2023 -- H 5646

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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. 2023

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A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE

Introduced By: Representatives Potter, Morales, Tanzi, McGaw, Cotter, Sanchez, and Cruz
Date Introduced: February 15, 2023

Referred To: House Finance

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) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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."

(9) 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."

(10) 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."

(11) 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.

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

(13) 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.

(14) 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."

(15) 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).

(16) 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.

(17) The five (5) year MCO contracts previously set to renew or expire in April 2022 have been extended and new five (5) year contacts are set to be finalized in July 2023.

(18) Given the $1.7 billion taxpayer dollars and increasing amounts given to MCOs and the current lack of adequate monitoring and oversight, the time to act is now.

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

40-8-33. Medicaid managed care transition to state-run program.

(a) The executive 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 Medicaid program within two (2) years from the effective date of this section.

(b) 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.

(c) 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

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE

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This act would require EOHHS working with the auditor general to develop a plan within two (2) years of the passage of this act to transition to a fee-for-service state-run Medicaid program.

This act would take effect upon passage.

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