Minnesota Department of **Human Services**

June 18, 2012

Mr. Alan Freund, Associate Regional Administrator
United States Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region V
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Mr. Freund,

I write in response to questions contained in CMS's letter to the Department of Human Services ("Department" or "DHS"), dated May 16, 2012. There are two caveats to the Department's responses below. First, the Department understands, through its discussions with CMS, that where a time period is not specifically identified in the questions herein, the Department should assume the question relates to the years CY 2005-2009. Second, to the extent the Department's responses are related to Minnesota's managed care rate setting, many of the Department's staff who made high-level decisions involved with historical rate setting are no longer employed by the Department. In turn, the Department has prepared these responses based on actuarial, and other, documentation referenced herein and memory of the current employees with personal knowledge of past discussions. The Department believes that former employees, who were directly involved in the historical rate setting processes, may have additional knowledge regarding the same. The Department's responses below are based on its best information to date. If the Department becomes aware of new information, the Department reserves the right and intends to update CMS with the same.

Minnesota Responses to Questions of May 16, 2012,
for Minnesota on Managed Care Rate-Setting

1. **When did Minnesota begin paying capitation payments to managed care organizations (MCOs) for PMAP, MinnesotaCare and GAMC benefits?**

Response: Minnesota began requiring Medical Assistance recipients to enroll in managed care in 1986 (in Hennepin, Ramsey, and Itasca Counties). Prepaid GAMC dates back at least 20 years. Managed care enrollment for MinnesotaCare began in 1996.

2. **Please provide a copy of the CY 2009 rate-setting documentation for GAMC.**

Response: The Department works with an actuary in setting capitation rates. For each contract year, the rate setting documentation for GAMC consists of a letter from the Department's actuary reflecting rate methodologies included in the rate calculations used for the next calendar year's contracts. After receiving clarification from CMS that this request is for rate-setting documentation for CY 2005-2009,

enclosed please find copies of the letters from the Department's actuary for these years, and the Department's corresponding rate calculation spreadsheets employing the actuarial methodologies.

3. Which of the following data sources did the State use to set its program rates for GAMC?

a. MCO encounter data
b. MCO financial data
c. Historical fee-for-service data
d. Other (please explain in detail)

Response: In general, each year, the data used to set rates was derived from a number of sources, including: information filed by the MCOs with the Minnesota Department of Health, which regulates HMOs in this state; information requested by DHS and received from the MCOs; and information contained in MMIS. In GAMC, fee-for-service data has not been used for many years. Although this may not be an exclusive list for all years from 2005 to 2009, these are the types of sources:

Information from the Minnesota Department of Health:

- Copies of the Minnesota Supplement Report #1, Statement of Revenue, Expenses and Net Income filed by each MCO

Information requested by DHS and provided by the MCOs:

- Cost information by category of service and by rate groupings
- Restated net hospital and medical expenses for Medicaid-covered services provided by the MCOs based on more recent experience
- Certifications, provided by the MCOs, of the percentages of expenses that were for non-covered services
- Information regarding reinsurance premiums and recoveries

Information from DHS records:

- Amounts withheld and returned to the MCOs
- Various enrollment and other capitation reports from DHS

4. Please explain, in layperson's language, the risk adjustment methodology to set MCO capitation payments (both the Johns Hopkins Adjusted Clinical Groups grouper as well as plan-specific adjustment factors). Please also describe the underlying data source(s) used to develop the plan-specific risk adjustment factors.

Response: DHS currently uses ACG software in developing risk scores. The ACG software has been in use since Minnesota began risk adjusting plan rates. It is one of several well-accepted tools in the industry for this purpose. This risk score is used to adjust the capitation payments each month for the plans. DHS utilizes a concurrent ACG model (as opposed to a predictive model). The weights for each

plan were updated quarterly using a year of claims data with a nine-month lag. For example, plan encounter claims for the measurement year ending March 31, 2011 would affect payment in January 2012. The goal is to better reflect in the payment differences in illness burden of members in the plan by use of the diagnosis information on the encounter claims. In the Minnesota market, the ACG tool seems well-accepted by providers. Diagnosis information is specific to the health plan that paid the claims and is not used in risk scores for other health plans. DHS determines what portion of the overall rate should be risk adjusted. In 2010, fifty-percent of the rate was risk-adjusted. The sum of the individual member scores comprises the health plan score.

5. What does the adjustment titled "Contribution to Surplus" represent –

a. MCO reserve requirements; profits; or something else?

Response: "Contribution to surplus" essentially means underwriting gain. In Minnesota, all HMOs are non-profit organizations. Historically, capitation rates for the GAMC program did not include a factor for contribution to surplus/underwriting gain. For CY 2006, GAMC rates were also adjusted to redistribute available GAMC funding based on each health plan's mix of public program business. The contribution to surplus factors used in Medicaid (MA and MinnesotaCare) are included in the enclosed actuarial letters. Actuarial certification is not required for capitation rates used in state-funded programs. Capitation rates in state-funded programs are not regulated by Title XIX.

b. How does the State or Milliman determine the appropriate specific adjustment (ranging between .5% and 1.75%)?

Response: Historically, factors that have influenced the State's determination of the contribution to surplus are:

- State budget considerations;
- The negotiation process with the MCOs;
- The impact of using the same capitation rate for each plan; and
- Program changes associated with higher uncertainty.

c. Are these plan-specific adjustments? If so, how are the plan-specific adjustments determined?

Response: No. Contribution to reserve adjustments are not specific to each MCO.

6. If an MCO pays a penalty (e.g. for not meeting specific contract performance requirements), is the MCO permitted to include that penalty payment as an administrative expense reported to the State?

Response: Yes. Currently, if a MCO pays a penalty it may record it as an administrative expense on the Minnesota Department of Health's Health Plan Financial and Statistical Report.

a. If so, is that administrative expense counted in future calculations of the administrative component of the MCO's capitation payment?

Response: As noted below, historically, the Department has not used administrative financial penalties as a contract enforcement tool. So, there is no effect on future capitation rate calculations. If there are significant penalties paid in the future, they will be accounted for in the rate development process to ensure that the administrative expenses are not included in the capitation rates.

b. How much, if any, in penalties has each of the MCOs paid to the State in each of the past 5 calendar years?

Response: The MCOs did not pay any administrative financial penalties to the Department for the years 2005 through 2009. The Department currently, and historically, has used the Minnesota Department of Health ("MDH") to audit the MCOs and, therefore, it is possible that penalties could have been paid to MDH. MDH posts the last two years of penalties on its website. Historically, the Department has managed contract violations by notifying the MCOs and requiring corrective action.

At the direction of Commissioner Jesson and with the agreement of the health plans, the 2012 contracts contain changes to provide the Department better ability to assess substantial fines for certain types of violations. The Department may now impose administrative financial sanctions that include the withholding of all or a portion of the capitation payments until deficiencies are resolved, and for general deficiencies, monetary payments of up to $5,000 per day plus actual costs caused by the MCO of up to $250,000. For deficiencies related to violations of enrollee due process rights, the Department may impose a $15,000 sanction per deficiency.

7. If an MCO does not earn part of the capitation payments that are withheld by the State until performance is proven, how are those "unearned" or withheld capitation payments factored into future rates?

Response: Currently, the capitation rates are set based on expected costs for the MCOs. If, in a previous year, an MCO lost funds as a result of unearned or withheld capitation payments, the Department would not add additional funds in a future year.

8. We understand that the 1% profit limit on MCOs applied solely to the CY 2011 contracts. Why is the State not imposing that limit in CY 2012? Does the State intend to take any further actions on limiting MCO net revenues?

Response: The Dayton Administration inherited the executed CY 2011 contract from the previous administration. Because we believed that, historically, the contracts were too generous, we negotiated a one-time 1% profit cap on these contracts while we reformed the contract process for the future. The CY 2012 rates for the metro area were determined by competitive bidding, which will serve to limit the revenues of the largest population enrolled in the largest MCOs. The new rates negotiated in the competitive bidding process also helped to appropriately reset rates for the contracts in greater Minnesota. Thus, the competitive bidding process resulted in a significant rate reduction which applied statewide. We believe the market will allow the optimal cost basis for the programs because, to maintain

enrollment, health plans will need to develop aggressive plans to have the lowest premium over the long term. In the very near future, we will be announcing more details about competitive bidding opportunities in greater Minnesota, which we hope will achieve further rate reductions and better value for Minnesotans.

9. Did the State stop paying the MCOs when the GAMC program was transitioned from an "insurance product" to an uncompensated care hospital grant in 2010?

Response: Yes. The State stopped paying the MCOs when the "uncompensated care hospital grant" known as the Coordinated Care Delivery Systems began June 1, 2010. When a GAMC enrollee was no longer enrolled in an MCO, the MCO received no capitation for that enrollee.

a. If so, how was that effectuated, since CMS did not receive any rate or contract amendments reflecting that change?

The MCO contract, as approved by CMS, limited participation in managed care for persons enrolled in the GAMC part of the Families and Children contracts. The contracts provide:

> **Preamble**
>
> This contract represents the Prepaid Medical Assistance/Prepaid General Assistance Medical Care and MinnesotaCare programs for persons eligible for Medical Assistance under the age of 65, and all eligible persons in General Assistance Medical Care (GAMC) *from January 1, 2010 through February 28, 2010,* and MinnesotaCare. [Emphasis added.]
>
> **Article I Overview:**
>
> As of March 1, 2010, funding for the GAMC program will be suspended, and PGAMC will no longer be available through this Contract. Terms of this contract in reference to GAMC will no longer be applicable, unless funding is restored during Contract Year.

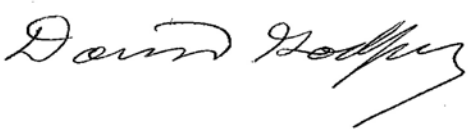
The contract was amended in February, 2010 to delay the sunset of GAMC to April 1, 2010. The amendment was not submitted to CMS for approval because it had no effect on the federally-funded programs. The amendment was as follows:

> **REVISION 1. (Preamble)**…The final paragraph of the Preamble is amended as follows:
>
> This contract represents the Prepaid Medical Assistance/Prepaid General Assistance Medical Care and MinnesotaCare programs for persons eligible for Medical Assistance under the age of 65, and all eligible persons in ~~General Assistance Medical Care (GAMC) from January 1, 2010 through February, 2010, and~~ MinnesotaCare. This contract represents all eligible persons in General Assistance Medical Care (GAMC) from January 1, 2010 through March 31, 2010, unless the STATE is otherwise required by law to continue the Prepaid GAMC program after March 31.

REVISION 2. Article 1 Overview is amended as follows:

Overview. This Contract applies to the health benefits the MCO shall provide through the Prepaid Medical Assistance, Prepaid General Assistance Medical Care and MinnesotaCare programs for persons eligible for Medical Assistance under the age of sixty-five (65), and all eligible persons in General Assistance Medical Care (GAMC) and MinnesotaCare. The Medical Assistance, General Assistance Medical Care and MinnesotaCare Medical Care programs are public health benefits programs intended to provide Enrollees with access to cost-effective health care options. As of ~~March~~ April 1, 2010, unless otherwise required by law, managed care funding for the GAMC program will be suspended, and PGAMC will no longer be available through this Contract. Terms of this contract in reference to GAMC will no longer ~~be applicable,~~ apply unless ~~funding is restored during Contract Year~~ the Prepaid GAMC program is restored by operation of law.

Sincerely,



David Godfrey
Medicaid Director