHS) reserves the right to accept any or all of these offers without further negotiation. However, if DHS determines that it is in its best interest to request a best and final offer, it will invite selected Responders to submit one, and DHS will provide the timetable for the submission.

A description of each of the required documents is as follows:

Cover Letter

So that the Department may better understand your bid, please provide a cover letter explaining your methods and assumptions in developing the rates for 2012. At a minimum, the cover letter should include an explanation of the following rate development components:

- **Base data used**. Describe the base experience period and data used to develop the 2012 rates.

  - **Data Adjustments.** Provide a detailed explanation of the data adjustments applied to the base data. Data adjustments may include, but are not limited to, the following:
  - **Large Claim Adjustments.** Used to smooth any potential volatility as a result of an abnormal distribution of catastrophic claims.
  - **Incurred but not paid (IBNP) adjustments.** In order to account for any claims that may still be outstanding in the base data, identify adjustment factors for Incurred but Not Paid (IBNP) claims to complete the data.
  - **Third Party Liability (TPL) Adjustments.** Rates bids should be net of any TPL recoveries by the MCO. Include a description of the adjustments to the base data for the impact of TPL payments, including both cost avoidance and pay and chase type claims.
  - **Pharmacy rebate adjustments.** Prior to March 23, 2010, MCOs may have received pharmacy rebates which reduced the net cost. However, as many of these rebates are now being paid to the State, it may be necessary to make an adjustment to account for the lost rebates.
  - **Other adjustments.** Other adjustments as necessary such as investment income adjustments, reinsurance adjustments, capitated expenses that are not in encounter data, etc.

  - **Normalization.** Provide a detailed explanation of the adjustments applied to the data to normalize the data to reflect the Medicaid and MinnesotaCare managed care program in the rate setting period. Normalization adjustments may include, but are not limited to, the following:
  - **Payment Rate Adjustments.** Payment Rate adjustments could result from legislative (or executive) action in FFS payment rates, adjustments to account for bidding MCO's payment arrangements, or new contracting arrangements (e.g. total cost of care contracting).

- **Duration Adjustments.** Duration Adjustments measure the relative cost of members based upon the length of time between the first Medicaid member month and the beginning of the member's MCO start date.

- **Policy Change Adjustments.** Policy change adjustments are made to account for budget actions through statutory changes. These projected changes in expenditures are due to rate, benefit, or eligibility changes occurring after the base period. Adjustments are made for any policy changes to bring historical data to the rate setting period.

- **Population Change Adjustments.** A population change adjustment is needed when there is a difference in the membership reflected in the base data and the current Medicaid managed care program. Often this shift will result from an implementation of a waiver or another change in the eligibility requirements.

- **Trend.** Provide a description of the trend factors applied to adjust the base period claim costs to the rate setting period (2012). Responders should include a detailed explanation of how trend factors were developed and applied across counties, eligibility groups and service categories.

- **Cost Containment Adjustments.** Describe the procedures and processes established in the MCO to control medical and administrative costs.

- **Administrative / Profit Load.** Provide a description of the MCO fixed and variable administrative expenses, as well as risk margin/profit built into the proposed rates.

- **Risk Adjusted Rates.** Provide a description of any risk adjustment applied to the base data to normalize the rates for each rate cell.

Instructions for Excel Templates

To provide a responsive cost bid, four Excel templates must be completed:

- Summary of medical loss ratio, administrative expense ratio, and contribution to reserves for the past 5 calendar years
- Summary of administrative costs by category for the past 5 calendar years
- Bidding template for PMAP families, children and adults without children

- Bidding template for MinnesotaCare families, children, and adults without children

Summary of Medical Loss ratio, Administrative Expense Ratio, and Contribution to Reserves (Attachment I)

Separately for the PMAP and MinnesotaCare products included in this RFP, provide ratios of expenses to revenue (as percentages) for the following business categories for the past five years:

- Hospital/medical services, including pharmacy costs
- Administrative expenses
- Contribution to reserves (net gain) from operations.

Only the administrative expense ratios (Columns 2 and 5) will be used in scoring. The medical loss ratio and contribution to reserves percentages will be informational only.

Summary of Administrative Expenses (Attachment II)

This document must be submitted but will not be scored as part of the Cost Bid.

Please provide percentage estimates of expenditures for each of the past 5 years (2006 – 2010), in each of the following administrative categories for the combined PMAP and MinnesotaCare populations:

- Billing and enrollment
- Claim processing
- Fraud detection and prevention

- Customer service
- Product management and marketing
- Underwriting
- Regulatory and government compliance
- Lobbying
- Provider relations contracting
- Quality assurance and utilization management
- Wellness and health education
- Research and product development
- Charitable contributions
- Premium taxes and surtax
- General Administration

The sum of the percentages should be 100% each year, representing all of the administrative costs for the year.

Instructions for Completing the PMAP Bidding Template (Attachment III)

Responders to this RFP will propose rates for 2012 for the PMAP parents, children, pregnant women, and adults without children populations in the seven-county Twin Cities metropolitan area. The proposed rate should be divided into three components: medical costs, administrative costs, and contribution to reserves. By submitting proposed rates, the Responder is agreeing that all contracted services can be provided for that rate. Certification to that effect by a qualified actuary will be required as part of the bid submission. Failure to provide certification by the due date (June 16, 2011) will be cause for disqualification as a nonresponsive proposal.

The bidding template includes 17 separate rate cells corresponding to age, gender and family status of PMAP enrollees. Estimated 2010 enrollment in each rate cell is included in the template. **For each county in which the respondent is licensed**, a per member per month (pmpm) dollar amount should be proposed for each rate cell for medical costs, administrative costs, and contribution to reserves. The template combines Scott and Carver counties, and a bid for those counties should be inclusive of both counties.

There is very little claims or enrollment history for the new Medial Assistance expansion population of adults without children, as this group only became eligible for PMAP in April, 2011. Responders will need to use their own claims experience in developing bids for 2012. However, they may use the same enrollment assumptions and estimates that The State used in developing the 2011 MA expansion rates. To summarize these assumptions, by January 1, 2012:

- Approximately 29.6% of the expansion population will be similar in morbidity and cost to the 2009 GAMC population,
- Approximately 21.1% of the expansion population will be similar to the 2009 Transitional MinnesotaCare population,
- Approximately 49.2% of the expansion population will be similar to the 2009 MinnesotaCare adults without children.

Respondents should be aware of several required payment adjustments for the PMAP program, which could affect the rate proposals. Specifically, the following adjustments to the final payment rates will be made:

- Nine and one half percent (9.5%) of the final rate will be withheld from monthly capitation (Minnesota Statues 256B.69, subdivision 5a.) Contractual arrangements for 2012 will specify the terms under which the withheld funds will be returned. However, the proposals should assume that all of the withheld funds will be returned in July, 2013, and should therefore include the value of the withheld funds in the rate proposal.
- Funds are carved out of the final rates to support medical education. Because managed care organizations do not receive these funds in the final payment and the funds do not

factor into the costs of care for the MCOs, the rate proposal should not include any adjustment for the medical education carve out. Final rates paid will add a medical education component to the proposed bids.

- In Hennepin and Ramsey counties, enhanced hospital payments are added to the capitation in selected rate cells which are paid directly by the MCO to certain safety net hospitals located in those two counties. The amount of the payment varies each year. Because the additional funds are paid directly and do not affect the MCO's costs, the rate proposals should not include any estimates of the value of the enhanced hospital payments. These will be added to the proposed rates as part of the final payment to the MCO.

- An across-the-board ratable reduction of 2.5% is calculated and subtracted from the final rate before payment is made to the MCO. The rate proposal should include the value of this ratable reduction, as final payment to the MCO will deduct it.

- A 1% tax on premiums paid to the MCO and a 0.6% per enrollee surtax are required by state law. The value of these taxes will be added to the final rate paid, and the proposed rates should therefore not include any allowance for this administrative cost.

- Beginning March 23, 2010, rebates for pharmacy claims were paid to the State. Therefore, Responders should include in their 2012 bids the full cost of pharmacy coverage under PMAP, without assuming that any rebates will offset those costs. The 2008 and 2009 claims experience in the data book provided with this bidding document would include these offsets.

In addition to these adjustments, there may be other changes in eligible populations, benefits, taxes, or provider payment changes in the next few months as a result of the 2011 legislative session. Any such changes will be incorporated into the final payments rates for 2012, but should be excluded from your cost bid proposal

Instructions for Completing the MinnesotaCare Bidding Template (Attachment IV)

Responders to this RFP will propose rates for 2012 for the MinnesotaCare parents, children, pregnant women, and adults without children populations in the seven-county Twin Cities metropolitan area. The rate proposals should be provided for three components: medical costs, administrative costs, and contribution to reserves. By submitting proposed rates, the Responder is agreeing that all contracted services can be provided for that rate. Certification to that effect by a qualified actuary will be required as part of the bid submission. Failure to provide certification by the due date (June 16, 2011) will be cause for disqualification as a nonresponsive proposal.

The bidding template includes 21 separate rate cells corresponding to age, gender, family status, and income level of MinnesotaCare enrollees. Estimated 2010 enrollment in each rate cell is included in the template. **For each county in which the respondent is licensed**, a per member per month (pmpm) dollar amount should be proposed for each rate cell for the three rate components (medical, administrative, and reserves). On the template, Scott and Carver counties are combined, and Responders' bids should be inclusive of both counties.

Respondents should be aware of several required payment arrangements for the MinnesotaCare program, which could affect their rate proposals. Specifically, the following adjustments to the final payment rates will be made:

- Eight percent (8.0%) of the final rate will be withheld from the monthly capitation (Minnesota Statues 256L.12, subdivision 9.) Contractual arrangements for 2012 will specify the terms under which the withheld funds will be returned. However, the proposals should assume that all of the withheld funds will be returned in July, 2013, and should therefore include the value of the withheld funds in the rate proposal.
- An across-the-board ratable reduction of 1.0% is calculated and subtracted from the final rate before payment is made to the MCO. The rate proposal should include the value of this ratable reduction, as final payment to the MCO will deduct it.
- A 1% tax on premiums paid to the MCO and a 0.6% per member surtax are also required by state law. The value of these taxes will be added to the final rate paid, and the proposed rates should therefore not include any allowance for this administrative cost.

- Beginning March 23, 2010, rebates for pharmacy claims were paid to the State. Therefore, Responders should include in their 2012 bids the full cost of pharmacy coverage under MinnesotaCare, without assuming that any rebates will offset those costs. The 2008 and 2009 claims experience in the data book provided with this bidding document would include these offsets.
- Beginning July 1, 2011, for the adults without children population in MinnesotaCare, the hospital inpatient benefit will be carved out and paid on a fee-for-service basis. Consequently, the bid for these rate cells in 2012 should not include the inpatient benefit.
- There is a legislated 15% reduction included in the current rates for the MinnesotaCare adults without children. However, DHS is not asking the MCOs to include this reduction in their bid proposals. The proposals should be bid based on claims experience, and certified on that basis. Any legislated rate reductions in place currently or for 2012 will be applied as required to the accepted bids.

In addition to these adjustments, there may be other changes in eligible populations, benefits, taxes, or provider payment changes in the next few months as a result of the 2011 legislative session. These changes will also be incorporated into the final payments rates for 2012.

Protocol for Evaluation of Proposals

Evaluation of the cost components of Respondents' proposals will make up fifty percent (50%) of the total evaluation. Cost proposals will only be evaluated for Respondents who qualify on the technical components. Any proposals disqualified on the technical aspects will not be evaluated further on the cost components.

Evaluation of the cost proposal will involve two separate components as identified in the RFP as revised, (revised April 25, 2011).

- History of administrative costs on PMAP and MinnesotaCare business (10 points)
- Evaluation of proposed rates in each county (90 points)

Administrative Cost Evaluation

In Attachment I for each of the past five years, points will be awarded based on the level of administrative expenses (as a percent of revenue) for PMAP and MinnesotaCare separately.

The following chart shows the points awarded for each year for this component:

Administrative Expense Ratio	Number of Points each Year for PMAP	Number of Points each Year for MinnesotaCare
< or = 8.2%	1.0	1.0
>8.2% but < or = 10.0%	0.5	0.5
>10.0 %	0.0	0.0

Rate Proposal Evaluation

Evaluation of the rate proposal will involve several steps to guarantee that the final rates are actuarially sound and offer the best value for the State.

Step 1: Each rate cell bid (aggregated medical, administrative, and reserve rates) will be compared to an actuarially pre-determined benchmark and acceptable range. The benchmarks will not be made available until contract negotiations are completed. Any bid within the range will be acceptable. A bid above or below the range will be determined to be not actuarially sound. In this case, the bid may not be accepted, may be evaluated as proposed, or rate cells below the range may be brought up to the acceptable range. This will be done for each rate cell in each county for which the Responder bids.

Step 2: For each county (or combination of counties in the case of Scott and Carver), the acceptable bids will be multiplied by the estimated 2010 enrollment in each rate cell, summed across all MinnesotaCare and PMAP rate cells and divided by the total enrollment in the county for both programs. This will result in an average pmpm rate bid by the Responder for the county being bid.

Step 3: The average pmpm for each Responder will be compared to each of the other Responders. The bid with the lowest pmpm will receive a score of 80. Other bids will receive a score proportional to the ratio of that bid to the lowest bid received.

Step 4: The MCO with the lowest bid will receive 10 bonus points. The MCO with the second lowest bid will receive 5 bonus points. Other bidders will not receive any bonus points.

Example: Three bids are submitted for County A, and the average rate for MCO 1 is $150 pmpm; for MCO 2 it is $175 pmpm; and for MCO 3 is $190 pmpm. MCO 1 will receive a score of 80 +10 bonus points or 90 total points on the rate proposal. MCO 2 will receive (150/175) x 80 + 5 bonus points = 73.6 points, and MCO 3 will receive (150/190) x 80 = 63.2 points.

The scores on the administrative expense ratio and the rate proposal will be added together to determine the total score on the Cost Bid component.

Statement of Actuarial Certification

If the proposed rates are accepted by the State, the MCOs will be expected to provide all contracted services, pay administrative expenses, and provide for a modest contribution to reserves. To minimize disruption of service to enrollees, and provide financial stability for the State, certification by a qualified actuary to this effect is also required as part of the cost bid component. Failure to provide a certification of the rates will be cause for disqualification of the Responder's proposal.