Testimony Oct. 28, 2014 Legislative Commission on Data Practices

My name is Buddy Robinson. I'm Co-Coordinator of the Greater MN Health Care Coalition, or GMHCC. I'm also Staff Director of the MN Citizens Federation Northeast.

GMHCC is a non-profit, non-partisan organization of over 3,000 members. We represent the interests of all low and middle income health care consumers. Our member organizations have been active for almost 40 years in state health care policy. We have been researching and reporting for eight years on the issue of state overpayments to HMOs.

I have five points to give you today.

First: The question of how much the HMOs pay doctors and hospitals in the state's public programs is a huge issue. An enormous amount of money is at stake.

GMHCC's research, and other studies such as the Segal report, have described gross overpayments; profits three to four times what they were supposed to be; questionable and even illegal expenditures; and unnecessarily high financial reserves. Since the early 1990s, the big four HMOs have reported a total of over one billion dollars in profits from the state's programs. All evidence, including the Segal report, connects the excessive profits to a lack of actual payment data. The state never undertook external independent audits, and it never collected and used actual paid claims data.

Second: The lack of payment data is a situation of two sets of books.

The facts point to the likelihood of the HMOs paying the doctors and hospitals one set of amounts, then turning around and telling the state that they had paid out different, higher amounts. The evidence pointing to this so strong that, after our organization explained it to ten federal investigators in November 2012, they announced the launching of a major investigation two business days later. The US Dept. of Justice, and the US Dept. of Health and Human Services, Office of Inspector General, are still deeply involved in their investigation. They're concerned about violation of the federal False Claims Act with inflated payment numbers. They're examining the HMOs' payment data to look for the discrepancies. The total amount of inflated payments could easily exceed half a billion dollars, and perhaps over a billion.

If you think two sets of books is inconceivable, please note that this year a federal Court of Appeals found Blue Cross Blue Shield of Michigan guilty of deceiving the corporations which hired it to manage their coverage. When Blue Cross presented bills to these companies to pay the medical expenses of their employees, they secretly padded the bills with extra charges. In their defense, Blue Cross stated this is standard practice throughout the insurance industry.

Third: The HMOs' rationale for their payments to be "trade secret" doesn't hold water.

They told you this spring that if their payment data were public, they would be forced by health care providers to pay more, and the state would have to pay more for the public programs. This is a theory without proof. If you would like some proof, then look at these two examples: ***Example One:*** **We have County Based Purchasing systems in this state** which get the same per-person payments as the HMOs. What they pay providers is NOT secret. These systems function well, and they even pay dentists much more than the HMOs, so that dental access is not a problem. ***Example Two:*** **Look at Connecticut.** At the start of 2012, they stopped contracting out Medicaid to insurance companies. They switched to a system, coordinated by primary care clinics, where the state pays the providers, and the amounts are public. Did the costs go up with public data? No. The per-person spending went down by 2%, while Medicaid spending nationwide went up 7.6%. So, Connecticut saved 9% compared to if it had kept using the insurance company middlemen.

Fourth Point: Actual data is not being fully used.

The Dept. of Human Services recently told us that they are starting to use the HMOs' records of what they actually pay providers, to set their payments to the HMOs. But, they are not fully there yet. And, there still are excessive profits.

For 2013, the big four HMOs reported $141 million in profits from the public programs -- over three times what they were supposed to earn. This $141 million represents 77.6%, of their total profits in 2013.

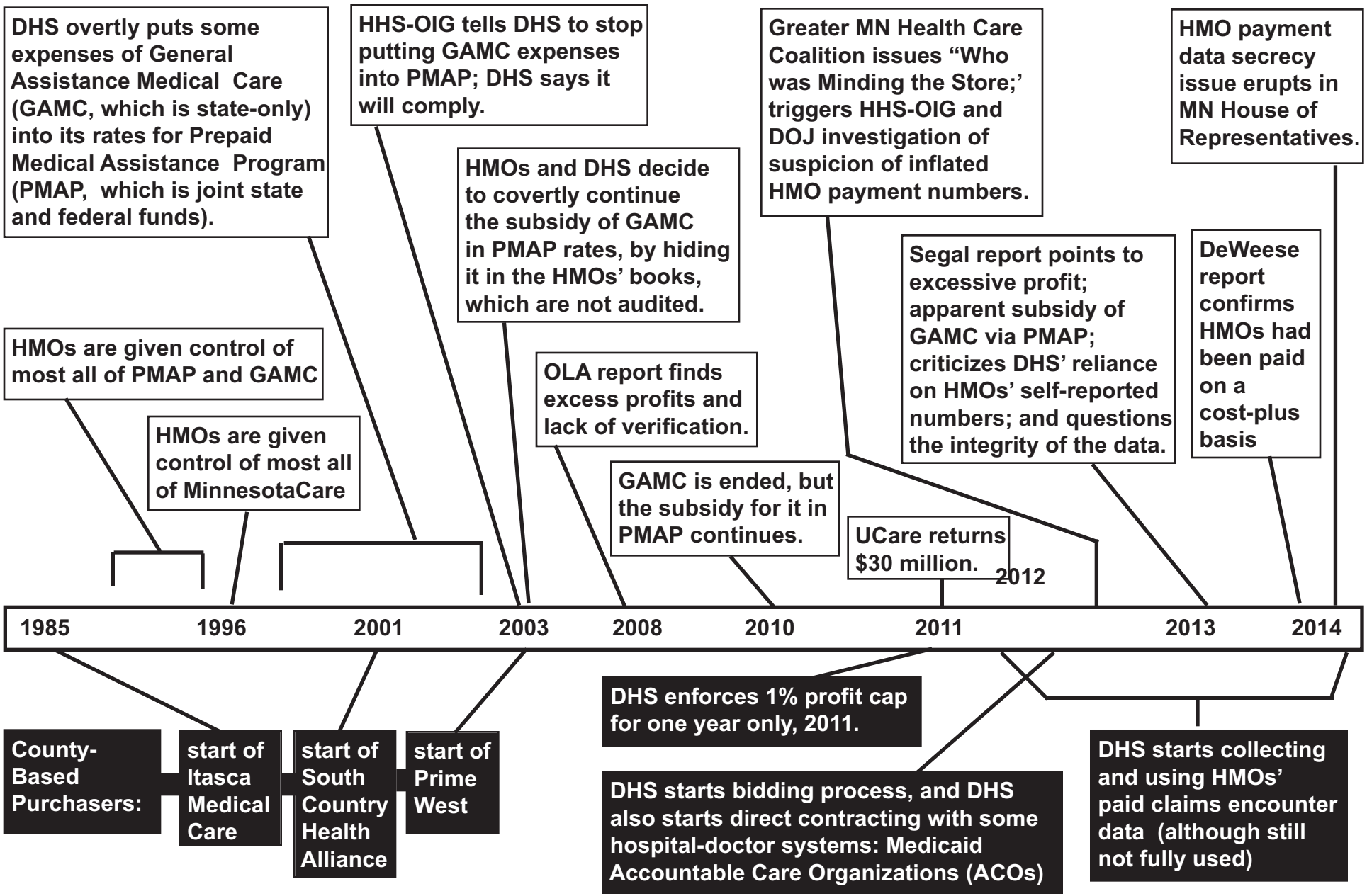
And finally: What should this Commission do?

We ask that the Commission recommend to the Legislature to not grant the HMOs an exemption from data disclosure. Besides all the reasons I've stated, if the legislature were to grant it, it would not look well for the state to be giving additional secrecy protection to the HMOs right when they are in the middle of a federal fraud investigation.

In addition, we ask that you recommend that the Legislature consider revoking the non-public data designation that was enacted for the HMOs' expense information for the public programs.

Thank you for this opportunity to testify.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION V
233 NORTH MICHIGAN, SUITE 1360
CHICAGO, IL 60601

November 20, 2012

Report Number: A-05-13-00011

Ms. Lucinda Jesson
Commissioner
Minnesota Department of Human Services
Elmer L Anderson Building
540 Cedar Street
St. Paul, MN 55101

Dear Ms. Jesson:

The purpose of this letter is to notify you of our intention to conduct a review of the Minnesota Department of Human Services. The Region V Office of Investigations has requested assistance from our office. The objective of the requested review is to determine whether information used for capitation rate setting for Minnesota's Health Care Programs was reasonable, allocable and allowable. Our review of certain public insurance programs managed by the Minnesota Department of Human Services will be for the period January 1, 2008, through December 31, 2009.

As a recipient of U.S. Department of Health and Human Services (HHS) grant funds, Minnesota Department of Human Services is subject to Office of Inspector General (OIG) audits and other reviews. Pursuant to 45 CFR § 92.42(e), OIG has the right to timely and unrestricted access to all books, documents, papers, or other records that are pertinent to the Federal grant award.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, providing the information requested by this letter is a permitted disclosure because it (1) is "required by law" to be produced to OIG as part of your participation in a Government benefits program (45 CFR §§ 164.512(a) and 164.103) and (2) will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (45 CFR §§ 164.512(d) and 164.501).

MN HMO state program profits, 2013 highlighted

HMO	Item	MSHO	SNBC-MA	PMAP	MnCare	Total	%
Blue Plus	Total Revenue	316,815,216		410,345,344	194,978,949	922,139,509	
	Net Income Gain or Loss	27,106,091		33,636,604	11,249,163	71,991,858	
	Profit Percentage					0.078070463	7.80%
HealthPartners	Total Revenue	107,044,000		341,858,000	90,569,000	539,471,000	
	Net Income Gain or Loss	10,078,000		1,585,000	1,745,000	13,408,000	
	Profit Percentage					0.024853977	2.48%
Medica	Total Revenue	306,824,913	261,864,474	562,241,704	109,962,673	1,240,893,764	
	Net Income Gain or Loss	-2,496,474	5,665,256	-2,515,944	-2,454,790	-1,801,952	
	Profit Percentage					-0.00145214	-0.14%
Ucare	Total Revenue	297,509,326	222,418,885	788,118,453	164,178,589	1,472,225,253	
	Net Income Gain or Loss	1,762,001	4,507,776	30,047,033	21,103,094	57,419,904	
	Profit Percentage					0.039002119	3.90%
Grand Total 2013	Total Revenue					4,174,729,526	
	Net Income Gain or Loss					141,017,810	
	Profit Percentage					0.033778909	3.37%

Percent of total 2013 profits:

The four HMOs' reported total 2013 state public program profits were $141.017 million.

Their grand total reported profits of all lines of business for 2013 was $181.651 million.

The profits from the state's public programs constituted 77.6% of all of their profits.

Notes:

All figures are from the HMOs' Minnesota Supplement Report #1 forms.

"Total Revenue" is line item 8 on the MN Supplement Report #1.

"Net Income Gain or Loss" is item 30 on the MN Supplement Report #1. It includes investment income.

Information compiled by: Greater Minnesota Health Care Coalition

Connecticut Health Policy Project

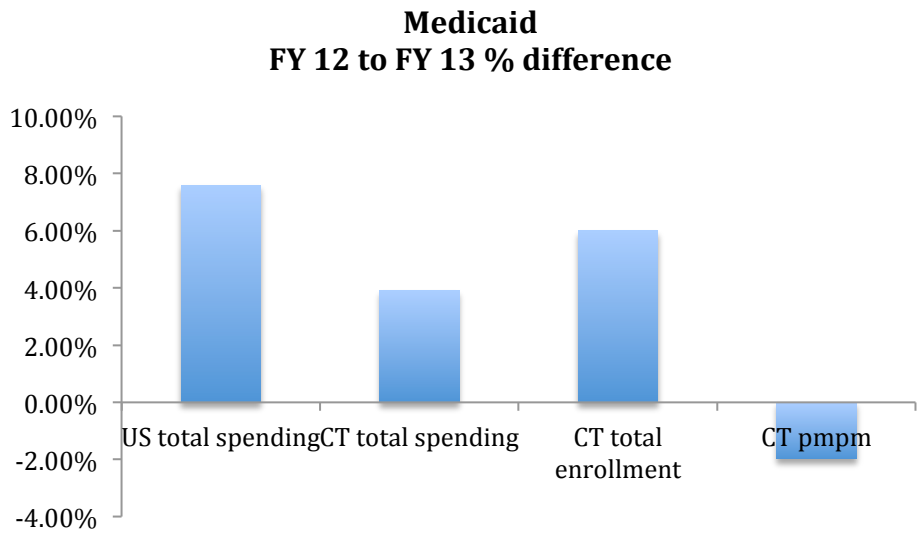
Issue Brief February 2014

Connecticut's Medicaid program success:

Significant improvements in access, quality care and cost control

January 1, 2012 Connecticut's Medicaid program shifted payment models from capitated managed care organizations to self-insuring with an Administrative Services Organization and person-centered medical homes to coordinate care for clients. Since that time, access to care, the number of participating providers and most quality measures are up; costs per member per month are down.

Between Fiscal Years 2012[1] and 2013, Medicaid spending rose by 3.9%[2] while enrollment in the program grew by 6%[3], bringing per member per month costs down 2%. In comparison, total Medicaid spending across all states grew by 7.6%.[4]



Between 2012 and 2013, Connecticut's Medicaid program has enjoyed significant improvements in access to high quality care, and lower costs.

[1] The change in payment model was only effective for half of FY 2012, lowering savings estimates.
[2] Annual Reports of the State Comptroller -- Budgetary Basis, 2012 and 2013
[3] DSS Active Assistance Unit reports
[4] State Expenditure Report FY 2011-2013, November 2013, NASBO

Connecticut Medicaid cost, quality and access to care[5]		
Metric	Performance	Timeframe
Providers participating in Medicaid	Up 5,180 32% increase	Jan 2012 to June 2013
Person centered medical homes (PCMHs) -- providers	Up 243 35% increase	Q3 2012 to Q2 2013
PCMHs – clients in one	205,905 25% increase	Q3 2012 to Q2 2013
Hospital admissions	Down 3.2%	Q1 2012 to Q1 2013
Days in hospital	Down 5.0%	Q1 2012 to Q1 2013
Inpatient costs per member per month	Down 1.8%	Q1 2012 to Q1 2013
Cost per hospital admission	Down 2.7% or $200 each	Q1 2012 to Q1 2013
ED visits	Down 3.2%	Q1 2012 to Q1 2013
Non-urgent ED visit costs	Down 11.7%	Q1 2012 to Q1 2013

Particularly encouraging is the expansion of person-centered medical homes. Medicaid clients cared for in PCMH practices rather than non-PCMHs are

- **23% more likely** to receive adolescent well care
- **20% more likely** to receive well-child visits in the 3rd, 4th, 5th and 6th years of life
- **26% more likely** to receive adult preventive health services
- **27% more likely** to receive an eye exam as part of diabetes care
- **wait less time** for an appointment for care that is needed right away
- **more likely** to get appointments for a check up or routine care with their provider
- **more likely** to have their child's provider listen carefully and know important information about their child's medical history[6]

Bottom line: Connecticut's Medicaid program has improved access to quality care and controlled costs since shifting away from a capitated managed care payment model to a self-insured model that focuses on care coordination.

[5] DSS presentation to MAPOC, Oct 11, 2013
[6] DSS presentation to MAPOC, January 10, 2014