Oversight and Accountability of Health Plans Serving Minnesotans Enrolled in Medicaid

Financing	
Statements	**Facts**
The State awards huge contracts – totaling over $3 billion per year –without competitive bidding or auditing, and with minimal reporting.	Health plan participation in Minnesota Health Care programs is required by law and therefore the state does not solicit bids. State law (Minnesota Statutes 62D.04, subd. 5) mandates that any HMO licensed in Minnesota must participate in state public programs. The Minnesota Department of Human Services (DHS) sets the rate it will pay a health plan to provide coverage for state public program enrollees. Although health plans do not bid, applications are required. To meet the DHS procurement process, a health plan must reapply to offer coverage. DHS issues requests for proposals from plans that want to participate in a particular program and region of the state. All interested plans – including those already offering coverage – must submit a complete response and be evaluated for participation.
	Audited information is available on the MDH website for each health plan. The information is reported by program (MA, MinnesotaCare, MSHO, commercial etc.) Included in the summary are: • Revenues (Line 8) • Medical/Hospital Expenses (Line 18) • Administrative Expenses (Lines 20-22) • Net Gain (loss) from operations (Line 24)
	Three Minnesota and one federal agency hold health plans accountable. • Independent audits by Departments of Commerce, Human Services, Health • Centers for Medicare and Medicaid Services • Yearly state-mandated external financial audits Independent audits of financial statements ensure accurate reporting.
	DHS is responsible for evaluating the quality of care provided to individuals enrolled in Minnesota's publicly-funded managed care organizations. DHS hired a Michigan firm audit the health plans and ensure reports submitted by health plans throughout the year are complete and accurate. The findings are reported in the Medicaid-mandated Annual Technical Report (ATR). The last report was 197 pages of organization-by-organization analysis. In addition, MN Community Measurement and DHS conduct research and report publically on the care received by enrollees.
	DHS also reports spending by product, 2009 $6.778 billion Medicaid spending — $526 million MinnesotaCare spending $2.017 billion for health plans — $510 million for health plans $4.760 billion for DHS fee for service — $15.8 million for DHS

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The system is rigged in a manner that whatever the contractors spend, the state will pay the bills.	The state's contracts with health plans (2011 contract, page 63, section 4.2) require the plans to take the full financial risk for covering enrollees in state public programs. By contracting with the health plans, the state is able to ensure enrollees will have access to providers all over the state (which wasn't always the case before managed care became involved.) By requiring health plans to take all financial risk, the state can plan and budget based on a fixed amount of funding, providing stability and predictability for the state. The risk is on the health plans. In addition, the contract states (page 63, section 4.1.17) that a health plan will not recoup prior years' losses so the state does not pay for whatever the health plans spend.
	DHS payments to health plans are based on data: • Data on medical care spending drives the DHS rate setting process • Each year DHS issues a new contract, new base rate • DHS looks back at medical care costs over the past two to three years to develop base rate • Base rate is estimated average cost per member across all participating plans • Administrative spending by DHS is capped at 6.6 percent of medical care costs, plus state taxes, fees, etc. • Base rate adjusted for legislated changes in benefits, eligibility, medical care costs DHS then adds an expected margin of 0 to 2 percent. This entire process develops an "actuarially sound" rate.
The state covers all costs. The state must cover all of the costs, including the administrative costs, so that the HMOs will be "actuarially sound."	Actuarially sound rates are required when federal dollars are involved. The State must certify to CMS that the rates are sound in order to receive any federal matching dollars. This law was created to protect patients. Social Security Act Sec. 1903 [42 U.S.C. 1396b]. Rates are independently certified by a DHS-appointed actuary. Soundness is based on defined criteria: • type of population covered • cost of the care • inflation trends • organization's cost containment efforts • amount of care received • actual plan benefits • regional cost differences • other factors for the individuals in the program

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Oversight	
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The state has no way of knowing if people enrolled in state public programs are receiving care.	Each month the health plans submit reports to DHS. These reports contain information on every state public program enrollee visit to a health care provider. In 2011 this data includes: • Member name and unique member state ID number • ID of Doctor, nurse, who provided the care; clinic number as well. • Date of service or date prescription was picked up • Description of what care was provided (procedure codes or revenue codes) • Drug name and number, if appropriate • Description of the diagnosis, except pharmacy & dental claims • How much the health plan paid for the services • Where the service took place. There are separate codes to describe services in a hospital, a clinic, the home, a nursing home, etc.
	Payments to a health plan are withheld until the plan meets the goal for preventive care visits for children. Health plans report progress toward to goal on the 10th of every month. This goal includes components about good physical and mental health, including: • Complete physical exam • Shots • Hearing check • Vision check • Lab tests • Checks on development and growth • Referral to the dentist Preventive care for adults and children is reported through audited HEDIS quality reports, and the state's report conducted annual with MN Community Measurement. These reports are available online. MN Community Measurement report. 147 pages. HEDIS reports, by plan, commercial and public program enrollees.

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Oversight	
Statements	**Facts**
The state has no way of knowing if people enrolled in state public programs are receiving care.	The Health Care Expenditures report breaks out spending by age, program and service in the following categories: • Inpatient hospital • Clinic or outpatient hospital • Home care • Pharmacy • Skilled nursing facility • Dental care Other reports include: • any complaints and complaint resolution • child and teen immunizations and preventive care • any denial, termination or reduction of services • health risk screenings • enrollee satisfaction survey results Each health plan sent more than 205 reports to DHS last year. In addition, audited HEDIS submissions and MN Community Measurement reports also document the appropriateness and quality of care Minnesotans receive.
The state has no way of knowing how much money is eaten up by administration.	The state capped at 6.6 percent, plus state taxes and fees, the amount of money that can be spent on public program administrative costs. In addition, MDH publishes a yearly report detailing salary and other spending in 14 health plan administrative categories including lobbying, claims processing, customer service, taxes, provider relations & contracting, fraud detection, etc. Administrative spending by each health plan by product (Commercial, PMAP, MinnesotaCare, MSHO, etc.) is documented in the yearly Minnesota Supplement Report #1. Statement of Revenue, Expenses and Net Income. Page 1, Lines 20 and 21.
HMOs define what they count as administrative costs and what they count as health care, enabling them to hide spending on administrative overhead.	The Minnesota Department of Health defined and reports on health plan administrative spending each year.

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Despite two Legislative Auditor reports calling for greater scrutiny, DHS has not conducted any audits.	DHS, Commerce and Health all have requirements for the health plans. Looking at the requirements from one agency in isolation or one type of audit isn't the complete picture. All audits are either conducted independently or reviewed by an independent organization to ensure accuracy. Health plan information currently on the MDH website includes: • Two independent audits ensure health plans are providing quality health care coverage and following all Minnesota rules and regulations. • Financial reports showing revenue and expenses by product and categories of spending, IRS 990 forms, executive compensation, financial audit results • Statistics on how many people enrolled in a health plan received annual checkups and screenings, immunizations, appropriate treatment for infections and lung diseases, appropriate care for heart conditions, diabetes, depression, asthma, and more. These reports allow Minnesota health plans to be compared with health plans across the country. • Enrollment by product, age, county • Comparisons and summaries of complaints about health plans

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Past Legislation

Statements	Facts
These contract holders are not required to use "GAAP" (Generally Accepted Accounting Principles). Legislation was introduced in 2010 that would require the HMOs to meet a medical "loss ratio," refunding money to the state if they spent too much on administrative overhead. Pressure from the HMOs succeeded in blocking this legislation, so there is still no oversight of this $3 billion in public contracts.	In March 2010 Sen. Sharon Erickson Ropes introduced SF 2986. <u>Changing health plan accounting systems</u> The bill would have required the health plans to maintain GAAP accounting for government programs. This is inconsistent with the requirements the plans must comply with for other agencies, including DHS, Commerce, Health and the federal Medicare program. In addition, the National Association of Insurance Commissioners and the U.S. Department of Health and Human Services require health plans follow Statutory Accounting Principles, not GAAP accounting principles. SAP requires health insurers to have resources on hand to pay all claims. GAAP does not have the same immediate requirements. <u>Health plan Medical Loss Ratio would include provider administrative costs</u> The bill established new MLR requirements on one state public program offered by health plans. At the same time, federal health reform was mandating new MLR requirements for health plans. Creating state law that is inconsistent with federal law would have required required health plans to maintain two or three different MLR calculations: one for PMAP, another for other state public programs and one to comply with new federal law. As drafted, SF 2986 would have required health plans plans to include the administrative expenses of clinics, hopsitals and other health care providers in the health plan's MLR calculation. The bill would have penalized health plans if the provider group failed to meet the loss ratio required in the bill. In order to include the providers' administrative costs in the MLR calculations, health plans would have to receive details on clinic and hospital administrative expenses. <u>Citizen auditors would be allowed access to health plan books</u> The bill would give providers access to health plans' books related to costs and expenses that go into determining the medical loss ratio, essentially allowing providers to review the rates and payments of their competitors. <u>Robust reporting and oversight of the system</u> Full and robust oversight of the entire health care system helps ensure the interests of Minnesotans are protected. In fact, Minnesotans deserve to know even more about the value of health care in this state: both the cost and quality. The entire health care system is reponsbile for slowing rising costs. Minnesota's health plans support transparency and are already required by multiple agencies to provide information on spending.

Source: Minnesota Council of Health Plans, January 2011