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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2022

A N A C T

RELATING TO HUMAN SERVICES – MEDICAL ASSISTANCE

Introduced By: Senators Bell, Quezada, Murray, Kallman, Anderson, and DiMario

Date Introduced: March 01, 2022

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Legislative findings.

The general assembly finds and declares the following:

(1) Medicaid covers approximately one in four (4) Rhode Islanders, including: one in five (5) adults, three (3) in eight (8) children, three (3) in five (5) nursing home residents, four (4) in nine (9) individuals with disabilities, and one in five (5) Medicare beneficiaries.

(2) Prior to 1994, Rhode Island managed its own Medicaid programs; directly reimbursing healthcare providers by paying fee-for-service ("FFS").

(3) Currently, the state pays about $1.7 billion to three (3) private health insurance companies, Neighborhood Health Plan of Rhode Island, Tufts Health Plan and United Healthcare Community Plan (Managed Care Organizations - "MCOs"), to “manage” Medicaid benefits for about ninety percent (90%) of all Rhode Island Medicaid recipients (approximately three hundred thousand (300,000)); the other ten percent (10%) remains FFS.

(4) MCOs are not actual health care providers - they are middlemen who take set per-person per-month fees from the state, pass some of that money to actual health care providers, and keep the rest as MCO profit.

(5) MCOs increase their profits by limiting health care goods and services for Medicaid patients.

(6) Theoretically, MCOs are supposed to help states control Medicaid costs and improve access and health care outcomes; however, there is no significant evidence of this.

(7) Peer-reviewed research, including two (2) separate literature reviews done in 2012 and 2020, concluded: "While there are incidences of success, research evaluating managed-care programs show that these initial hopes [for improved costs, access and outcomes] were largely unfounded."

(8) Since 2009, every annual Single Audit Report by the Rhode Island Office of the Auditor General has found that the state lacks adequate oversight of MCOs.

(9) In 2009, Connecticut conducted an audit which found it was overpaying its three (3) MCOs (United Healthcare Group, Aetna, and Community Health Network of Connecticut) nearly fifty million dollars ($50,000,000) per year.

(10) In 2012, Connecticut returned to a state-run fee-for-service Medicaid program and subsequently saved hundreds of millions of dollars and achieved the lowest Medicaid cost increases in the country and improved access to care.

(11) In 2015, the Rhode Island Auditor General found that Rhode Island overpaid MCOs more than two hundred million dollars ($200,000,000) and could not recoup overpayments until 2017.

(12) In 2015, Governor Raimondo began efforts to “Reinvent Medicaid” that led to increased Medicaid privatization, including the UHIP/RI Bridges project and MCO five (5) year contracts.

(13) In the FY 2017, FY 2018, and FY 2019 Single Audit Reports, the Rhode Island Auditor General bluntly concluded, "The State lacks effective auditing and monitoring of MCO financial activity.”

(14) In its latest FY 2020 Single Audit Report, the Auditor General notes that EOHHS failures to collect adequate information from MCOs has had the “effect” of, “Inaccurate reimbursements to MCOs for contract services provided to Medicaid enrollees.”

(15) The federal Center for Medicaid and CHIP Services (CMCS) determined that in 2019, Rhode Island spent the second highest amount per capita for Medicaid patients out of all states and had a, “High overall level of data quality concern.”

(16) The Rhode Island executive office of health and human services (EOHHS) has not taken sufficient actions to address problems with MCO oversight, for example:

(i) Until 2021, EOHHS made Rhode Island one of only six (6) states with MCO contracts that had not required MCOs to spend at least eighty-five percent (85%) of their Medicaid revenues on covered services and quality improvement (i.e., have a Medical Loss Ratio, MLR, of 85%);

(ii) Unlike thirty (30) other states, EOHHS failed to require MCOs to remit to the state Medicaid program excess capitation revenues not adequately applied to the costs of medical

services;

(iii) EOHHS failed to file annual Medicaid reports; publishing FY 2019 data in a report dated May 2021; and

(iv) EOHHS failed to ensure that FY2021 MCO quarterly reports were made in a "Financial Data Reporting System," as set forth in a response to criticisms raised by the Rhode Island Auditor General.

(17) Other states that more recently adopted Medicaid MCO managed care, such as Iowa and Kansas, have suffered cuts in health care, far less than expected savings, and sacrificed oversight and transparency.

(18) During the COVID-19 pandemic, Rhode Island Medicaid enrollments increased about twelve percent (12%) as people lost their jobs and health insurance.

(19) During the pandemic, MCO private insurance companies earned record profits while health care providers such as hospitals suffered severe financial losses from deferred elective medical procedures.

(20) Rhode Island EOHHS wants to continue to help private MCO insurance companies by giving a set per person per month fee to health care providers in order that health care providers assume "full risk capitation."

(21) Rhode Island is the only state in the country that has an "Office of Health Insurance Commissioner" whose top listed priority is to, "Guard the solvency of health insurers."

(22) Private health insurance companies have more government funding and support than any other type of business in Rhode Island.

(23) The Centers for Medicare and Medicaid Services (CMS) has issued guidance intended to help states monitor and audit Medicaid and Children's Health Insurance Program (CHIP) managed care plans to address spread pricing and appropriately incorporate administrative costs of the Pharmacy Benefit Managers (PBMs) when calculating their medical loss ratio (MLR).

(24) States that chose to establish minimum MCO MLRs with requirements to return monies may recoup millions of Medicaid dollars from plans that failed to meet the State-set minimum MLR thresholds.

(25) Given the $1.7 billion taxpayer dollars given to MCOs and the current lack of adequate monitoring and oversight, the costs of audits set forth by this legislation are justified and necessary.

SECTION 2. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-33. Medicaid programs audit, assessment and improvement.

(a) The auditor general, in consultation with the executive office of health and human

services, shall hire and supervise an outside contractor or contractors to audit the state's managed care entities in order to determine whether managed care entities are providing savings, access and outcomes that are better than what could be obtained under a fee-for-service program managed by the state.

(b) Managed care entities shall provide information necessary to conduct this audit, as well as all legally required audits, in a timely manner as requested by the outside contractors.

(c) Failure of a managed care entity to provide such information in a timely manner shall permit the state to seek penalties and terminate the managed care entity’s Medicaid contract.

(d) Staff and outside contractors working on the audit shall not have relevant financial connections to managed care entities or the outcome of the audit.

(e) The auditor general shall present the results of the audit to the public and general assembly within six (6) months after the effective date of this section.

(f) If the audit concludes that a fee-for-service state-run Medicaid program could provide better savings, access and outcomes than the current managed care system, the office of health and human services and the auditor general shall develop a plan for the state to transition to a state-run fee-for-service program within two (2) years from the effective date of this section.

(g) Contracts with managed care entities shall include terms that:

(1) Allow the state to transition to a fee-for-service state-run Medicaid program within two (2) years from the effective date of this section;

(2) Require managed care entities to meet a medical loss ratio (MLR) of greater than ninety percent (90%), net of pharmacy benefit manager costs related to spread pricing;

(3) Require managed care entities to remit to the state Medicaid program excess capitation revenues that fail to meet the ninety percent (90%) MLR; and

(4) Set forth penalties for failure to meet contract terms.

(h) The attorney general shall have authority to pursue civil and criminal actions against managed care entities to enforce state contractual obligations and other legal requirements.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HUMAN SERVICES – MEDICAL ASSISTANCE

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This act would require the auditor general to oversee an audit of Medicaid programs administered by managed care organizations. The auditor general would report findings to the general assembly and the director of the executive office of health and human services (EOHHS) within six (6) months of the passage of this bill. The director of EOHHS would provide the general assembly with a plan within two (2) years of the passage of this act to end privatized managed care and transition to a fee-for-service state-run program if the audit demonstrates the plan would result in savings and better access and healthcare outcomes.

This act would take effect upon passage.

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