Response to: Minnesota Department of Human Services
2016 Statewide Managed Care Procurement -- Request for Comments

From: Greater Minnesota Health Care Coalition Dec. 8, 2014

Greater MN Health Care Coalition (GMHCC) is a non-profit, non-partisan organization of 3,000 low and moderate income members in Minnesota, with offices in Mora, Duluth and St. Cloud. We have been researching, analyzing, reporting, and testifying on issue regarding the state's capitated managed care health programs for seven years. We have the following comments regarding several of the items mentioned in the DHS Request for Comments:

1. b. Communication/ Provider Engagement / Provider Relations:

DHS should identify and measure, via responses from a representative sample of providers, the quality and responsiveness of the managed care contractor's communications with providers; attitudes displayed in negotiations; willingness to receive and use providers' input regarding allocation of payment resources; promptness in processing prior approvals; promptness in providing reimbursements; and promptness in resolving problems with approvals or payments. If a pattern emerges regarding providers experiencing problems in these regards with a managed care contractor, DHS should require and monitor a correction procedure.

1. e. Provider Network Adequacy, Capacity and Enrollee Access

DHS should take special care to identify and measure the managed care contractor's network adequacy, capacity and enrollee access for areas which have existing problems: Dental services especially, and also mental health services. DHS should require the managed care contractor to provide information on what their reimbursement rates are for service categories which are not attracting adequate numbers of providers, such as dental care, and what increases in reimbursements would be needed to increase the provider participation to an adequate level, even if these amounts would be above the DHS Fee For Service rates.

DHS should require and review reports from the managed care contractor regarding use of Emergency Rooms by its enrollees for dental pain and infection that could have been avoided with regular dental care, and give a financial accounting of those ER expenses. DHS should also require and review reports from the managed care contractor regarding how many enrollees are making regular (at least annual, and preferably semi-annual) visits to a dentist. DHS needs to obtain and monitor calculations by the managed care contractor of how much it spends for dental-related ER for its enrollees, versus how much it could have spent instead on routine dental care for all its enrollees – with adequate reimbursement to dentists to garner their participation – which would have avoided the ER use. If the managed care contractor is calculating that it earns more profit by paying for ER for a limited number of enrollees versus paying for adequate routine dental care for all enrollees, this practice must be policed and stopped.

1. g. Cost (medical and administrative)

DHS needs to identify and measure, with very reliable means, the integrity of the managed care contractors' reporting of payments to medical providers and other subcontractors. This includes requiring the submission of paid claims encounter data in ways that DHS can easily use to tabulate total or near-total medical and subcontractor actual payments, instead of relying on summary data provided by the managed care contractor and/or its hired CPA auditing firm.

Until such time that DHS is collecting, analyzing and fully using paid claims encounter data to ensure data integrity of medical expenses, DHS should undertake external, independent audits of the managed cared organization's medical and administrative expenses, making use of an auditing firm which does not provide auditing services for health insurance companies or HMOs. We realize that the Minnesota legislature mandated in statute that the Office of Legislative Auditor (OLA) hire an outside auditing firm for just this purpose; ***however, the fulfillment of this is in doubt,*** since the OLA has sought legislative permission to (1) Not contract with an outside firm, (2) Conduct a review in-house which could be less than a full audit, and (3) Remove the requirement to see if any state or federal laws have been violated.

It is very important for DHS to note the concerns broadly shared by the National Association of State Medicaid Directors, stated in their September 2, 2014 report "Medicaid Managed Care Modernization", about the integrity of data used for managed care capitation rate setting: "When fraud, waste, or abuse exist in the Medicaid program, precious resources are diverted from enrollees that need it and healthcare suffers (p. 4)." A fundamental principle of managed care is that states must know who is receiving payment for which services on behalf of a specific recipient. Reliable and accurate data are the most important aspect to ensuring program integrity in managed care systems. Therefore, states must require managed care entities to transfer reliable and accurate data in a timely fashion (p. 5)." "States should articulate expectations for the entity's procedures for the detection and investigation of possible fraud, waste and abuse (p. 15)."

GMHCC adds and stresses the following point: The concept of "actuarial sound rates" does not include any requirement in and of itself to provide verification of data integrity and reliability, and does not include any concern for how high the profit margins are -- as long as they are above the break-even point. The actuarial soundness concept also has a vague standard for "reasonableness" of rates, which can be interpreted as "within a reasonable range" regardless of whether the underlying expense data is accurate or whether it is artificially inflated. It behooves DHS, in its role as fiscal guardian for the wise and efficient use of taxpayer resources, to ensure that managed care rates, besides being "actuarially sound" and "reasonable" are also based on (1) true, verified expense data; (2) the absence of excessive profits; and (3) the absence of excessive financial reserves built with tax payer funds.

Regarding administrative expenses, DHS needs to identify and measure assurances and validation of detailed administrative expense data, including portions of executive compensation assigned to the public programs; prohibitions of lobbying and marketing expenses and full disclosure regarding these.

DHS should also insist that managed care contractors not be allowed to post Premium Deficiency Reserves as expense items which reduce their stated profits from the state programs on their financial statements.

4. What should the state consider in evaluating health care reform initiatives and alternative payment arrangements (total cost of care, accountable care organizations, sub-capitation, bundled payments, and other incentives)? How should DHS measure participation/creation of these efforts?

DHS should consider and regulate the following factors:

(1) Profit margins of state contractors, and also their administrative entity subcontractors;
(2) Adequacy of reimbursements to providers such as dentists and mental health services to generate adequate participation to ensure adequate enrollee access;
(3) Levels of financial reserves to cover claims, in terms of safe minimums and also devising a method to identify and prohibit excess reserves; and
(4) If an accountable care organization (ACO) has to contract with an HMO or other entity for financial risk management, then DHS needs to impose close scrutiny as to whether the ACO or the HMO is making decisions about provider reimbursements, level and quality of service delivery, reasonableness of administrative fees of financial risk management services, and level of profit for the HMO or other entity providing that service. DHS contracts must specify and enforce that the ACO provider organization makes these decisions, not the subcontracted entity for financial risk management.

5. How can the state measure and require proposing entities to demonstrate coordination of care across the continuum of health care services and with and among entities such as health care providers, counties, social services agencies, community organizations, local public health, community behavioral health providers and others?

Regarding coordination with community organizations, DHS should require the managed care contractors to state which community organizations in their service territory they are contacting, and provide copies of their invitations for input. DHS should contact these organizations to find out their satisfaction level with their degree of allowed input and responsiveness to their concerns. If additional organizations contact DHS to state that they want to provide input and are not being recognized to do so, DHS needs to respond to their concern.

7. How should the state evaluate subcontractor performance (e.g., dental, pharmacy benefit management, case management/care coordination and claims processing)?

DHS needs to receive and review details of actual reimbursements to subcontracted pharmacy benefit managers (PBMs) and dental third party administrators in particular. Regarding PBMs, DHS needs to receive and evaluate information on (1) Full disclosure of all rebates, discounts, chargebacks and other direct or indirect price adjustments which the managed care subcontractor receives from the PBM, and/or from drug wholesalers, and/or from drug manufacturers; and (2) Full disclosure of what payments are actually given to pharmacies, and what profit margins are earned by the PBMs.

Regarding dental benefit subcontractors, DHS needs to receive and evaluate information on the actual reimbursement amounts given to dentists; the reasonableness of expenses of the benefit administrators; and the profit margins earned by these benefit administrators. In addition, DHS

needs to require managed care contractors which have inadequate numbers of participating providers to demonstrate what efforts they undertook to offer higher reimbursements in order to obtain adequate provider participation. DHS needs to closely evaluate not just the number of participating dentists, but also the restrictions that some dental offices utilize, such as not accepting new public program patients, or only under restricted circumstances. DHS needs to require, and monitor, managed care contractors to accurately post the true list of participating dentists; update these when changes occur; and prohibit the practice of posting names of dental offices which are not participating at all, and identifying which ones are not accepting new public program patients.

DHS also needs to receive and review details from subcontractors for claims processing and other administrative services' reimbursed expenses, and evaluate these for reasonableness of fees. It is highly important to at least do this in the case of Medica, which subcontracts most of its administrative expense to UnitedHealth Care, because DHS needs to ensure that public funding is not being used to subsidize excessive profits of UnitedHealth Care. DHS should also require Medica to explain why, after so many years, it continues to subcontract most of its administrative work to UnitedHealth instead of bringing it in-house, and to demonstrate that it could not save on expenses if it did so.

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