ISSUE BRIEF:
MEDICAID REFORM EXPANSION INTO MIAMI-DADE STILL TOO RISKY

Background: Florida's Medicaid Reform Pilot Program was launched in July 2006 and currently covers 5 counties, including Broward and Duval. Then-Governor Bush proposed and the Legislature approved a request to the federal government seeking a waiver of many of the usual Medicaid rules.

The primary motivation behind Reform was and still is the desire to slow the growth in Medicaid costs, but the waiver approval was premised on consumer "empowerment" and protections. Proponents claimed that Reform would "*introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost*."

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Current Status: We are now 21 months into the Medicaid Reform experiment, and there is still no evidence that Reform is meeting any of its originally stated goals.

Nevertheless, despite the questions and concerns, some **legislative leaders continue to call for expansion of the Medicaid Reform Pilot this legislative session, at least to include Miami-Dade County**. House Speaker Marco Rubio asserted that "*expanding Medicaid Reform into Miami-Dade County is an important step in creating a system that can survive and is a step that we should enact this session*." House Health Care Council Chair Aaron Bean is also pushing for expansion, although he admits that there are problems and plans to seek "*comprehensive reform to the reform package*".

By contrast, key health leaders and experts have expressed strong concerns about expanding Reform in 2008, including:

- The Agency for Health Care Administration's (AHCA's) Inspector General: "*Further expansion of Medicaid Reform should be delayed until such time as [improvements] are met and [service] data sufficient to conduct at least preliminary assessments of cost effectiveness is available.*"
- The Secretary (now former Secretary) of AHCA: *"This lack of available data and outside review, coupled with concerns raised by other external studies and our own internal evaluations, have led the agency to the conclusion that we are not prepared to recommend expansion of the pilot to other counties this year."*
- The lead researcher for the Medicaid Reform Evaluation project team: "*It is too soon to tell whether and how Reform is working—especially in terms of the big picture questions: access, costs, outcomes.*"

Thus, **there is no legitimate basis for expanding the Medicaid Reform experiment at this time.** The possibility of long-term cost savings on the horizon will not help balance the State budget this year. **But the risk to very low-income and often vulnerable consumers is very real, especially considering the many promises that Reform has yet to deliver.**

PROMISE #1:

Medicaid Reform will slow the growth in Medicaid costs by using the private sector to ensure better coordinated and efficient care and to reduce the "over-use" of health services by consumers.

REALITY: Expanding Reform won't save the State much money next year.

Florida had estimated that it could save well over $900 million in 2008-09 as a result of Reform, but that was based on the assumption of statewide implementation. The actual savings created by expansion into Miami-Dade would save at most $20 million (about 1% of the State's budget shortfall) next year. Expanding Reform won't address the State's financial woes. The main thing that expanding Reform in the 2008 Session would do is make significant, risky and likely irreversible changes to the Medicaid system in Miami-Dade that ensure that the interests of health plans are addressed before those of consumers.

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PROMISE #2:

The trade-off to limiting benefits and services in order to control costs is that consumers will have more options, from which they can choose the plan that best meets their needs. And despite their very limited resources, Medicaid consumers will get the support they need to make meaningful and informed choices.

More specifically, as the State worded it, "*the fundamental basis of reform is…transparency* [i.e., shining a light on what is really happening] *and consumer empowerment.*" This at a minimum must include: 1) a focus on public reporting of health outcomes and consumer satisfaction, and 2) the support of choice counselors who assist consumers in

understanding their options.

REALITY – If anything, the lack of transparency and consumer empowerment are a threat to consumers' health:
To date, there have been NO plan-specific performance reports of any kind. In fact, the limited performance-related information released by AHCA is careful to remove all references to specific plans.

Even now, information about plans' Preferred Drug Lists are not posted by many plans on their websites, even though contracts were amended to require this as of October 2007. Accurate provider directories are equally difficult to access.

AHCA has invested significant resources in developing software to show which plans cover which medications and which pharmacies work with which plans. AHCA has declined to make simple changes to make the program available to the public. The only alternative is to call choice counselors, who spend an average of only 8 minutes with callers, a lack medical training and are known for the high rate of errors in the information they provided.
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PROMISE #3:
By creating a system that *"ensures measurement of the performance of all plans",* Medicaid Reform will significantly improve consumers' health outcomes. This measurement, along with the free flow of information to the public, will also give health plans a real incentive to compete to provide better quality and more choice.

REALITY - AHCA is still flying in the dark with respect to measuring outcomes, cost-effectiveness, etc.
Only now is AHCA just beginning to gain access to some data that may eventually allow them to partially analyze plan performance. Through February, only 4 of 13 HMOs had even started to submit encounter data from 2007, while 5 were still submitting data from 2006. AHCA is also in the process of changing over to a new Medicaid fiscal agent and new medical information management system. The implementation date for the new system has been pushed back into FY 2008-09. Only after the new system is launched will AHCA be able to modify what data is reported. Even then, AHCA still has no plans to collect and analyze critical information pivotal to accurate assessment of plan performance, such as the number of services/medications denied, or the extent to which care is delayed by the increased administrative burden. Finally, a review of the basis for setting plans' payment rates mandated by the Legislature last fall won't be available until next fiscal year. AHCA is nowhere near ready to provide meaningful reporting of plans' performance.
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PROMISE #4:
Medicaid Reform will prevent the many plans entering the market from targeting only healthier patients for enrollment. It will do this by paying plans higher rates for their enrollees with more health problems.

REALITY – We haven't even begun to see what plans will do when this major change really kicks in:
Currently, only 50% of the rate paid to HMOs is based on the relative health of their enrollees, and so these plans remain insulated from the full impact of "fully risk-adjusted rates" until 2008-09. In addition, HMOs currently benefit from an additional protection approved by the Legislature that guarantees that they be paid no less than a guaranteed minimum rate, no matter which consumers they enroll. Through February in Broward County, for example, 8 out of 18 plans had targeted healthier consumers to the extent that they would have been paid at a rate below the guaranteed minimum, if not for that additional protection. Broward HMOs in February received gifts of increased premiums as much as 30% higher than what they should have received. The other type of Reform health plan ("provider service networks") is paid for each service they provide. The first PSNs will not become subject to capitation (i.e., paid a flat rate per enrollee) until 2009-10.
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PROMISE #5:
Medicaid Reform will reward consumers for practicing "healthy behaviors" and assuming more personal responsibility for their health.

REALITY – "Enhanced benefits" have provided virtually no benefit and rewarded nothing:
During the first 19 months of Reform, consumers performed more than 600,000 healthy behaviors, but actually received an average TOTAL "benefit" of less than $3 worth of over-the-counter items. Furthermore, credits generally become available for use by consumers months after they earn them through healthy behaviors. So the extent to which these credits actually provide an incentive of any kind is in serious question. In fact, the majority of the credits are "earned" for routine office visits that would have occurred regardless. Yet for many activities where an incentive might help, the reporting process is so complicated that almost no credits were awarded.