

Testimony of David Feinwachs, M.H.A., M.A., J.D., Ph.D.

Before the  
U.S. House of Representatives Committee on Oversight and Government Reform  
Subcommittee on Health Care, District of Columbia, Census, and the National Archives and the  
Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending  
Wednesday, April 25, 2012

Thank You, Mr. Chairman and distinguished members of the subcommittee for inviting me today. I am David Feinwachs. I was, for nearly 30 years, the general counsel of the Minnesota Hospital Association. This is the trade association for all the hospitals in Minnesota. In addition to serving as their general counsel, I also directed their legislative advocacy.

In 2010, the Board of the Minnesota Hospital Association established as one of its priorities achieving transparency and accountability in Minnesota's publically funded health care programs. These programs included Medical Assistance (aka, Medicaid), Minnesota Care and the now defunct General Assistance Medical Care Program (GAMC). It's important to note that Medical Assistance is jointly funded in Minnesota, as in other states, by millions of federal and state dollars, in contrast to the Minnesota Care program and GMAC, which are supposed to be strictly state funded.

I was assigned as the lead staff person in this area. I began my work by analyzing what data I could obtain regarding these programs. I noticed that our managed care organizations (HMOs) made considerably more profit in the publically funded programs than they did in their commercial insurance products. I quickly came to realize that the question of whom or what regulated these managed care entities is difficult to answer. These HMO contractors have had these management contracts for over 15 years.

In Minnesota, all HMOs are statutorily required to be non-profit organizations. Their licensure is granted by the Minnesota Department of Health. The regulation of their financial transactions is the responsibility of the Minnesota Department of Commerce. And their involvement in the management of public programs, such as Medicaid, is regulated by the Minnesota Department of Human Services. This fragmented, uncoordinated regulatory scheme made it difficult, if not impossible, to gain a clear understanding as to how our public programs operated. This fact is confirmed by the Minnesota Department of Health's February 15, 2012 Report.<sup>1</sup>

During the 2010 legislative session, I worked for the introduction and enactment of legislation which would have required three things: (1) the establishment of a specific medical loss ratio for public programs; (2) the use of outside third party audits; and (3) a requirement that the state's healthcare programs use the Generally Accepted Accounting Principles to determine how public funds are allocated among administrative expenses, reserves and medical payment. This legislation was consistent with the position of the board of the Minnesota Hospital Association.

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<sup>1</sup> Advisory Group on Administrative Expenses Report to the Minnesota Legislature 2012 Minnesota Department of Health, February 15, 2012.

This proposal had its first legislative discussion in a committee hearing in February of 2010. I provided testimony in support of these concepts. After the hearing, the executive director of the Minnesota Council of Health Plans, which is the trade association for the HMOs in Minnesota, scheduled a meeting with my boss, the president of the Minnesota Hospital Association. My boss told me of the meeting and informed me that the Minnesota Council of Health Plans (for the HMOs) had asked that I be prohibited from providing further public testimony on these issues. He explained to me that the Council believed so long as I was not the public face on these issues they could defeat these proposals.

The president of the Minnesota Hospital Association did instruct me not to testify on these issues again. I was concerned as to why the hospital association would agree to do this, but I followed the directive and I inquired if there were other limitations on pursuing the hospital association's goal of transparency and accountability. I was told the only prohibition was on testifying before the legislature and in all other respects I was to continue to pursue legislation requiring transparency and accountability in our public programs.

Throughout the remainder of the 2010 legislative session I prepared testimony, which was delivered by others, briefed legislators, lobbied the issue and did background research all directed at achieving the Minnesota Hospital Association's goal. In May of 2010, near the end of our legislative session, it became clear that Minnesota was going to repeal its state-only funded General Assistance Medical Care program. During the repeal debate I suggested to legislators that this repeal would create a windfall for our HMOs since we had pre-paid them for a program that would no longer exist and therefore we should consider clawing back some of this money.

At the time this was suggested, the Director of Managed Care Contracting for the Minnesota Department of Human Services, Ms. Karen Peed, testified that any such attempt to recover money would be illegal and would in fact violate federal principles of actuarial soundness. Prior to Ms. Peed's testimony our Department of Human Services had prepared a fiscal note<sup>2</sup> indicating that any fines, penalties or assessments of any nature against the HMOs would not yield savings because such sums would be incorporated into the health plans experience rating for subsequent years and returned to them in later years as increased payments. I found this assertion and the fiscal note to be very troubling. I began to ask questions about how the statements made in the fiscal note could be reconciled with the commonly held belief that our HMOs entered into risk bearing contracts with our Department of Human Services.

After the close of the legislative session, I made a video that summarized the issues that had been raised during the course of the legislative process. In this video, I raised questions about how either government or taxpayers might ever be able to detect cross subsidization between non-federally qualified state programs and/or commercial insurance products and especially the Medicaid program. When I use the term cross subsidization, I refer to the inappropriate allocation of administrative expenses, insurance reserves, which are massive, and other costs to the Medicaid program which taxpayers should not have to cover.

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<sup>2</sup> Fiscal Note: SF 2986-1E Narrative "If a health plan does not meet the 93.5% 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. Dated 4/12/10.

In July of 2010, I began to make inquiry of certain current and former Minnesota Department of Human Services employees. These employees were asked what the level of administrative expense was before we outsourced these programs to HMOs and whether or not they thought the outsourcing was a good idea.

One of the retired Minnesota Department of Human Services employees who was interviewed reported the inquiry to the Department. Following this report, Ms. Karen Peed, the State's Medicaid Contracting Director, informed the Minnesota Council of Health Plans that these questions were being asked. The response from the Council and its member HMOs was grossly disproportionate to the issue. The Minnesota Medicaid Director then contacted the president of the Minnesota Hospital Association. Following this contact I was summoned to a meeting with the president and Vice President of Regulatory Affairs for the hospital association. At this meeting I was asked if I had made these inquiries and told them that I had. I explained that these inquiries were essential to achieving an understanding of the operation of our state programs.

During the course of that meeting and immediately after, I explained to the other gentlemen involved that I believed that I had uncovered a massive financial fraud against the government of the United States, and that the member hospitals of the Minnesota Hospital Association were among the victims of this fraud.<sup>3</sup>

On August 13, 2010, I was asked by the hospital association's Vice President of Regulatory Affairs to be an undisclosed participant in a conference call with Minnesota's Managed Care Contracting Director, Karen Peed. The purpose of the call was to explore the department's reluctance to try to obtain additional federal money through such strategies as intergovernmental transfer and certified public expenditures, both of which are suspect but legitimate mechanisms. I had been instructed not to speak during the course of the call because it was feared that Ms. Peed might not be candid and forthcoming if she knew I was listening.

During the course of this conference call, I heard Ms. Peed make the following statement: "If you can't keep a secret you have to leave the room, but we have been adjusting the reserve amount for state-only funded programs by making it essentially zero, and increasing the amount for PMAP federal programs, blending the rate and returning it to the insurers." Mr. Anderson confirmed this statement in a subsequent deposition.<sup>4</sup>

Immediately after the phone call I met with the president of the Minnesota Hospital Association and told him what had been said. I explained to him the significance of the Peed statement. I told him it appeared that the State of Minnesota and HMOs were engaged in the manipulation of the Medicaid rate certification process. This manipulation was apparently designed to obtain unwarranted federal funding in violation of federal cost allocation principals and regulations.

I subsequently showed the Hospital Association President and Vice President for Regulatory Affairs a copy of the Report of the Government Accountability Office (GAO), dated August 4, 2010 (GAO-10-810). This report was consistent with my assertions in so far as the report expressed concerns that such manipulations would not be detected by the Center for Medicare

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<sup>3</sup> Deposition of Matthew Anderson, April 27, 2011, pages 107-109.

<sup>4</sup> Deposition of Matthew Anderson, April 27, 2011, pages 60-62.

and Medicaid Services (CMS) and further the report stated in unequivocal terms that there was no standard of actuarial practice that applied to work performed by actuaries working in the Medicaid rate certification process.

On August 18, 2010, the president of the Minnesota Hospital Association related to me a chance encounter that he had with the executive director of the Minnesota Council of Health Plans. He told me that she was very angry about the work that I was doing and that he had told her that: “Dave has gotten it in his head that DHS and/or the plans are manipulating the rate certification process to get unwarranted federal funding.”

I asked what the Council’s response was to his comment. I was told that the executive director of the Minnesota Council of Health Plans had said, “So what if we are, it is no different than hospital cost shifting.” Upon hearing this, I informed the president of the Minnesota Hospital Association that I vehemently disagreed with this characterization and told him in my view this would be like comparing pan handling to bank robbery. “One is annoying, the other is a crime.”

Several days later, I was informed there had been a meeting scheduled. The meeting participants would be the executive director of the Minnesota Council of Health Plans, the President of the Minnesota Hospital Association and me. The stated purpose of the meeting was to “clear the air.”

At this meeting, which was held on September 8, 2010, the executive director of the Minnesota Council of Health Plans stated, “we are inextricably tied together in this Medicaid program and if we go down you go with us!”

I continued to work on behalf of the Minnesota Hospital Association on the issues of transparency and accountability until October 20, 2010 when I was placed on administrative leave. On November 9, 2010, my employment with association was terminated. Although I was offered two severance agreements from the hospital association I refused them because I did not want to be limited in what I could do or say regarding this or other issues.

Following the termination of my employment with the hospital association, I continued my advocacy at the Minnesota legislature. This advocacy continues to this day. In January of 2011, I brought a lawsuit against the Minnesota Council of Health Plans and subsequently against several of their member health plans alleging tortious interference with my employment. As a byproduct of this litigation, I obtained access to documents and testimony depositions, which significantly furthered the understanding of what was occurring in the HMO administration of Minnesota’s public programs.

During the course of the 2011 Legislative Session I was able to get various legislators to introduce a dozen pieces of legislation directed at the issues of transparency and accountability in the management of Minnesota’s public health care programs. There was considerable legislative interest regarding these topics in no small part due to a multi-billion dollar budget deficit. Despite the looming deficit and the fact that these proposals would have saved the state money, not one of these bills received a hearing.

Another notable event occurred during the course of the 2011 legislative session. This event was the unprecedented give-back of thirty million dollars by UCare, the smallest of Minnesota's four principal HMOs. The \$30 million dollar amount was exactly the rough estimate that my colleagues and I had been repeatedly telling Minnesota legislators was the minimum overpayment that the HMOs' likely received during just the fiscal year at issue.

This give-back was heralded as a donation to ease the state's budget crisis. Although announced as a donation, select legislators received correspondence from UCare dated March 16, 2011, which explained the give back as a refund of overpayment resulting from an inflated Medicaid rate related to the subsidization of the now defunct General Assistance Medical Care Program. The statement contained in this document was completely consistent with the assertions I had advanced.

In January of 2012 I began to utilize the now publicly available documents and transcripts from my lawsuit as well as the UCare letter of March 16, 2011, to brief legislators, the media and the general public regarding my concerns relative to the integrity of Minnesota's Medicaid program. Despite the fact that the subject matter was somewhat arcane and tedious, to their great credit, both print and television media explored the issue in depth. As a result of the media attention, grassroots advocacy and the efforts of many medically related groups (such as the Minnesota Dental Association, the Minnesota Chiropractic Association, the Minnesota Podiatric Medical Association, the Minnesota Nurses Association and virtually every other health care association with the notable exception of the Minnesota Hospital Association), legislation has now been introduced in 2012 which would require independent third party audits, establish a prohibition against the state's consulting actuary from also consulting with the state's HMO vendors and would require the real time use of encounter-claims and payment data. This legislation is moving through the process but has been significantly altered by opponents, including the Minnesota Department of Human Services.

On February 13, 2012, the Minnesota Department of Human Services Commissioner Lucinda Jesson was interviewed by Jay Kolls, an investigative reporter from KSTP television. The reporter showed Commission Jesson documents and transcripts obtained from my lawsuit and asked, "Would that be defrauding the federal government?" Commissioner Jesson responded by saying, "Let me just say two things. Let me be very clear. We are not doing it that way anymore... and Karen Peed is no longer in charge of contracting with the plans."

The next day, February 14, 2012, I testified before a joint hearing in the Minnesota House of Representatives of the Committees on Health Finance and Reform. During my testimony I asserted that this so called "donation" by UCare was actually the refund of an overpayment caused by an improperly inflated Medicaid rate. In making this argument, I presented legislators with the letter written by UCare's CEO, Nancy Feldman, dated March 16, 2011. I also presented to legislators a sampling of the documents and transcripts I had obtained in the course of my litigation. During the course of the hearing I asked two critical questions. First, I asked given the fact that everyone seems to agree that non-federally qualified programs are being subsidized by the Medicaid program, do we all agree that the federal government is aware of this? Second, I asked if the health plans involved in the management of these public programs were actually assuming any insurance risk? Despite the fact that both the chief actuary for the Minnesota Department of Commerce and the Commissioner of the Department of Human Services provided

testimony at the hearing, both inquiries went unanswered. Following the February 14, 2012 hearing the UCare issue has received heightened media attention.

In the aftermath of the February 14, 2012 hearing, it has come to light that the Minnesota Department of Human Services has been less than candid in their handling of these issues. The Minnesota Legislative Auditor has recently discovered that documents that he had requested on more than one occasion from the Minnesota Department of Human Services have been withheld. Minnesota Law is clear in its requirement that the legislative auditor is entitled to the receipt of such documents. The principal document in question is correspondence from CMS to the Minnesota Department of Human Services dated July 1, 2011. This correspondence seeks recovery of the federal share of the thirty million dollar UCare give-back. This document conflicts with the Minnesota Department of Human Service's assertion that the UCare giveback had been properly characterized as a donation and that this characterization had been accepted by the Center for Medicare and Medicaid Services.

On February 15, 2012, the Minnesota Department of Health released a report that was prepared with the assistance of Deloitte Consulting LLP. This report concluded that: "To the extent health plans participate in the commercial market as well as the state public programs, it was not possible to determine if administrative expenses and investment income was being properly and fairly allocated among all of an HMO's lines of business." The title of this report is Advisory Group on Administrative Expenses, Report to the Minnesota Legislature 2012 Minnesota Department of Health, February 15, 2012.

It is clear that something is very wrong in Minnesota. It is not possible to obtain a straight answer to the following simple question: who certifies the Minnesota Medicaid rates to the federal government? Minnesota's health plans say the Minnesota Department of Human Services does this. The Minnesota Department of Human Services say it is done by the state's consulting actuary. The state's consulting actuary says that the health plans and the Minnesota Department of Human Services do it. Someone must do it, and more importantly, someone must be accountable for having done it.

Bear in mind the conclusion reached in the report of the General Accountability Office dated August 24, 2010: "With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending."

The Center for Medicare and Medicaid Services (CMS) is highly vulnerable to fraud because it focuses solely on the receipt of information and disregards the veracity and authenticity of information that is submitted to them. The federal government has exhibited a trust in this area that borders on recklessness. It is assumed that auditing and verification of information that is submitted to obtain federal funds has occurred when in fact it has not.

Minnesota's experience demonstrates the nature of this problem. According to the 2008 report of the Minnesota Legislative Auditor, Minnesota's managed care capitation rates for public

programs are relatively high compared to other states.<sup>5</sup> Minnesota's managed care spending per enrollee grew faster than the national rate in recent years.<sup>6</sup> Minnesota's managed care organizations have not reported aggregate losses from public programs in recent years<sup>7</sup>. However, health plans have consistently reported losses for the General Assistance Medical Care program.<sup>8</sup> Despite these facts, Minnesota's health care providers have experienced flat or decreasing reimbursement levels for more than a decade. Hospitals have seen some increases but certainly not enough to make them whole in the aggregate. All health care providers report losses on public programs both in the aggregate and individually. Also of concern is the fact that the State of Minnesota has used the same consulting actuary for as long as anyone can remember. I am not aware of any evidence to suggest that this actuarial work has ever been put out for bid. Until quite recently the state's consulting actuary has been permitted to consult with at least some of the state's HMO vendors.<sup>9</sup> It appears that the most recent attempt to address this conflict of interest is simply to require different employees from the same actuarial firm to represent both the state and its vendors. These facts, combined with the apparent manipulation of the Medicaid rate certification process requires immediate and thorough auditing of Minnesota's Medicaid Program.

Equally important is the question of how long we have employed the mechanism which our Department of Human Services Commissioner now disclaims with the statement, "We are not doing it that way anymore..." How much money is owed to the federal government for the period of time that we did in fact "...do it that way"? We must confront the fact that in the absence of thorough and truly independent audits how do we know if we are not still "doing it that way"?

The federal government must take steps to require independent and rigorous auditing of the information which is and has been received by the Center for Medicare and Medicaid Services. The government has an obligation to taxpayers to recover funding, which was improperly obtained through a manipulation of the rate certification process.

The federal government must also view, with a jaundiced eye, any request for block granting made by states, such as Minnesota, who now seek to avoid prospective accountability requirements for federal funding. This strategy of sweeping past practices under the rug and directing the federal government's attention elsewhere must be rejected.

It would, in my opinion, be ill advised to weaken requirements for transparency and accountability on those who have avoided both by manipulating and exploiting the existing system to defraud the federal government.

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<sup>5</sup> Office of the Legislative Auditor, State of Minnesota, Evaluation Report, Financial Management of Health Care Programs, February, 2008, page 38.

<sup>6</sup> Ibid page 40.

<sup>7</sup> Ibid page 42

<sup>8</sup> Ibid page 43

<sup>9</sup> DHS response regarding competitive bidding and managed care. December 1, 2011. DHS has a contract with Milliman for actuarial services related to Minnesota Health Care Programs. The current contract prohibits the actuary from entering into consulting contracts with health plans that deliver PMAP services. Past administrations have permitted actuaries that contract with the state to enter into consulting contracts with health plans that have PMAP contracts.

Minnesota, which is considered a health care leader nationally, appears to have been lured into highly questionable conduct, perhaps for as long as 15 years. It is possible this conduct is occurring in other states as well. In our current system it would be difficult for the federal government to detect this because as the GAO pointed out in its August, 2010 report, “the federal government focuses on the appropriateness of data rather than their reliability.”<sup>10</sup>

With the recent failure of the Minnesota legislature to order truly independent audits, past and future, I can think of no more appropriate place than this committee for me to make these comments. What is required here is significant government oversight and regulatory reform. The lack of oversight by CMS as documented in the GAO report and as experienced in Minnesota is of great concern. It is to a degree understandable because of misplaced blind trust on the part of the federal government in institutions such as managed care organizations and state agencies.

My advice to federal regulators is contained in the maxim, “Fool me once, shame on you. Fool me twice, shame on me.” The amount of potentially misappropriated federal funding for the time in question in Minnesota alone is very large. If you add in the possibility of similar occurrences in other states the amount is staggering.

I want to thank Chairman Gowdy, Chairman Jordan and members of the subcommittee for holding this hearing. I am pleased to answer any questions you may have.

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<sup>10</sup> GAO -10-810



**David Feinwachs, M.H.A., M.A., J.D., P.H.D.**

**Health Lawyer Strategist Political Advocacy Educator**



**Professional Experience**

**Volunteer Advocate for transparency and accountability in the funding and operation of Minnesota's public health care programs.**

**2010-Present**

- 2011 Recipient of the Minnesota Nurses Association Paul and Sheila Wellstone Social Justice Award. "Given to someone who speaks out "courageously and consistently for others" and has had an "unwavering voice ... undiminished by political tides."

**General Counsel**

**1981-2010**

Minnesota Hospital Association  
and Aging Services of Minnesota  
St. Paul, Minnesota

- Senior management and legal counsel to the Minnesota Hospital Association and Aging Services of Minnesota and their subsidiary corporations. Counseled and advocated every major legislative and policy initiative undertaken by the Minnesota Hospital Association in the last three decades.
- Director of Government Relations. Registered lobbyist at both the federal and state level; Achieved numerous statutory modifications which have positively impacted medical care. Examples include Minnesota's Averse Event Reporting Law, administrative uniformity legislation standardizing all insurance billing in the State of Minnesota; and modifying Minnesota's False Claims Act creating a provider right to cure.
- Routinely responded to inquiries related to legal aspects of patient health care administration such as: liability, informed consent, reimbursement, medical ethics, antitrust, accreditation, fraud and abuse; and a wide variety of health law issues.
- Frequent speaker at educational programs.
- Named one of Minnesota's leading health care lawyers by Minnesota Physician Magazine in August 2005.
- Negotiated an agreement with the Minnesota Attorney General's office which governed pricing for the uninsured and fair collection practices on behalf of all Minnesota hospitals.

**General Counsel**

**1980 — Current**

Paster Enterprises  
St. Paul, Minnesota

Directs legal affairs of shopping center development firm as general counsel. Principally responsible for lease review, negotiation and enforcement. Coordination with outside counsel. Risk management and corporate planning.

**Assistant Professor/Adjunct Faculty**  
University of Minnesota  
Carlson. School of Management and

**1991 — Current**  
University of MN

School of Public Health and  
University of St. Thomas  
Graduate School of Business  
Develop and teach graduate level courses in health management, policy and health law to  
students seeking master's degree in public health and health care administration.  
Develop and teach pre-licensure courses for persons seeking nursing home administrator  
licensure.

Three-time recipient of MHA Excellence in Teaching award.

**Director, Center for Long Term Care Administration** **1994 — 2002**  
**University of Minnesota**

Carlson School of Management

- Directed the program that provides academic preparation for persons seeking licensure as nursing home administrators in the state of Minnesota.

**Educational Background**

B.A., Biology — 1973	Macalester College
B.A., Sociology (with distinction) — 1973	St. Paul, Minnesota
Master of Hospital and Health Care Administration — December, 1978	University of Minnesota School of Public Health Minneapolis, Minnesota
Juris Doctor (emphasis on health care) January, 1980	William Mitchell College of Law St. Paul, Minnesota
Master of Arts in Medical Sociology September, 1980	University of Minnesota Graduate School Department of Sociology Minneapolis, Minnesota
Doctor of Philosophy (health care management) — May, 1990	University of Minnesota Graduate School Department of Social and Administrative Pharmacy Minneapolis, Minnesota

**Licensure**

Attorney Admitted to the Bar of: • Supreme Court of Minnesota • U.S. Federal District Court Minnesota • U.S. Court of Appeals for the Eighth Circuit • U.S. Supreme Court Licensed Nursing Home Administrator State of Minnesota	<b>1980 — Current</b>
Licensed Private Investigator State of Minnesota	<b>1978 — Current</b>

Committee on Oversight and Government Reform  
Witness Disclosure Requirement – “Truth in Testimony”  
Required by House Rule XI, Clause 2(g)(5)

Name:

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1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None

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2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

None

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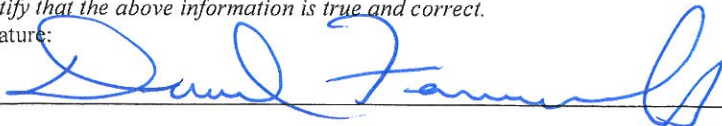
3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None

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*I certify that the above information is true and correct.*

Signature:



Date:

4-20-12