

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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July 3, 2013

Ms. Seema Verma, MPH
SVC, Inc.
485 Bolderwood Lane
Carmel, IN 46032

Dear Ms. Verma:

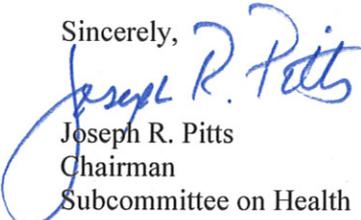
Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2013, to testify at the hearing entitled "The Need for Medicaid Reform: A State Perspective."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Friday, July 19, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Most states have implemented Medicaid managed care to some degree, but there remain certain areas of the program that do not have much managed care penetration, such as long-term care and behavioral health. Obviously, there are valid concerns about these especially vulnerable populations, but as Medicaid costs continue to balloon, do you see a need for more managed care in these areas? If so, what kind of rules, if any, should the Congress or the Administration give states with regard to Medicaid managed long-term care and/or behavioral health? Are there particular state programs that serve as an effective model for how to implement managed care in these areas of Medicaid?
2. Much news has been made in recent months about using Medicaid dollars to enroll individuals in private coverage through the state exchanges. What federal barriers exist for states to exercise this option, and what unanswered questions do states have with regard to premium assistance?

The Honorable Michael Burgess

1. In your testimony, you cite reduced provider reimbursement rates as a reason behind the decreasing number of primary care providers willing to accept Medicaid patients.

How can the federal government ensure provider rates are set at levels that encourage provider buy-in?

2. As one of the major architects of Indiana's Medicaid 1115 Waiver program, "Healthy Indiana", you helped the state implement a consumer-driven approach to Medicaid reform, enabling Medicaid beneficiaries to get a high-deductible health plan and a health savings account.

How did this consumer-driven approach to Medicaid affect patient access to providers?

3. Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the "payor of last resort". The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.
 - a. Are you aware of what challenges states continue to face in recovering third-party payments?
 - b. What impediments prevent third-party payers from following through on their payments?
4. How does the recent increased use of managed care in Medicaid influence third-party liability issues?

5. The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?

The Honorable Bill Cassidy

1. In your testimony you highlight the fact that current Medicaid regulations “disempower individuals from taking responsibility for their health” and that within the Medicaid program “there are no incentives for states to achieve quality outcomes.” These two areas must be addressed in order to achieve better health outcomes and responsible state and federal healthcare spending.

The concept of patient activation and the robust science behind it is rooted in the notion of empowering individuals. By definition, activated patients effectively manage their own health to the degree that they are competent to do so. Once a provider understands what an individual is and is not capable of, the provider can identify behavior change opportunities that are realistic and achievable. Through tailored support and education, patients become more successful managers of their health and healthcare. This approach has proven to reduce emergency room visits, hospital admits and readmission, increase medication adherence and improve chronic condition management.

A limited number of Medicaid programs are utilizing the Patient Activation Measure survey in order to improve allocation of resources and provide real patient-centered care – to treat the individual, not simply their symptoms. Organizations using PAM have demonstrated improved outcomes and cost savings of \$300 to \$3,700 per patient per year depending on the program. Cost savings are driven by fewer ER visits and hospital admits.

Do you agree that in order to substantially improve outcomes and lower healthcare spending, patients must be engaged in managing their own health? Should federal Medicaid regulations facilitate the incorporation of patient activation measurement in state’s Medicaid programs?

The Honorable Gus Bilirakis

1. Can you talk about you work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?
2. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?