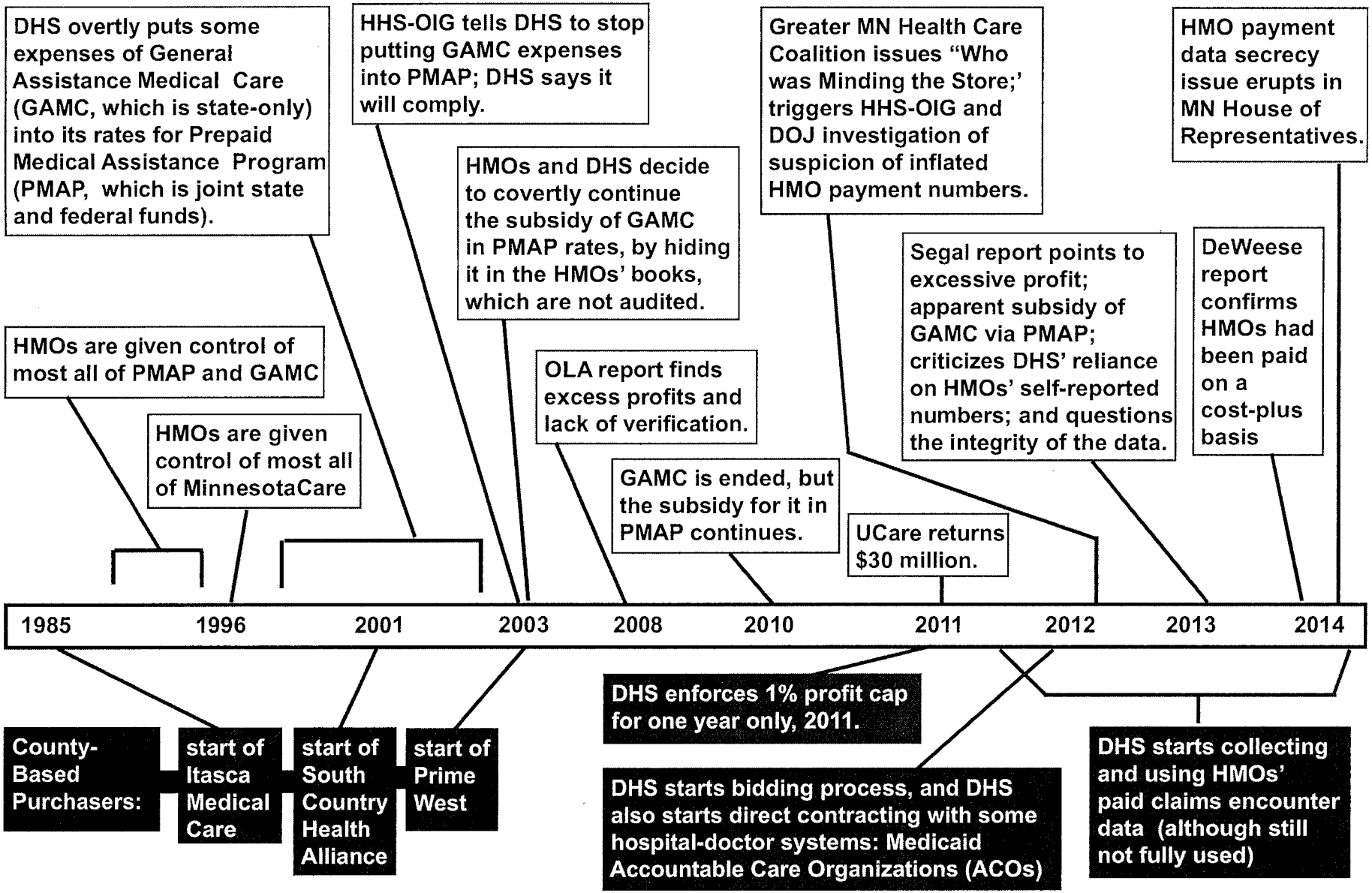
Issue Timeline of: Minnesota managed care programs; overpayment of HMOs; questions of inflated payment data; and secrecy of data



DHS = Mn Dept. of Human Services.
OLA = Mn Office of Legislative Auditor
HHS-OIG = US Dept. of Health & Human Services, Office of Inspector General
DOJ = US Dept. of Justice

Chart by: Greater MN Health Care Coalition

Notes for chart of time line of HMO overpayment, data inflation, and data secrecy issues:

(1) Box which says "HHS-OIG tells DHS to stop putting GAMC expenses into PMAP; DHS says it will comply": Nov. 10, 2003 Letter by US Dept. of Health & Human Services Office of Inspector General to DHS Commissioner Kevin Goodno: "the State agency included administrative costs and a profit factor for its State-funded Prepaid General Assistance Medical Care program in the actuarial rate calculations for the Program in 2001 and 2002. This was contrary to Federal cost principles... the State agency needs to change its rate setting process by excluding costs from other programs."

(2) Box which says "HMOs and DHS decide to covertly continue the subsidy of GAMC in PMAP rates, by hiding it in the HMOs' books, which are not audited:" This decision to continue the subsidy and hide it is not an overtly-documented fact, but there are a couple of documents which give some indication of this, plus several references in subsequent years (including testimony to the legislature, and in the Segal report) about PMAP rates being intentionally generous in order to compensate for underpayment of GAMC.

(3) Box which says "GAMC is ended, but the subsidy for it in PMAP continues:" UCare's CEO Nancy Feldman explicitly stated this in a March 16, 2011 letter to legislators: "Historically, DHS set rates for General Assistance Medical Care [which] resulted in health plan losses which were offset by higher Medical Assistance payments. When GAMC moved out of managed care in mid-year 2010, Medical Assistance rates were not lowered to reflect this overpayment."

(4) Box which says "UCare returns $30 million:" It deliberately does not say "donate," since UCare's auditors and CEO originally said that the payment was clearly a return of excess profit from 2010, even though they later changed the story to "free will donation to help the state budget." The fact that DHS ended up giving half of it to CMS shows that it was return of excess payment; and DHS itself even later claimed that the money was a return of excess profit.

(5) Box which says "DeWeese report confirms HMOs had been paid on a cost-plus basis:" This report did not make the point very strongly or fully explicit, but instead made a passing, parenthetical reference to it in one passage. It is a critically important, because DHS had always insisted over the years that it was paying the HMOs on a risk contract (insurance) basis, where the HMOs were in danger of suffering losses as well as enjoying profits. Gov. Dayton himself, in July of 2012, said on MPR that the contracts had been cost-plus. If the contracts were officially done on a cost plus basis, then annual auditing would have to had been done, as required by federal rules. However, by calling them risk contracts, the state was under no federal obligation to do any outside auditing.

Information by: Greater MN Health Care Coalition, Mora MN www.gmhcc.org

GMHCC letter to members of House civil Law, health care policy, and health care finance committees: May 2, 2014

RE: HF 2167 Health Plans' request for amendment for exemption from data disclosure

Dear Members of the House Civil Law, Health and Human Services Policy, and Health and Human Services Finance Committees,

The Board of the Greater Minnesota Health Care Coalition is writing to you in reaction to the Minnesota Council of Health Plans' request to you for an exemption from data disclosure requirements. The HMOs wish to keep as "trade secret" the amounts that they pay medical providers in the state's low income programs, and are seeking an amendment to exempt them.

Our organization, which has over 3,000 low and moderate income health care consumer members, urges you to not allow the HMOs to keep these payment amounts secret. With our research, analysis and reports over the past seven years, we have repeatedly demonstrated to the legislature, the public, and federal investigators how Minnesota has greatly overpaid the HMOs, resulting in inordinate, wasteful profits. Reports commissioned by the state, principally the 2013 Segal Company report, but also others in 2012 and 2014, confirm our findings. The most important point in the Segal report is that improper overpayments were directly related to the HMOs' actual payment data having been kept secret, even from the state itself. Presumably, the state is finally now using true payment data to set the managed care Medicaid rates, although in exactly what way has not been publicly explained.

We wish to take exception to several key points in the April 25 testimony of Kathryn Kmit of the Council of Health Plans:

1. ***"Price transparency will drive up prices":*** In theory, thanks to secret prices, the HMOs play the providers against each other to hold down reimbursements, while transparency would drive prices up in a "race to the top." But, this is contradicted by prior statements to the legislature that the HMOs generally set their prices a small amount above the published Fee For Service rates, with little room for negotiation. The HMOs are overly modest about their ability to force terms on most health care providers. And in the case of one HMO, HealthPartners, they are primarily paying providers in the hospital-clinic system that they own.

There is a huge contradiction in that providers report basically flat increases from the HMOs over many years, while the per-person payment from the state to the HMOs rose dramatically. Price transparency would solve this mystery and allow legislators to know what portion of the money they allocate actually gets spent on hospitals and doctors.

2. ***"Health plans do not have a choice on whether or not to bid on contracts with the state."*** In fact, this is not a blanket rule, because the PreferredOne HMO does not have this requirement. In addition, all four big HMOs (Blue Plus, Medica, HealthPartners, UCare) have commercial insurance affiliates. They don't have to maintain HMO divisions and bid on the state programs if they don't want to. Are they overly dependent on the public programs for their overall profits?

3. ***"The health plans...drive down the cost of health care":*** Minnesota's managed care Medicaid program was promised to reduce the cost of health care, but the evidence, especially from the Segal report, shows that the opposite has happened. Note the following paradox: Minnesota has among the lowest Medicare Fee For Service reimbursements in the country, but

the per-person amount we pay the HMOs for managed care Medicaid is among the highest. Differences in benefits don't account for this. It reflects the improper overpayments, which are based on self-reported data which could easily be inflated. That gives a much more logical motive for the HMOs' desire to keep their payment data secret.

In regard to the new DHS practice of competitive bidding, the $175 million in reported savings connects with the notion that the HMOs had been overpaid before that. Whether all excess has been squeezed out so far, however, is unclear. One year ago, Scott Leitz (then DHS Assistant Commissioner) testified that the competitive bidding had held the HMOs' profits down to 1% in 2012, similar to the 1% cap imposed for the one year of 2011. However, the new figures for 2013, in the HMOs' Minnesota Supplemental Reports, show that they claim earnings of 3.3%, when MSHO and investment income is included. Even if those two items are excluded, the profit is still 2.77%. *Why are profits, and inherent overpayments, climbing back up again?*

4. "***Health plans are at financial risk, not the state***": Again, it is the opposite which has actually been true, at least for the years up to 2011. Our organization pointed this out in our 2012 report, "Who was minding the store?" It is echoed in the April, 2014 MDH report by the DeWeese consultants, who refer to "what was historically an actuarially approved 'cost plus' environment." (page xi) When you look at the 3.3% overall profits for 2013 (all claiming strong public program profits except for a 0.1% loss for Medica), in general there is little for the HMOs to worry about profitability.

One remark Ms. Kmit said in discussion, not in written testimony, was a worry that there would be a deluge of data requests. The HMOs might worry about not just accurate answers for what they paid medical providers, and what health risk scores they gave to enrollees; but also specific communications between themselves and state agencies, and the state's hired actuary, Milliman. Remember that on April 10, 2013, one of the Segal Company consultants testified to the legislature that: "The methodology being utilized was suspect, or the data being utilized was suspect, or some combination of the two." It's important for the legislature and the public to learn whether anything untoward was discussed and acted upon, especially in light of the intensive federal investigation underway, which is examining the question of the integrity of the HMOs' reported expenses.

More broadly, the central point is that if the state is ever going to get control of its health care expenditures, it first has to know just how much of the money it gives the HMOs is actually being spent on low income medical services. You need to reject the scare mentality that price disclosure will somehow cause state expenditures to rise. Please remember that at the April 25 hearing, DHS General Counsel Amy Akbay did not echo the HMOs' dire warnings, and DHS is neutral on the entire bill. If anyone should know if price disclosure would result in DHS having to spend more money, it would be DHS.

Greater MN Health Care Coalition urges you to enact HF 2167 as written, without any amendment for exemptions for the Health Plans. If you wish any further detail on our points, please contact GMHCC Co-Coordinator Buddy Robinson.

On behalf of the Board,
Jerome Challman, Chair