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The Honorable Marvin L. Abney, Chairman
Of the House Finance Committee
State House
Providence, RI 02903

RE: AHIP Comments on H-7689, A House Resolution Requesting the Auditor General to Oversee an Audit of Medicaid Programs Administered by Managed Care Organizations [OPPOSE]

To Chairman Abney and Members of the House Committee on Finance,

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on H-7689, a House Resolution that requests an audit of Medicaid programs, and potentially requires the director of the Executive Office of Health and Human Services and the Auditor General to develop a plan to end privatized managed care and transition Rhode Island to a fee-for-service state-run program.

We share Rhode Island's strong commitment to ensure health care access to the most vulnerable populations that is effective and affordable. However, transitioning Rhode Island's Medicaid program to fee-for-service (FFS) runs counter to these goals and will result in inefficient, unaccountable, poorer quality of care for beneficiaries, at a significant cost to the state.

Forty-one states (plus DC and Puerto Rico) rely on Medicaid managed care health plans to provide high-quality, coordinated care for their growing Medicaid populations. One in four Americans are covered by Medicaid, including millions of children, older adults, people with disabilities, and millions of veterans. Medicaid managed care organizations (MCOs) serve more than 70 million enrollees – more than 80% of people with Medicaid[1]utilization of generic prescription drugs, and other effective solutions like programs focused on routine and preventive care.

Not only do Medicaid MCOs provide high quality care, but they are also responsible stewards of taxpayer dollars. They perform a significant range of network management, care management, and operational functions for states, demonstrating how efficiently and effectively they serve Medicaid enrollees and hardworking taxpayers. Medicaid MCOs achieve cost savings for states while outperforming the fee-for-service program on key quality measures. Moreover, beneficiaries enrolled in Medicaid health plans are more likely to receive preventive services, as well as have fewer hospital admissions, and better access to primary care than a fee-for-service program.

Much research has been done on the value of Medicaid managed care. We highlight the following which shows how much would be lost for vulnerable populations in moving Rhode Island's Medicaid program to FFS. Any perceived deficiencies in Rhode Island's Medicaid program should be targeted and focused; and does not support eradicating the current Medicaid managed care system.

AHIP-Menges Group Managed Care Study Series

Throughout 2020, the Menges Group conducted a series of studies on the performance of Medicaid managed care plans to examine key performance metrics, including quality performance and value; use

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[1] AHIP, ***Integrating Medicaid Prescription Drug Coverage: Better Health Outcomes and Budget Savings.*** https://ahiporg-production.s3.amazonaws.com/documents/202304-AHIP_MedicaidRxCvg.pdf.

of innovative programs; and technology. The studies evaluated the highest quality and most cost-effective strategies to deliver care to high-risk, high need populations.

The Value of Medicaid Managed Care: Making Prescription Drugs More Affordable for States and Taxpayers finds that Medicaid MCOs saved over 25% more per prescription than traditional Medicaid fee-for-service and help keep Medicaid affordable and effective for enrollees and taxpayers.

- ***Medicaid managed care plans' net costs per prescription (which factor in rebates) were roughly 27% below the net costs in traditional Medicaid FFS program.*** The lower costs yielded $6.5 billion in net savings for states and taxpayers during fiscal year 2018.
- Medicaid managed care plans consistently control prescription drug costs more effectively than traditional Medicaid. ***Over the 5-year period from 2013 to 2018, net costs per prescription increased 13% faster in FFS settings than in Medicaid managed care plans.***
- ***States that used Medicaid managed care to deliver integrated drug benefits instead of prescription drug carve-outs realized big savings—with upwards of 25% lower net drug costs.*** A comparison of states with integrated drug coverage versus carve outs showed higher generic dispensing rates and much lower growth rates in net costs per prescription.

The Value of Medicaid Managed Care: Improving the Quality of Care in Medicaid finds that as part of their commitment to serving Medicaid enrollees and ensuring their access to high-quality care, Medicaid managed care plans have continued to consistently improve their performance across a range of quality measures over a 5-year period.

- ***Medicaid managed care plans improved their performance on 26 out of 30 (87%) key HEDIS® and CAHPS® quality measures*** between 2014 and 2018. The improvements covered a broad range of measures–from providing comprehensive diabetes care to controlling high blood pressure.
- 77% of Medicaid managed care enrollees in 2018 were members of NCQA-accredited health plans, up from 71% in 2015. Accreditation by the NCQA signifies a high level of quality.
- ***Twenty-four states (e.g., Rhode Island) recognize the value of ongoing quality improvement in their managed care programs by incentivizing Medicaid managed care plans to meet or exceed quality targets.*** The number indicates the value states place on Medicaid managed care plans and the quality they provide.

The Value of Medicaid Managed Care: Innovating in Medicaid finds that innovative solutions from Medicaid managed care plans expand access to doctors and improve quality of care, particularly as a result of the COVID-19 pandemic.

- ***Medicaid managed care plans are creating and covering telehealth programs that expand access to care and increase the ability of doctors to coordinate care for patients.*** These solutions address rural access to care, behavioral health services, and chronic pain management.
- ***Medicaid managed care plans are demonstrating breakthrough programs to reduce social and financial barriers to health***, such as deploying mobile produce markets with fresh vegetables to neighborhoods with limited supermarket access, or teaching enrollees with chronic health conditions how to cook healthy meals.
- Medicaid managed care plans are improving the ways enrollees can access provider networks, including creating tools that allow enrollees to locate doctors more easily in their networks, view practice information, and rate their doctors.

Care that Is Fair and Just: Improving Health Equity Through Medicaid Managed Care shows managed care plans' commitment to ending discrimination and systemic racism. For years, managed care plans have been hard at work mitigating socioeconomic conditions, reducing health disparities, and advancing health equity for more than 50 million Americans. Medicaid FFS models are designed to simply pay for medical products and services without a focus on or expertise for improving health outcomes or quality.

Medicaid managed care models, on the other hand, can include health outcome and quality improvement goals with financial incentives and hold managed care plans accountable for meeting those goals.

- Medicaid managed care plans improved their performance on 87% of key quality measures related to patient satisfaction, provision of services, and health outcomes between 2014-2018.
- ***In 2020, AHIP launched a Health Equity Measures for Value-Based Care Workgroup to identify measures that would advance health equity and work with policymakers and measure developers to encourage their use to accelerate work that advance health equity.***

The Value of Medicaid Managed Care: States Transition to Managed Care shows more states are relying on Medicaid managed care to take on care management and administrative services, saving money and ensuring quality. Since FFY 2017, capitation expenditures have exceeded FFS expenditures. Medicaid is now predominantly a managed care program. But it's important to note that states do not relinquish control of their Medicaid programs when they opt for managed care. Instead, ***states shift from active benefits administrators to active contract and oversight management, holding plans highly accountable for the delivery of care to their citizens.***

- Medicaid managed care plan enrollment more than doubled (increased by 121%) between fiscal years 2010 and 2018—from approximately 26 million to over 56 million. ***As of 2018, more than 75% of all Medicaid enrollees were enrolled in a Medicaid managed care plan, up from about 50% in 2010.***
- Medicaid is now predominantly a managed care program. Capitated payments to Medicaid managed care plans exceed fee-for-service expenditures and have done so since fiscal year 2017.
- States are increasingly relying on Medicaid managed care to provide care management and administrative services. ***States continue to shift from being active benefits administrators to providing contract management and highly accountable oversight for Medicaid managed care plans.***

For these reasons, we oppose H-7689 and urge the Committee not to pass this bill.

Thank you for your consideration of our comments. AHIP and its members stand ready for further discussions on this important topic.

Sincerely,
America's Health Insurance Plans

By:____________________________
Terrance S. Martiesian

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.