Thank you for inviting me to testify at this hearing today. With your permission, I'll give a brief version of a much longer statement I would like to enter into the record.

Mr. Chairman and members of the Committee, over the next 10 years the federal and state governments will spend roughly 7 TRILLION in combined dollars to run the Medicaid program.

A very significant percentage of the Medicaid program will be run through what most of us call managed care.

Essentially, the states will take the federal dollars they receive merged with their own dollars and hand them over to a third party, a managed care company, to provide services for Medicaid beneficiaries.

The federal government has encouraged states to do so and certainly the current trend is for more and more managed care.

It is also federal policy that states are supposed to impart some due diligence and oversight by knowing where Medicaid dollars are being spent and CMS, likewise, is supposed to confirm that states are properly overseeing where their Medicaid dollars are being disbursed.

In August 2010, the Government Accountability Office issued a report that highlighted the inconsistency of CMS's oversight of state rate-setting.

Mr. Chairman and members of the Committee, my ongoing investigation into federal and state oversight of managed care contracting leaves me gravely concerned that accountability is severely lacking in a program that is spending 7 TRILLION combined federal and state taxpayer dollars.

Today, this hearing will focus largely on what has occurred in the state of Minnesota.

There are allegations that the state systematically overpaid managed care companies to cover Medicaid beneficiaries while under paying the same plans for coverage of individuals paid for with state-only dollars.

This appears to be another example of the old game of states pushing the bounds to maximize federal dollars received while minimizing state dollars spent.

If that isn't bad enough, when one of the plans tried to return the overpayment, documents show that the state schemed to keep the federal government from receiving its share of the overpayment to one specific company, UCare. [1]

My investigation has turned up troubling questions that I am very pleased your committee will be able to explore further with relevant witnesses today.

Lucinda Jesson of the State of Minnesota has very difficult questions to answer such as …

[1] Emails provided by the State of Minnesota (Attachment 1).

Was the state systematically overpaying managed care plans on Medicaid while underpaying the same plans to provide care for individuals covered with state-only dollars?

Documents show that at least once before a managed care company returned funds in 2003. How long has systematic overpayment been occurring in Minnesota? [2]

Documents from the four plans in Minnesota prove that each one consistently showed excess revenues derived from Medicaid while showing losses on the state-only plans. Was the state aware of this disparity? [3]

And while the state now trumpets the fact that they collect repayments for excess revenue over 1%, does the state have any auditing mechanism in place to confirm that the amounts reported by the managed care companies are accurate?

Cindy Mann, of CMS, also has some very difficult question to answer.

In 2010, the GAO raised significant questions about CMS's oversight of rate setting. What have you done to assure beneficiaries and taxpayers that rates are being appropriately set?

In your March 21, 2011 letter to the state of Minnesota, you asked if "the state included reserve fund requirements in calculating actuarially sound managed care rates"? Isn't that your job to know the answer?

What assurance can you give us that what has gone on in Minnesota hasn't gone on all over the country?

Mr. Chairman, my investigation should not be interpreted as questioning the role of managed care in Medicaid.

To the contrary, I think having a risk-based, outcome-driven role for managed care in Medicaid has tremendous potential to produce high quality care for Medicaid beneficiaries.

However, for this to happen, CMS and the states have to live up to their responsibilities in overseeing contracts with managed care.

In closing Mr. Chairman, while my investigation is ongoing, one specific solution is becoming fairly clear to me.

States should be required to know the medical-loss ratio of every managed care company they contract with specific to the Medicaid beneficiaries they serve.

That medical-loss ratio should be clearly defined by CMS and consistently implemented across every state that uses managed care.

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[2] 11-3-2003 Medica Talking Points provided by the State of Minnesota (Attachment 2).
[3] Data provided by HealthPartners Inc, Medica, and UCare (Attachment 3).

That medical-loss ratio should be based on independently audited, verifiable encounter data and expense data.

That medical-loss ratio should make clear what administrative expenses are related to the provision of Medicaid benefits and what administrative expenses are not.

That medical-loss ratio should be transparent for CMS, the states, and the public to see.

Let me be clear, I do not support a federally defined, minimum threshold for medical-loss ratio that requires all plans below a certain threshold to refund dollars.

Instead, I believe that purchasers, in this case states, using transparent information about how their dollars are being spent are best suited to make decisions about the value provided from managed care companies.

We have legitimate disagreements about many issues in Congress, but on this issue, there can be no disagreement. We must have a better understanding of where 7 TRILLION dollars will be spent by the Medicaid program.