Senator
John Marty

May 18, 2011

Cynthia Mann
Director of the Center for Medicaid and State Operations
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

I am writing to encourage CMS not to extend Minnesota's 1115 Waiver of the Medicaid Program.

It may seem unusual for a state senator to argue against continuation of a federal waiver that the state has been operating under for so long. However, the lack of accountability and the poor oversight of this "demonstration project" have resulted in less access to health care for many low income Minnesotans. It has also wasted millions in state and federal Medicaid funds.

The scope of the mismanagement is huge. The problem is so severe and has been going on for so long, that it is not clear that the problem can be fixed. To avoid wasting future Medicaid funds, I ask you end the waiver program in Minnesota and have the state contract directly with hospitals, clinics, doctors, and other providers to deliver health care to low income people.

Despite the fact that the Medicaid population is low income and higher risk than the commercial insurance population, the HMOs have been making over four times as much in profits (technically "earnings," since Minnesota law requires them to be non-profit) on the state business than they are on their commercial business in recent years.

Some evidence of the extent to which these funds have been mismanaged:

Minnesota's Medicaid managed care programs and contracts have never been fully audited, despite being two decades old. In 1993, the Department of Human Services (DHS) conducted a study to find out whether the HMOs were saving the state money compared to the direct contracting model, but the study was hampered by a lack of data from the HMOs. Even so, the study raised many questions about whether the state was getting its money's worth, citing concerns that program participants were not receiving appropriate levels of preventive services such as cancer testing. Rather than demand more data from the insurance companies receiving the state money, DHS buried the study. A front-page newspaper exposé of the study was subtitled, "Study Shelved After HMOs Complained." The story reported that DHS "reassigned

State Capitol, St. Paul, MN 55155 • [redacted] • [redacted]

the researcher...and abolished his job—leaving the agency without the ability to study the HMOs any further." *Star Tribune, "A study that raised concerns about how well HMOs serve the poor feel on deaf ears at the Human Services Department. Study shelved after HMOs complained." (March 13, 1994).*

Minnesota's rate-setting process is a mystery, at best. Late last year, my office requested an explanation from DHS about how our rate setting process works. We received an unsigned, convoluted memo that left us wondering whether DHS knew what they were doing. The DHS official responsible for Medicaid rate setting has testified that DHS relies on the HMOs to provide the data used to develop the rates, and does not audit that data. DHS doesn't even ask further questions unless they see obvious discrepancies. In a February hearing, the DHS official's defense of DHS' lack of oversight was weak: "...it is not ***completely*** taken on blind faith." (emphasis added.) The encounter and claims data that would be necessary for DHS to negotiate rates, or at least make sure that they are reasonable, are not available because the HMOs claim that it is "proprietary data." In effect, DHS has no way of knowing whether the rates it is "certifying" to CMS are reasonable or not.

Also, under the Medicaid program, the HMOs have no Medical Loss Ratio to meet. Even if they did have such a requirement, the state allows them to set their own definitions of medical and administrative expense. Many state officials assume that the HMOs are operating efficiently, based simply on the HMOs *self-reported* low administrative costs, which the HMOs base on their own definition of administrative costs. Back in 2001, Minnesota's attorney general exposed that one HMO was classifying tickets to Timberwolves basketball games and golf packages for their executives as medical expenses. The attorney general reported great frustration in his inability to get the data necessary to conduct proper oversight. We also have no way of knowing if the HMOs are comingling funds between their Medicaid contracts and their commercial business.

Perhaps the clearest evidence that these Medicaid HMO contracts are out of control is that one of the smaller HMOs recently made one of the largest charitable contributions in state history – a $30 million donation, not to some charitable foundation, but to the state general fund, because they recognized that they have been making too much money off of the Medicaid contract, especially when the state's budget problems are leading to deep cuts in health care programs for the poor and disabled.

Regardless of how the rates are set, Minnesota uses state and federal Medicaid funds to pay all costs incurred by HMOs, even fines and penalties. The DHS official in charge of Medicaid rate setting has testified that the state believes that it must cover ***all*** expenses the health plans claim, no matter how unreasonable, so that the HMOs are "actuarially sound". In fact, the DHS fiscal analysis of legislation that would have required the HMOs to meet a medical loss ratio, said that if a health plan does not meet the loss ratio and pays a penalty, "the cost of paying the penalty will be included in the health plan's experience in subsequent years and may result in higher DHS capitation rates." In other words, because Minnesota payments to HMOs under the 1115 Waiver are based on their previous year's expenditures, we get the absurd result that DHS uses state and federal Medicaid dollars to pay all expenses the HMOs incur, even fines and penalties for breaking the law!

Minnesotans are not getting the services for which they have paid. The HMOs are paid to manage care for program recipients, but we are not getting our money's worth. Last year when Minnesota replaced a state-funded health care program where care had been "managed" by the HMOs, with direct contracts with four large hospitals, Hennepin County Medical Center

(HCMC) found that of the 8000 enrollees that it was taking, a couple hundred had been hospitalized *three or more times in the previous year.* HCMC recognized that these individuals were not getting basic care, so they established a small primary care clinic, which resulted in significant savings by preventing the need for hospitalization. For years, the state paid the HMOs to manage their care, yet they did such a poor job that a hospital was able to step in and do a far better job in just months.

Note: The HMOs and the state agencies will undoubtedly point to the numerous reports that are filed by the HMOs, "boxes of data," to dismiss concerns over the lack of accountability. Yes, the HMOs provide numerous reports and information to the state. And, there are many hardworking people in the agencies, collecting that data and attempting to provide oversight. Likewise there are many good people working at the HMOs. ***But, lots of data and numerous reports do not equal effective oversight.*** *Unfortunately, the encounter and claims data needed to effectively negotiate rates and hold the HMOs accountable are being treated as "trade secrets" by the HMOs. Despite numerous reports and paperwork, nobody is minding the store, providing real oversight over costs and care. That is evident when the DHS official in charge of managed care contracts believes Medicaid needs to pay even for fines and penalties incurred by the HMOs.*

The issue of good stewardship of Medicaid dollars is even more pressing now that Minnesota has greatly expanded its Medicaid enrollment, through the early enrollment option under PPACA. I am proud that Governor Dayton's first major action was to opt into this life-saving initiative. This expansion of coverage will make a tremendous difference in the lives of many low income people, but it also means these HMO contracts are growing even bigger.

Although the governor has expressed strong interest in improving accountability, the mismanagement has been so bad for so long, that it could take years to straighten out that mess. If we have not had a true audit of the contracts even once in twenty years, it will take a lot of time to audit, let alone fix the problem. With literally billions of state and federal dollars at stake, we cannot afford to continue pouring more money into this dysfunctional program. Nor can the state count on savings from competitive bidding or other reforms when we don't have access to real-time, verified and comprehensive data.

According to CMS, the purpose of the 1115 Waiver is "to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute." Minnesota has been operating a "demonstration" program with managed care organizations under a waiver since the 1980s, yet the state has never completed a study to determine whether the HMO contracts were better than having the state contract directly with providers.

The real issue here is fiscal responsibility. Although the HMOs have been claiming for years that Fee-For-Service (FFS) is more expensive when the state contracts directly with providers than when the HMOs pay providers (also through FFS), in the two decades that Minnesota has operated this "demonstration" project, the state has never done a true cost comparison. While the per capita cost of DHS's fee-for-service enrollees is higher than those in the HMOs, this is due to the fact that the higher-need patients (elderly, people with disabilities) are DHS enrollees, not in the HMO contracts. The only available evidence directly comparing the two options (from GAO, comparing traditional Medicare with Medicare Advantage) is that direct administration is cheaper, not more expensive than privatizing the programs:

"Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. In 2006, Medicare paid $59 billion to Medicare Advantage (MA) plans—an estimated $7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS)." *Feb. 28, 2008 GAO Report*

With the gross mismanagement of Minnesota's Medicaid contracts illustrated earlier in this letter, on top of the evidence that managed care is more expensive than direct contracting, the huge amount of wasted funding merits the prompt termination of the "demonstration project."

Even if the 1115 waiver program would, somehow, instantly become properly managed in Minnesota, the evidence is that it would cost more than direct contracting of the Medicaid program.

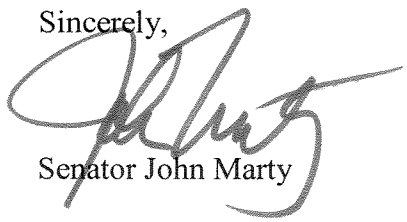
Consequently, I strongly urge CMS not to extend Minnesota's 1115 Waiver of the Medicaid Program. Minnesota can save money by providing care to Medicaid enrollees directly, managing the care through the "Primary Care Case Management" option, which does not require any CMS waiver.

Should CMS choose to extend the waiver, I ask you to require Minnesota to meet strict accountability standards, similar to what CMS required in Florida. Those requirements must include a comprehensive audit done by an independent organization that has not had any contracts or financial ties to the State of Minnesota or any health plan or health provider in recent years, as well as immediate implementation of an electronic information clearinghouse for encounter and claims data. Additionally, CMS should direct the state to stop letting the HMOs hide behind "proprietary data" and require the state to certify Medicaid rates directly rather than rubberstamping the data that the HMOs provide.

It is time to ensure that state and federal Medicaid funds are wisely spent to provide health care to low income Minnesotans. Again, I urge you not to extend Minnesota's 1115 waiver. Short of that, please require true accountability.

I would be pleased to discuss this further, if you have any questions, or if I can be of any assistance.

Sincerely,



Senator John Marty