GREATER MINNESOTA HEALTH CARE COALITION
GMHCC.org

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Oct. 31, 2014

Commissioner Lucinda Jesson
MN Dept. of Human Services
540 Cedar St.
St. Paul, MN

Dear Commissioner Jesson,

We want to deeply thank you and the senior DHS staff who met with a delegation of Greater MN Health Care Coalition (GMHCC) representatives on Aug. 26, and spent a generous amount of time with us. We were glad to hear that DHS is making progress towards using paid claims encounter data; the desire for further efforts to get the public program profits down to their intended margins; the focus on direct contracting with hospital-doctor groups via Medicaid Accountable Care Organizations; and the interest in a single-administrator system for dental benefits. GMHCC agrees with and applauds these efforts. The purpose of this letter is to re-cap our understanding of what we learned at the meeting, and address some follow up steps. There are four topics we wish to comment on:

A. Managed care rate-setting claims data:

Our understanding from the comments that were made are:

1. Although paid claims encounter data for 2011 were not very useable, the claims data for 2012 and 2013 have been cleaned up and are fairly reliable.
2. Starting last year and continuing into this year, DHS' tallies of the claims data by category (such as In-patient hospital, out-patient, pharmacy, emergency room) are now being used as an aid in helping to validate the summary expense numbers provided by each managed care organization (MCO). DHS said that GMHCC will be able to see copies of these tallies and comparisons.
3. For the rate-setting for 2015 rates (which are being computed this year), the figures for the base year are coming from the MCO's numbers, although DHS' tallies of 2013 paid claims are being used to check these numbers.
4. In addition for the rate-setting for 2015 rates, the three years of trend factors (2011, 2012 and 2013) also are relying on the MCO's numbers, because DHS only has reliable paid claims data for two of these years -- 2012 and 2013.
5. DHS anticipates that for 2016 rates, which will be computed next year, it will be able to use its tallies of paid claims data for the base year expenses of 2014, and also use paid claims data for the trend projections calculated from 2012, 2013, and 2014 expenses. The 2016 rates would be the first time that paid claims encounter data could be used for both the base year and the trend projections.
6. In general, DHS wants to ensure that the way it is collecting and tallying paid claims encounter data is very reliable, before moving to fully depend on it for the rate setting.
7. In addition to the above, DHS will be putting the managed care contracts out for re-bid, following an RFP to be issued in January, 2015. The need to do this reflects, in part, the fact that the HMOs' reported profits for 2013 are still much higher than the target margins, as well as the question mark about the health status of the influx of new Medical Assistance and MinnesotaCare enrollees. Commissioner Jesson said that GMHCC is welcome to provide some comments this fall for the RFP. We accept this invitation and wish to provide comments for the RFP.
8. *Additional information of ours:* It was pointed out that the reported profits for 2013 included a large amount of Premium Deficiency Reserve (PDR) add-ins for Blue Plus, which had been posted as

expense items in previous years. Apart from these $48 million in PDRs in the 2013 profits, there is still $93 million in state program profits besides this for the four HMOs, which is a 2.2% margin, and over twice the target. One of the Blue Plus expense item PDRs was $25 million in 2011. That money could otherwise have been included in Blue Plus' return to the state of its 2011 profits over 1%.

B. Inclusion of contribution to reserves in rate setting:

We asked if DHS would consider reducing or zeroing out a contribution to reserves, in any particular year, for any HMO which has an excessive amount of financial reserves. Our understanding of your position is that DHS has repeatedly advocated for this viewpoint with its hired actuary (Milliman – Milwaukee), but that DHS has not been able to convince Milliman; and DHS has to leave this decision to the professional judgment of the actuary it has hired. CMS does not seem to be open to this approach to the margins either, and DHS wants to get CMS to see this differently, as well. At the same time, however, DHS thinks it would be improper for it to consider the idea of seeking a different actuary who might, unlike Milliman, feel it appropriate to alter the margin target in relation to the level of reserves.

GMHCC respectively disagrees with this viewpoint. We feel this is such a significant amount of money that to be fiscally responsible, DHS should see if it can switch to a different actuary who would take it into account. As we mentioned, this point has no generally accepted professional standard, and therefore different actuaries are free to feel and act differently about this; and CMS has provided no directives about this. As we also stated, the insurance companies "shop around" to find actuaries who hold the viewpoints they desire, and DHS puts itself at a disadvantage if it doesn't do the same.

C. Reimbursements to dentists:

Our understanding is that DHS favors the idea of a single-administrator for dental benefits, as a means to resolve the problem of the HMOs offering too small a reimbursement to dentists to cause enough of them to participate and achieve adequate access for enrollees. As we noted, Prime West and Itasca Medical Care manage, out of the same capitation rates as the HMOs, to pay dentists much higher amounts and secure adequate participation and access.

Follow up comment: GMHCC has looked at the report on this subject that DHS gave to the legislature in February of this year. We are concerned about vague language such as "adopt elements of the single administrator model" without specifying which elements are recommended, and the lack of a clear recommendation for a carve-out of the dental funding.

GMHCC strongly supports the idea of a single administrator for dental benefits. We feel these three elements are needed: (1) Carve-out of the dental funding from the capitation rate; (2) The state must decide the reimbursement amounts to be paid to dentists, not the HMOs or a third-party administrator; and (3) The state must provide an adequate amount of reimbursement to generate participation and access. GMHCC would be very interested in advocating vigorously for such a proposal.

We also suggest that DHS examine closely the system that Prime West has developed to pay dentists as well as involve them in helping to decide spending priorities. We look forward to working with DHS to promote the single-administrator model.

D. Secrecy status of payment data:

We are aware of the mandate DHS was given by the legislature to conduct a study of the potential effects of public disclosure of what the HMOs pay medical providers in the state programs. Commissioner Jesson indicated that, possibly, the DHS report might not give a particular recommendation to the legislature, but rather provide a list of options. At the Aug. 26 meeting, Patrick Hultman said that GMHCC would be invited to provide some comments. We wish to do so.

In relation to this issue, we believe that one point needs to be cleared up, which we didn't get to mention at the Aug. 26 meeting: It is important to ascertain whether or not DHS ever officially granted and documented trade secret status for the HMOs' payment data, in the contracts DHS has signed. Our

understanding is that this hypothetically could have been granted once in the past, perhaps as much as 20 years ago, and that the status is self-renewing without need for periodic review by DHS.

Therefore, we would like to know: (1) Did DHS, at any time in its history, officially grant and document trade secret status for the payment data in its contracts with the HMOs? (2) If so, can we see a copy of the documentation to this effect, including the stated justifications for the trade secret status?

E. Re-cap of Follow-ups: (This is our understanding. Please correct us if anything is in error.)

1. Paid claims data: DHS will share with GMHCC its tallies of paid claims data by category of service for each HMO, and the comparison to the HMOs' self-reported summary numbers.

GMHCC requests that we be provided copies of the tallies and comparisons that have been completed to date.

2. RFP for competitive bidding: DHS invites GMHCC to provide comments and suggestions, along with other stakeholders, for the construction of its January RFP for the new round of competitive bidding.

GMHCC requests that we be provided information on what kind of comments we can make and the process to do this, and timelines.

3. Single administrator for dental care: DHS will be continuing to develop its ideas for recommending a single administrator for dental care.

GMHCC requests to be in conversation with DHS about this, to learn more details of DHS' views and to provide GMHCC's input.

4. DHS study on the impacts of publicly-disclosed payment information: DHS invites GMHCC to provide comments for its mandated study, due to be completed this December, on the expected effects of public release of the HMOs' payment data for the state programs.

GMHCC requests that we be provided with the opportunity to give input for this study. I have had email contact with Patrick Hultman about giving information, although this hasn't happened just yet.

5. Status of trade secret authorization: We did not make this request at the Aug. 26 meeting, but we want to do so now: (1) Did DHS, at any time in its history, officially grant and document trade secret status for the payment data in its contracts with the HMOs? (2) If so, can we see a copy of the documentation to this effect, including the stated justifications for the trade secret status?

We want to thank you again for the time and discussion on Aug. 26th. We learned a lot, and feel that we have a more solid relationship with you and your staff. We appreciate that these are complex and difficult topics; that DHS is working very hard on them; and that you also have many more things on your plate as DHS commissioner in addition to these items. For us, the meeting re-affirmed our belief that our organization and DHS share common goals, and can be working more closely together.

Sincerely,

Buddy Robinson

Buddy Robinson, Co-Coordinator,
Greater MN Health Care Coalition