

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

COMMITTEE ON ENERGY AND COMMERCE

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July 29, 2013

Mr. Tarren Bragdon
Chief Executive Officer
Foundation for Government Accountability
15275 Collier Boulevard, Suite 201-279
Naples, FL 34119

Dear Mr. Bragdon:

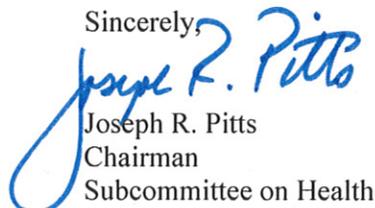
Thank you for appearing before the Subcommittee on Health on Monday, July 8, 2013, to testify at the hearing entitled "Making Medicaid Work for the Most Vulnerable."

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 Monday, August 12, 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 Michael Burgess

1. You have been involved in analyzing Florida's Medicaid Reform pilot over the past five years. A signature component of Florida's Medicaid pilot is the opportunity for Medicaid beneficiaries to have a choice of managed care plans. How has this increased level of choice affected patient health and outcomes? How did this consumer-driven approach to Medicaid affect patient access to providers?
2. Low provider reimbursement rates in many states have led many providers to cease caring for Medicaid patients. How does the program address provider reimbursement rates and maintain provider buy-in to the Medicaid program? How can the federal government ensure provider rates are set at levels that encourage provider buy-in?
3. The Florida Medicaid reform plan was predicated on patient choice of health plans. However, recently we've seen plans, like Aetna and United Healthcare, decline to offer coverage in the individual and small group markets in California. How did the Florida Medicaid program ensure there were a sufficient number of plans to offer beneficiaries' choice in plans? How would you ensure an adequate number of plans in rural regions?
4. In a 2011 paper you published for Heritage, you state that if "Florida's Reform Pilot were replicated nationwide...Medicaid programs could save up to \$29 billion annually". Do you believe Florida's plan could be replicated and effective in all 50 states? What can other states learn from Florida's Medicaid plan?

The Honorable Gus Bilirakis

1. The current funding formula for Medicaid appears to create an incentive to hurt the most vulnerable of our population. Currently, Medicaid covers traditional populations such as the elderly, the disabled, and children while only paying 57% of the costs on average. But under expanded Medicaid in the ACA, new able-bodied childless adults are eligible with the federal government paying 100% of the bill in the first few years and later 90% of the cost. Does this not create a perverse incentive to target a healthier population rather than the truly needy?
2. Under current law, the system seems to be rigged to maintain the status quo. If a state tries to reform their system to increase outcomes and reduce cost, they typically don't see most of the savings. How can we transform the system to incentivize states and allow them to a greater share of the savings?
3. Some states have attached a work requirement as part of their Medicaid program. Will you elaborate on this requirement, how does it work, and how has it affected the state's Medicaid program?
4. In a recent hearing on Medicare benefit redesign, I asked the panel would it be worthwhile to have the government set an actuarial value and allow for multiple Medicare plans in the marketplace. With Medicaid, at least in Florida, we seem to have taken steps to do that. Consumers may have 31 different benefit packages to choose

among, that may be more options than consumers have in the Health Exchanges. Is it a good idea to provide diversity of plan options to Medicaid beneficiaries?

5. Before Florida created a state-wide managed Medicaid plan, it created a smaller demonstration program. Will you tell us what lessons were learned in the demonstration plan? How does it serve as a model for the state? What were the patient outcomes in the demonstration?
6. The Administration seems focused on expanding Medicaid. How many people are Medicaid eligible and are not enrolled? Shouldn't we be focused on getting care to those groups before we focus on expanding Medicaid? Additionally, this expansion of patients will increase the patient load on the Medicaid system. Has there been an influx in doctors taking Medicaid? What will this patient surge do to the system?
7. How much has this administration embraced experiments in Medicaid? Florida recently received their waiver to roll out a statewide competitive managed care plan, but it took almost two years to obtain the waiver. What has been the experience of other states who applied for waivers, how was it interacting with CMS during the process, and how long did it take for CMS to approve the waiver?
8. 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 lessons should we take from it?
9. What reforms are needed to help beneficiaries transition off of Medicaid and into private insurance? What are the challenges that beneficiaries face?

The Honorable Renee Ellmers

1. I am concerned by the high rates of improper payment rates associated with eligibility errors in Medicaid, which over the 2010-2012 period averaged \$20 billion annually according to CMS. Every dollar that is spent in error on someone that could potentially not be a truly eligible Medicaid beneficiary, is a dollar that is taken from our most vulnerable citizens. With Medicaid enrollment at over 70 million now and 1 in 4 Americans expected to become a Medicaid beneficiary as a result of the ACA, do you believe there are measures in place to ensure proper eligibility verification?
2. What impact do you think the delay of the employer mandate reporting requirements might have on the number of individuals improperly enrolled in Medicaid?