Background Research for 2022 MCO bill

1. Medicaid covers approximately 1 in 4 Rhode Islanders, including 1 in 5 adults, 3 in 8 children, 3 in 5 nursing home residents, 4 in 9 individuals with disabilities, and 1 in 5 Medicare beneficiaries. http://files.kff.org/attachment/fact-sheet-medicaid-state-RI

2. Prior to 1994, Rhode Island managed its own Medicaid programs reimbursing health care providers directly. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Reports/QUALITY-STRATEGY.DRAFT.5.3.19.pdf

3. In 2009, Connecticut conducted an audit which found that it was overpaying its three MCOs (United Healthcare Group, Aetna, and Community Health Network of Connecticut) nearly **$50 million per year**. See https://www.kff.org/wp-content/uploads/sites/2/2011/12/dssaudit.pdf, https://www.wsj.com/articles/connecticut-moves-away-from-private-insurers- to-administer-medicaid-program-1458325696

4. In 2012, Connecticut removed private MCOs from its Medicaid program, and subsequently saved **billions of dollars** and experienced the lowest Medicaid cost increases in the country and improved access to care. See https://pnhp.org/news/connecticut-medicaid-prospers-post-capitated-managed-care/ citing https://chlpi.org/wp-content/uploads/2014/01/PATHS-Innovations-and-Insights-in-Medicaid-Managed-Care-3.21.16.pdf and http://cthealthpolicy.org/wp-content/uploads/2019/02/Medicaid-2019-brief-formatted-copy.pdf. See also https://cthealthpolicy.org/index.php/2020/02/19/medicaid-switch-from-mcos-saving-taxpayers-billions/, https://khn.org/news/connecticut-drops-insurers-from-medicaid/, https://www.wsj.com/articles/connecticut- moves-away- from-private-insurers-to-administer-medicaid-program-1458325696, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing and https://www.cga.ct.gov/2020/hsdata/od/Medicaid%20101-DSS%20Presentation.pdf.

5. "Historically, Connecticut Medicaid used a mix of capitated managed care and fee-for-service arrangements to provide services to members. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for members. Further, lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services." https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/Overview-of-HUSKY-Health---consolidated-issue-briefs-9-12-18.pdf

6. Since 1994, Rhode Island has privatized an ever-growing portion of its Medicaid program so that by 2019, 91% of all RI Medicaid recipients are in a managed care program, i.e., 283,033 Medicaid eligible individuals, and MCO payments comprise 60 percent of Medicaid benefit expenditures (i.e., about $1.7 billion). http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/SFY2018_Medicaid

_Expenditure_Report.pdf (document taken down), see document here and https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/SFY2017_%20RI_Medicaid_Expenditure_Report_7162018_Final.pdf

7. Since 2009, and in every year since, the RI Auditor General has reported problems with E O H H S oversight of MCOs. In its 2009 report, the Auditor General reported, "Due to the growing use of managed care contracts within the Medicaid program, DHS needs to increase its oversight and monitoring procedures to improve controls over managed care contract expenditures. DHS should consider implementing independent audit requirements into managed care agreements to validate the total cost of services provided to Medicaid eligible individuals, the amount of HMO recoveries that pertain to Medicaid claiming, and to evaluate the allowability of services reimbursed through managed care contracts." Similar and progressively more critical statements appear in all subsequent single audits.

   2009 –
   http://www.oag.ri.gov/reports/sa2009.pdf
   https://web.archive.org/web/20140218160521/http://www.oag.state.ri.us/reports/sa2009.pdf
   Previously at http://www.oag.state.ri.us/reports/sa2009.pdf

   2010 –
   http://www.oag.ri.gov/reports/sa2010.pdf
   https://web.archive.org/web/20140218161021/http://www.oag.state.ri.us/reports/sa2010.pdf
   Previously at http://www.oag.state.ri.us/reports/sa2010.pdf

   2011 –
   http://www.oag.ri.gov/reports/sa2011.pdf
   https://web.archive.org/web/20220304134342/http://www.oag.state.ri.us/reports/sa2011.pdf
   Previously at http://www.oag.state.ri.us/reports/sa2011.pdf

   2012 - http://www.oag.ri.gov/reports/sa2012.pdf
   Previously http://www.oag.state.ri.us/reports/sa2012.pdf

   2013 – http://www.oag.ri.gov/reports/sa2013.pdf
   Previously http://www.oag.ri.gov/reports/sa2013.pdf

   2014 – http://www.oag.ri.gov/reports/SA_RI_2014.pdf
   Previously at http://www.oag.ri.gov/reports/sa2014.pdf

   2015 – http://www.oag.ri.gov/reports/SA_RI_2015.pdf
   Previously at http://www.oag.state.ri.us/reports/SA_RI_2015.pdf

   2016 – http://www.oag.ri.gov/reports/SA_RI_2016.pdf
   Previously at http://www.oag.state.ri.us/reports/SA_RI_2016.pdf

   2017 – http://www.oag.ri.gov/reports/SA_RI_2017.pdf
   Previously at http://www.oag.state.ri.us/reports/SA_RI_2017.pdf

2018 – http://www.oag.ri.gov/reports/SA_RI_2018.pdf
Previously at http://www.oag.state.ri.us/reports/SA_RI_2018.pdf

2019 – http://www.oag.ri.gov/reports/SA_RI_2019.pdf
Previously at http://www.oag.state.ri.us/reports/SA_RI_2019.pdf

2020 - http://www.oag.ri.gov/reports/SA_RI_2020.pdf
Previously at http://www.oag.state.ri.us/reports/SA_RI_2020.pdf

http://www.oag.ri.gov/reports/2020_FinStmt_FindingsMC.pdf

8. In its latest report, EOHHS fails to mention the numerous ongoing MCO problems identified in the Auditor General's reports.
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/QUALITY%20STRATEGY.DRAFT.5.3.19.pdf

9. **NO PROOF MCOS IMPROVE COSTS, ACCESS OR OUTCOMES**

Peer-reviewed research, including two separate literature reviews done in 2012 and 2020, generally concludes:
"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." Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update, Daniela Franco Montoya, Puneet Kaur Chehal and E. Kathleen Adams; Annual Review of Public Health; April 2020 (citing https://tradeoffs.org/2021/11/04/medicaid-managed-care/)

States that have adopted Medicaid managed care have "either found the move to be cost-neutral or cost more than traditional state-run fee-for-service programs. This is consistent with peer-reviewed literature on managed care suggesting that savings, if any, are achieved primarily through reduced prices rather than through the more traditional tools of care management."
http://media.khi.org/news/documents/2013/01/14/managed-care-rwjf.pdf

"Results have also been mixed on the far fewer studies done on managed care's impact on health equity and racial disparities." See, e.g., Kuziemko, Ilyana, Katherine Meckel, and Maya Rossin-Slater. 2018. "Does Managed Care Widen Infant Health Disparities? Evidence from Texas Medicaid." American Economic Journal: Economic Policy, 10 (3): 255-83, DOI: 10.1257/pol.20150262
https://www.aeaweb.org/articles?id=10.1257/pol.20150262 (concluding that managed care widens infant health racial disparities).

When costs are controlled, it is because of reduced access and care. A 2021 article in the American Journal of Managed Care entitled, "Medicaid Managed Care Further Reform Needed To Deliver On Promise," concluded:
"Evidence indicates a need for further reform in Medicaid managed care to ensure that private managed care organizations are improving spending, access, and quality outcomes for beneficiaries.
Private managed care organizations are increasingly responsible for administering Medicaid benefits across the United States, yet there is little research on how they affect access, spending, and care quality. The limited research suggests that private managed care organizations may have slowed state spending growth but have not improved beneficiary care and may have reduced access for certain

populations. https://www.ajmc.com/view/medicaid-managed-care-further-reform-needed-to-deliver-on-promise

10. RI "REINVENTS" MEDICAID BUT MCO PROBLEMS PERSIST

In March 2015, Governor Raimondo began an initiative to "Reinvent Medicaid." No mention is made in the executive order of the Auditor General's reports nor any MCO over-payment issues, but instead, the reasons for the need to reinvent Medicaid noted were skyrocketing costs and a belief that there was overuse by improperly managed patients and doctors. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ReinventMedicaid/ExecOrder_ 15-08_02262015.pdf

In its SFY2015 Single Audit Report, the RI Office of the Auditor General again found multiple material weaknesses in internal controls and that specifically, RI Medicaid MCOs were **overpaid more than $200 million** due to overstated capitation rates for the Medicaidexpansion population. http://www.oag.ri.gov/reports/SA_RI_2015.pdf (Finding 2015-002).

The SFY2015 report further noted: "EOHHS lacks strong oversight procedures regarding fiscal monitoring and contract settlement for its managed care organizations (MCO). Capitation payments to managed care organizations represent nearly 75% of all Medicaid outlays. EOHHS needs to develop a comprehensive risk assessment and monitoring plan toensure that managed care expenditures are validated and settled each contract period. More stringent audit and financial monitoring procedures should be employed. (Finding 2015-066)" http://www.oag.ri.gov/reports/SA_RI_2015.pdf

The final "Reinventing Medicaid" report recommended doing exactly the opposite of what Connecticut had done just a couple years earlier and to "substantially transition away from fee-for-service models toa system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members." http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ReinventMedicaid/Final_report_R einv entMedicaid.pdf and https://www.medicaid.gov/Medicaid-CHIP-Program- Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact- pa2.pdf

Other recommended changes in the RI Medicaid Reinvention report focused on reducing demand for services and cutting reimbursements to providers. *Ibid*. It was predicted that savings would be about 4.4% of total per enrollee cost.

The Rhode Island Annual Medicaid Expenditures Report SFY 2017 (dated June 2018) confirms that Medicaid savings from 2013-2017 have not come from MCO managed care, but rather: "The steady decline in the average PMPM is reflective of the change in the overall nature of the State's enrolled Medicaid population, with growth since at least January 2014 being heavily concentrated among the nondisabled children and adults who have comparatively low costs. The reduction is also attributed to the implementation of the Raimondo Administration's Reinventing Medicaid initiatives in SFY 2016 that included certain programmatic changes, such as a 2.5% cut to hospital reimbursement rates, a 2.0% cut to nursing home reimbursement rates, and savings for new care coordination initiatives between the managed care organizations and providers." See Page 13

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SFY2017_%20RI_Medicaid_Expendi tur e_Report_7162018_Final.pdf

In its FYS2016 Single Audit Report, the RI Office of the Auditor General again found material weaknesses in internal controls and repeated its Finding 2015-066 by noting: "EOHHS lacks strong oversight procedures regarding fiscal monitoring and contract settlement for its MCOs. MCO capitation payments represent nearly 75% of all Medicaid outlays. EOHHS needs to develop a comprehensive risk assessment and monitoring plan to ensure that managed care expenditures are validated and settled each contract period. More stringent audit and financial monitoring procedures should be employed." (Finding 2016-066) http://www.oag.ri.gov/reports/SA_RI_2016.pdf

In its FYS2017 Single Audit Report, the RI Office of the Auditor General yet again found material weaknesses in internal controls and noted:

- "The continued and growing complexity of Medicaid program operations adds tothe challenge of accurately accounting for all Medicaid program related financialactivity within the State's financial statements." Finding 2017-002 (material weakness – repeat finding – 2016-010) at 2017 DAR page D-5. "EOHHS lacks strong oversight procedures regarding fiscal monitoring and contract settlement for its managed care organizations (MCOs).
- "Capitation payments to MCOs represent nearly 63% of Medicaid benefitexpenditures. EOHHS needs to develop a comprehensive risk assessment and monitoring plan to ensure that managed care expenditures are validated and settled each contract period."
- "More stringent audit and financial monitoring procedures should be employed. EOHHS needs to reassess all activities considered surveillance utilization review services (SURS) performed within the Medicaid program to comply with federal regulations and amend the State Plan to accurately reflect the State's current practices."
- Problems related to privatization of Medicaid also were noted in the 2017 Auditor General's report concerning the UHIP "debacle." http://www.oag.ri.gov/reports/SA_RI_2017.pdf. See also https://www.providencejournal.com/news/20190315/uhip-debacle-ri-to-extend- contract-as-deloitte-agrees-to-more-concessions

In April 2017, Rhode Island entered into a 5-year contract with three MCO companies, Neighborhood Health Plan of RI, Tufts Health Plan, and United Healthcare Community Plan,to administer the RI Medicaid program for 250,000 Rhode Islanders. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/PressReleases/MCOpressrelease04 201 7.pdf. Although these three entities have been described by the RI Executive Office of Health and Human Services (EOHHS) as "provid[ing] comprehensive health care services for Rhode Island's Medicaid population," it must be noted that these entities are actually middlemen"payers" who take money from state and federal sources to pay or pass through money toactual health care providers – keeping the amount kept for themselves largely unknown.

In its FYS2018 Single Audit Report, the RI Office of the Auditor General again found problems with MCOs:

- "EOHHS lacks strong oversight procedures regarding fiscal monitoring and contract settlement for its managed care organizations (MCOs). Capitation payments to MCOs represent nearly 60% of Medicaid benefit expenditures. EOHHS needs to develop a comprehensive risk assessment and monitoring plan to ensure that managed care expenditures are validated and settled each

contract period. More stringent audit and financial monitoring procedures should be employed." http://www.oag.ri.gov/reports/SA_RI_2018.pdf

The Rhode Island Annual Medicaid Expenditures Report SFY 2017 (dated June 2018) states: "This year's report breaks out administrative fees paid to managed care organizations (MCOs) as a separate provider type category. In previous years these expenditures were allocated across provider types. In SFY 2017 and SFY 2018, MCO "admin fees and taxes" (i.e.,(i.e., "administrative costs paid to the managed care organizations and state/federal taxes paid by the MCOs") accounted for 8% of expenditures." http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SFY2017_%20RI_Medicaid_Expenditure_Report_7162018_Final.pdf and http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/SFY2018_Medicaid_Expenditure_Report.pdf

It also noted, "14% of the RI budget for long term services and support (i.e., $368 million out of a total $2.6 billion) goes to MCOs for "admin [sic], premiums and taxes (i.e., "administrative costs paid to the managed care organizations and state/federal taxes paid by the MCOs")." http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/SFY2018_Medicaid_Expenditure_Report.pdf"

In its FYS2019 Single Audit Report, the RI Office of the Auditor General yet again found problems with MCOs:

> "EOHHS lacks strong oversight procedures regarding fiscal monitoring and contract settlement for its managed care organizations (MCOs). Capitation payments to MCOs represent nearly 60% of Medicaid benefit expenditures. EOHHS needs to develop a comprehensive risk assessment and monitoring plan to ensure that managed care expenditures are validated and settled each contract period. More stringent audit and financial monitoring procedures should be employed." http://www.oag.ri.gov/reports/SA_RI_2019.pdf

In FY2020 Single Audit Report, the RI Auditor General stated:

> "The State does not receive complete and accurate encounter data to fully support contract settlement (based on established risk corridors) to ensure adequate control over managed care expenditures. Validation of MCO medical expenditures not represented by encounter data is also incomplete. Effect: Inaccurate reimbursements to MCOs for contract services provided to Medicaid enrollees." http://www.oag.state.ri.us/reports/SA_RI_2020.pdf

In a later report, the Auditor added, "Due to the length of settlement periods, the extended duration of eligibility system issues, and the volume of transactions being accumulated and evaluated independent of regular program controls, risks relating to inaccurate financial activity and federal compliance have increased." http://www.oag.ri.gov/reports/2020_FinStmt_FindingsMC.pdf Finding 2020-004 (material weakness – repeat finding – 2019-002)

11. MCO actions and finances are not transparent. See US Dept. of Health and Human Services, Office of Inspector General, March 2021 Data on"Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate," https://oig.hhs.gov/oei/reports/OEI-02-19-00180.pdf "Opacity is often the norm" and that "enrollment data, demographic data like age, gender, and race and ethnicity" are unavailable despite being "foundational to any assessment of the

performance of individual MCOs." See "Transparency in Medicaid Managed Care: Findings from a 13- State Scan," Allie Corcoran, et al., Georgetown University Health Policy Institute, September 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/09/MCO-13-state-scan-v3.pdf

12. Other states, such as Iowa and Kansas, have recently privatized Medicaid by hiring MCOs and suffered significant problems. Specifically, "both Kansas and Iowa have suffered cuts incare, reduced far less costs than expected, and sacrificed oversight and transparency by handing their programs over to private entities. These changes have been devastating for many Medicaid recipients that once could depend on public provision for life-sustaining care." https://www.inthepublicinterest.org/wp-content/uploads/ITPI_PrivatizingVAMedicaid_March2018.pdf, See also https://tarbell.org/2019/04/iowa-privatized-medicaid-it-has-been-a-disaster-heres-why/

    More recently, Iowa Auditor of State Rob Sand released a report that shows the privatization of Medicaid in Iowa has resulted in an 891% increase in members being illegally denied services or care, and reported contract violations by both MCOs in the program. https://www.auditor.iowa.gov/reports/file/66425/embed

13. Oklahoma recently went to a single payer Medicaid system and achieved cost savings and better services. See 2020 analysis: https://okpolicy.org/managed-care-is-a-bad-investment-for-oklahoma/

14. There has been a 16.5% increase in RI Medicaid/CHIP enrollments due to COVID-19. https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ Growth rates from March 2020 to March 2021 across states ranged from 9.7% (Tennessee) to 37.0% (Nevada), but RI did not report. https://www.kff.org/coronavirus-covid-19/issue-brief/growth-in-medicaid-mco-enrollment-during-the-covid-19-pandemic/# Nonetheless, assuming that about 90% of Medicaid/CHIP enrollees are covered by MCOs, that would mean there was about a 15% increase in MCO enrollees. And RI would have to make payments for all of them.

    While states are paying more for increased enrollments, actual healthcare spending is down. https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidcostsuse_marchupdate_7

15. There have been significant increases in MCO profits during COVID-19. https://ccf.georgetown.edu/2022/02/11/medicaid-managed-care-financial-results-for-2021-a-big-year-for-the-big-five/ And it is important to examine whether states are overpaying MCOs. In Illinois, investigators found that the for-profit insurance companies running Illinois Medicaid collected hundreds of millions of dollars in extra profits during the COVID-19 pandemic — much of it for services never provided to patients. https://www.bettergov.org/news/illinois-medicaid-companies-rake-in-record-profits-from-pandemic/

16. Rhode Island was one of only five states with MCOs that did not set a Medical Loss Ratio for them nor clawback capitation payments if MLRs were not met.

https://ccf.georgetown.edu/2021/08/13/medicaid-managed-care-even-government-watchdogs-could-be-more-transparent/ and https://oig.hhs.gov/oei/reports/OEI-03-20-00230.pdf

This appears to have been changed by a new contracts (amended July 2, 2021) between RI and Neighborhood Health https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-10/nhpri-full-contract-managed-care_amendment-5_nhpri-signed_bls-signed__0.pdf , United Health https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-10/uhc-full-contract-managed-care_amendment-5_signed_20211006_bls-signed__0.pdf, and Tufts https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-10/tufts-full-contract-managed-care_amendment-5_clean-8-25-2021-signed_bls-signed_.pdf

RI has hired a contractor to figure out a way to determine MLR. See https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/RIteSmiles/11_Medicaid_Managed_Care_Program_Medical_Loss_Ratio_Calculation.pdf But the MLR reports required by these MCOs cannot be located online. Additional MCOs reporting required by EOHHS through a new "Financial Data Reporting System" (FDRS) also do not appear to have produced publicly available reports nor analyses. http://www.oag.ri.gov/reports/2020_FinStmt_FindingsMC.pdf ,

Note that when RI EOHHS describes MLR, they say "Pharmacy expenditures are shown as net of rebates." https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-05/RIMedicaidExpenditureReport_SFY19.pdf. See also https://healthpolicy.usc.edu/article/new-evidence-shows-prescription-drug-rebates-play-a-role-in-increasing-list-prices/ (noting that rebates increase list prices). This makes it likely RI is leaving money on the table. https://ccf.georgetown.edu/2021/08/13/medicaid-managed-care-even-government-watchdogs-could-be-more-transparent/

17. 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 PBM when calculating their medical loss ratio (MLR). A Fact Sheet on the Final Rule can be viewed at: https://www.cms.gov/newsroom/fact-sheets/establishing-minimum-standards-medicaid-state-drug-utilization-review-dur-and-supporting-value-based-0 The Final Rule can be viewed at:https://www.federalregister.gov/public-inspection/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-and

18. MCO defenders point to RI Medicaid MCOs getting National Committee for Quality Assurance ratings of 4.5 out of 5. Academic researchers, however, generally ignore this data because of: "doubts about the quality of the data, because beneficiaries regularly churn on and off the Medicaid rolls, and also because plan performance arguably can reflect data collection strategies as much as actual quality outcomes." Robert Wood Johnson Foundation study, https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html

19. According to an Illinois watchdog group, several states have discovered undeserved profits from Medicaid providers and begun recovery efforts.

- South Carolina currently estimates it will recoup $75 million.
- Minnesota estimates that nearly $78 million may be returned by the MCOs running that state's $7 billion Medicaid program in 2020
- New Jersey won federal approval to amend its managed care contracts and estimates it will save $400 million for the period of January through June 2020.
- In Illinois:
    - Covid 19 shutdown swelled the state's Medicaid rolls by 480,000 people as workers lost their jobs and lost their employer-sponsored insurance, state records show. Illinois paid the Medicaid providers for those additional clients.
    - A federal emergency measure barred states from striking Medicaid recipients from the rolls, even if those patients weren't getting care or simply couldn't be found.
    - At the same time, many Illinois Medicaid recipients deferred elective medical procedures during the pandemic, according to records and interviews with industry experts.
    - And at the pandemic's outset, Illinois pushed out $100 million in payments that are usually withheld until the companies meet performance measures. The aim was to ensure the firms got through an unprecedented and unpredictable period when losses or gains might be staggering.

https://www.bettergov.org/news/illinois-medicaid-companies-rake-in-record-profits-from-pandemic/

20. Despite all the problems with MCOs, RI continues to ignore them as cost-drivers and focus on providers as the problem by writing:

    "In addition, in SFY21, EOHHS proposed moving our MCOs to full risk capitation which would have eliminated the need for risk share settlements entirely. This was not enacted, and EOHHS did not propose it again in FY22 due to the pandemic and CMS' encouragement of risk corridors. However, EOHHS will move in this direction as soon as is feasible."
    http://www.oag.ri.gov/reports/2020_FinStmt_FindingsMC.pdf

21. Other MCOs articles to consider:
    https://www.healthaffairs.org/do/10.1377/hblog20180430.387981/full/ (part 1),
    https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/ (part 2),
    http://convergenceri.com/stories/what-are-the-actual-costs-of-privatizing-medicaid,4886,
    https://www.ajmc.com/view/medicaid-managed-care-further-reform-needed-to-deliver-on-promise Medicaid Managed Care in 2021: The Year that Was,"
    https://ccf.georgetown.edu/2021/12/21/medicaid-managed-care-in-2021-the-year-that-was/,