Background Research for 2021 MCO audit 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. In its latest report, EOHHS fails to mention the numerous 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

3. Since 1994, Rhode Island has privatized an ever-growing portion of its Medicaid programso 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

4. Since 2009, and in every year since, the RI Auditor General has reported problems with DOH 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 toevaluate the allowability of services reimbursed through managed care contracts." Similar and progressively more critical statements appear in all available subsequent reports. http://www.oag.state.ri.us/reports/sa2009.pdf,
   http://www.oag.state.ri.us/reports/sa2010.pdf,
   http://www.oag.state.ri.us/reports/sa2011.pdf
   http://www.oag.state.ri.us/reports/sa2012.pdf
   http://www.oag.state.ri.us/reports/sa2013.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2014.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2015.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2016.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2017.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2018.pdf
   http://www.oag.state.ri.us/reports/SA_RI_2019.pdf

5. 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. 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

6. In 2012, Connecticut removed private MCOs from its Medicaid program, and subsequentlysaved **hundreds of millions of dollars** and experienced the lowest Medicaid cost increases
in the country and improved access to care. 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 andhttps://www.cga.ct.gov/2020/hsdata/od/Medicaid%20101-DSS%20Presentation.pdf.

7. Oklahoma also went to a single payer Medicaid system and achieved cost savings and betterservices. https://okpolicy.org/managed-care-is-a-bad-investment-for-oklahoma/

8. A 2012 study sponsored by the Robert Wood Johnson Foundation generally concluded thatstates that had adopted Medicaid managed care nationally had 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. (20)
http://media.khi.org/news/documents/2013/01/14/managed-care-rwjf.pdf

9. In its SFY2014 Single Audit Report, the RI Office of the Auditor General noted multiple material weaknesses in internal controls and that: “The State needs to develop a comprehensive risk assessment and monitoring plan to ensure that Medicaid managedcare expenditures are validated and settled each contract period. (Finding 2014-068)” http://www.oag.ri.gov/reports/SA_RI_2014.pdf

10. In March 2015, Governor Raimondo began an initiative to “Reinvent Medicaid.” No mention is made in the executive order of the Auditor General’s report 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

11. 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).

12. 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

13. The final "Reinventing Medicaid" report recommended doing exactly the opposite of whatConnecticut had done 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

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

15. 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 toensure 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

16. In its FYS2017 Single Audit Report, the RI Office of the Auditor General yet again foundmaterial weaknesses in internal controls and noted:
    a. "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.

b. EOHHS lacks strong oversight procedures regarding fiscal monitoring andcontract settlement for its managed care organizations (MCOs).
c. Capitation payments to MCOs represent nearly 63% of Medicaid benefitexpenditures.
d. EOHHS needs to develop a comprehensive risk assessment and monitoring plan to ensure that managed care expenditures are validated and settled each contract period.
e. 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 privitazation 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. Seealso https://www.providencejournal.com/news/20190315/uhip-debacle-ri-to-extend-contract-as-deloitte-agrees-to-more-concessions

17. In its FYS2018 Single Audit Report, the RI Office of the Auditor General YET AGAINfound 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

18. In its FYS2019 Single Audit Report, the RI Office of the Auditor General YET AGAINfound 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

19. 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_Expen diture_Report.pdf

20. 14% of the RI budget for long term services and support (i.e., $368 million out of a total $2.6 billion) goes to MCO 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_Expe nditure_Report.pdf

21. 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 theRaimondo 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

22. 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/MCOpressrelease 04 201 7.pdf

23. 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.

24. Overview of recent Medicaid MCO issues see https://www.healthaffairs.org/do/10.1377/hblog20180430.387981/full/ (part 1) https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/ (part 2), and http://convergenceri.com/stories/what-are-the-actual-costs-of-privatizing-medicaid,4886

25. 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/

26. 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