

FOUNDATION FOR
GOVERNMENT
ACCOUNTABILITY

15275 Collier Blvd., Suite 201-279

Naples, Florida 34119

239.244.8808

www.FloridaFGA.org

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Committee on Energy and Commerce

Subcommittee on Health

Making Medicaid Work for the Most Vulnerable

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RESPONSES TO MEMBER QUESTIONS

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Tarren Bragdon

President and Chief Executive Officer

Foundation for Government Accountability

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?

Competition among multiple private plans has led to plans constantly striving to innovate, improve health outcomes and increase patient satisfaction. Plans in Florida’s Reform Pilot, for example, outperform the traditional Old Medicaid program in 22 of the 33 HEDIS health outcomes tracked by the state.¹ Better yet, Reform Pilot plans are improving far faster than Old Medicaid. Roughly 94 percent of the Reform Pilot’s regularly-tracked health performance measures have improved since 2008.²

Patients enrolled in the Reform Pilot are also more satisfied with their plan choices and the quality of care they receive. For 83 percent of patient-satisfaction measures, Florida’s Reform Pilot plans meet or exceed national benchmarks not just for Medicaid, but for commercial insurance as well.³ In 2012, the Florida agency overseeing the Medicaid Reform Pilot received just six complaints for every 10,000 patients.⁴ The plans also successfully resolved these complaints quickly, as no unresolved grievances were filed during the entire year.⁵

Patients in the Reform Pilot also reported that it was easier to find a doctor in their plan’s network who listened to them, explained things easily, showed them respect and spent enough time with them following passage of the reform.⁶ Medicaid patients were also more likely to have a personal doctor in the Reform Pilot than before.⁷ In fact, patients were half as likely to report difficulty finding a personal doctor as they were before the reform.⁸ It’s no surprise, then, that patients were less likely to resort to emergency room care following the reform.⁹

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

¹ Florida Agency for Health Care Administration, “Florida Medicaid reform: Year 7, 2nd quarter progress report,” Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_Q2_YR_7_Report_10-1-2012_12-31-2012_final.pdf.

² Ibid.

³ Tarren Bragdon, “Florida’s Medicaid reform shows the way to improve health, increase satisfaction and control costs,” Heritage Foundation (2011), <http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf>.

⁴ Florida Agency for Health Care Administration, “Florida Medicaid reform: Year 6 annual report,” Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

⁵ Ibid.

⁶ R. Paul Duncan et al., “Medicaid reform enrollee satisfaction: Year two follow-up survey,” Florida Agency for Health Care Administration (2010), http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/contracts/med027/Medicaid_Reform_Enrollee_Satisfaction-Year2_Follow_Up_Survey_Vol1_County_Estimates.pdf.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

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?

By giving plans the flexibility to negotiate higher rates with providers, patient-centered Medicaid reforms can maintain and improve provider buy-in, greatly expanding access to needed care. When Louisiana implemented its reforms, it established a provider rate floor based on Old Medicaid's fee-for-service rates.¹⁰ Plans and providers can negotiate higher rates, especially for hard-to-find specialists.¹¹ States can also ensure strong provider buy-in by establishing strong network adequacy standards in their contracts with private health plans.

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 of plans? How would you ensure an adequate number of plans in rural regions?

States looking to reform Medicaid are rightfully concerned with ensuring fair and adequate access to plan choices in both rural and urban areas. Florida's Reform Pilot covers patients from two urban counties, as well as patients from three rural counties.¹² One lesson learned from the Reform Pilot is to create multi-county regions that have a critical mass large enough to attract a significant number of plans.¹³ In order to further encourage participation in the rural regions, plans that bid successfully in more rural regions are guaranteed a contract in another region.¹⁴ If a plan terminates its contract in a rural region, it automatically loses its additional region.¹⁵ Kansas and Louisiana, on the other hand, ensured patients in rural regions would have adequate choices by requesting bids for plans that would operate statewide.¹⁶

The flexibility in designing benefit packages also creates an incentive for more plans to compete on value, ensuring patients will have a sufficient number of plans from which to choose. Louisiana, for example, received 14 bids for its Bayou Health reforms, although it only needed five statewide plans.¹⁷⁻¹⁸ In preparing for launching its reforms statewide, Florida received

¹⁰ Louisiana Department of Health and Hospitals, "Fact or fiction: Louisiana Medicaid's proposed coordinated care networks," Louisiana Department of Health and Hospitals (2011), http://dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/NoticeofIntent_Materials/CCNs_FACTsFctn_FINAL.pdf.

¹¹ Ibid.

¹² Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

¹³ Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), <http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf>.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Jonathan Ingram and Katherine Restrepo, "The Partnership for a Healthy North Carolina: Medicaid reform that works for patients, providers and taxpayers alike," Foundation for Government Accountability (2013), <http://www.medicaidcure.org/wp-content/uploads/2013/05/The-Partnership-for-a-Healthy-North-Carolina-MedicaidCure-Policy-Brief-5.pdf>.

¹⁷ Bayou Health received 10 letters of intent for the fully-capitated plans. See, e.g., Bayou Health, "CCN Prepaid procurement library: Potential CCN-P letters of intent," Louisiana Department of Health and Hospitals (2011), <http://dhh.louisiana.gov/index.cfm/page/277>.

between 13 and 18 letters of intent from each region, although the typical region will only contract with three to six plans.¹⁹⁻²⁰

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?

Patient-centered Medicaid reform can be effective in every state. Florida’s Medicaid Reform Pilot is one of the largest of its kind. The pilot covers more than 300,000 individuals, which makes the Reform Pilot larger than the Medicaid programs in 15 states and in the District of Columbia.²¹⁻²² The Reform Pilot covers patients in both rural and urban areas. The counties participating in the Reform Pilot range in size from fewer than 27,000 residents in Baker County to nearly 1.8 million residents in Broward County.²³

While no state is exactly the same, the core components and proven principles of Florida’s Medicaid reforms can be replicated in other states, with adjustments made to tailor the reforms to the unique circumstances in each state. Building a Medicaid program around reforms that empower patients with meaningful choices for their own health plans, provide robust competition among plans based on value, incentivize healthy behavior and provide for smarter funding and true accountability are key to making Medicaid work for the most vulnerable.

Other states can build on Florida’s success to design a Medicaid safety net that works best for patients and taxpayers alike. Similar reforms have already been implemented in Kansas and Louisiana and other states, such as North Carolina, are moving toward this patient-centered reform approach.²⁴

The Honorable Gus Bilirakis

¹⁸ Bayou Health received four letters of intent for the shared-savings plans. See, e.g., Bayou Health, “CCN Shared Savings procurement library: Potential CCN-S letters of intent,” Louisiana Department of Health and Hospitals (2011), <http://dhh.louisiana.gov/index.cfm/page/276>.

¹⁹ Florida Agency for Health Care Administration, “SMMC MMA program non-binding letters of intent,” Florida Agency for Health Care Administration (2012), http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/mma/List_of_respondents_092712.pdf.

²⁰ Florida Agency for Health Care Administration, “Florida Managed Medical Assistance program: Program overview,” Florida Agency for Health Care Administration (2012), http://www.fdhc.state.fl.us/Medicaid/statewide_mc/pdf/mma/Overview_of_Managed_Medical_Assistance_program_02-12-2013.pdf.

²¹ Florida Agency for Health Care Administration, “Florida Medicaid managed care and Medicaid pilot enrollment reports as of August 1, 2013,” Florida Agency for Health Care Administration (2013), http://ahca.myflorida.com/mchq/managed_health_care/MHMO/docs/MC_ENROLL/RF_NR_SMMC/ENR_Aug2013.xls.

²² Laura Snyder et al., “Medicaid enrollment: June 2011 data snapshot,” Kaiser Family Foundation (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8050-05.pdf>.

²³ Demographic Estimating Conference, “Florida population estimates for counties and municipalities: April 1, 2012,” Florida Office of Economic and Demographic Research (2012), http://edr.state.fl.us/Content/population-demographics/data/2012_Pop_Estimates.pdf.

²⁴ Jonathan Ingram and Katherine Restrepo, “The Partnership for a Healthy North Carolina: Medicaid reform that works for patients, providers and taxpayers alike,” Foundation for Government Accountability (2013), <http://www.medicaidcure.org/wp-content/uploads/2013/05/The-Partnership-for-a-Healthy-North-Carolina-MedicaidCure-Policy-Brief-5.pdf>.

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?

The Patient Protection and Affordable Care Act’s funding formula creates a perverse incentive for states to cut services and benefits to the most vulnerable and give preferential treatment to adults without any disabilities or dependent children. Under PPACA, states that choose to expand Medicaid will receive “enhanced” federal funding to cover able-bodied adults without children.²⁵ But states will receive much less federal funding for groups that the Medicaid safety net was originally intended to protect, including children, the elderly and individuals who are blind or disabled.²⁶

An example of a typical state attempting to cut \$300 million in state Medicaid funding from its 2020 budget highlights this perverse incentive best. The state could achieve those savings by cutting services and benefits to the most vulnerable by nearly \$700 million. This is because state funds cover approximately 43 percent of the costs of currently eligible individuals. But if the state wanted to protect those groups, and target only able-bodied adults without children, it would need to cut services and benefits by a whopping \$3 billion. This is because state funds will cover only 10 percent of the costs of newly eligible individuals.

PPACA’s funding formula prioritizes individuals who have never been considered a core section of the social safety net and who do not qualify for other types of welfare, such as TANF cash assistance, instead of groups that have been part of the targeted safety net for decades.

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?

Under current law, states that implement innovative reforms can expect to see the lion’s share of savings go to the federal government. The typical state will only see 43 cents of every dollar it saves from its Medicaid reforms—less than half of the savings that state created.²⁷ This provides states with fewer incentives to innovate, as most of the savings will accrue to the federal government. Congress could reduce this perverse funding dynamic by giving states a greater share of those savings. One option would be to allow states to keep some share—such as one-third or one-half—of the savings accruing to the federal government. This would promote innovation and provide states with greater financial incentives to implement bold solutions.

²⁵ 42 U.S.C. § 1396d(y).

²⁶ 42 U.S.C. § 1396d(b).

²⁷ Kaiser Commission on Medicaid and the Uninsured, “Medicaid financing: An overview of the federal Medicaid matching rate,” Kaiser Family Foundation (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf>.

Although this recommendation would appear to increase federal spending in the short-term by allowing states to keep a greater share of the savings they produce, it would reduce federal spending in practice by finally giving states a meaningful incentive to generate savings with Medicaid reform. These incentives would have a lasting effect upon the long-term federal Medicaid budget.

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?

Many state officials have expressed a desire to attach reasonable work requirements to Medicaid in order to move individuals out of poverty. Unlike other public assistance programs, such as TANF, there are no work requirements for working-age adults to maintain eligibility for Medicaid benefits. But eligibility for Medicaid may have a profound impact on participating in the labor force and on full-time employment.

By looking at previous Medicaid expansions to enroll working-age adults, a group of researchers at Emory University and the University of Colorado were able to estimate the impact Medicaid eligibility has on employment.²⁸ Those researchers found that full-time employment among the group of people newly eligible for Medicaid declined by more than 8 percent after becoming eligible.²⁹ They also found that the share of this group who didn't work at all increased by nearly 11 percent.³⁰ This is particularly troubling, given the fact that full-time employment moves people off of government dependence and into self-sufficiency.

State officials have seen the value of work requirements in their TANF cash assistance programs and wish to replicate that success in Medicaid. In 1996, there were more than 4.5 million families on AFDC, the predecessor of TANF.³¹ Unlike TANF, the AFDC program was an open-ended entitlement and had no work requirements for eligible adults. Instituting reasonable work requirements was a cornerstone of President Clinton's bipartisan welfare reform policy. Today, there are fewer than 1.9 million families receiving TANF cash assistance.³²

Giving states the flexibility to implement similar requirements for working-age, non-disabled adults would encourage hard work among low-income families, rather than punish it as the current open-ended Medicaid entitlement does. This would build on the successful state-led welfare reform of the 1990s and move people out of government dependency and into self-sufficiency.

Seeing the value of work and its impact on health, some states have begun integrating work with health outcomes. Kansas, for example, has created two unique employment-focused pilot

²⁸ Gery P. Guy, Jr. et al., "Public health insurance eligibility and labor force participation of low-income childless adults," *Medical Care Research and Review* 69(6): 645-662 (2012), <http://mcr.sagepub.com/content/69/6/645>.

²⁹ Ibid.

³⁰ Ibid.

³¹ Administration for Children and Families, "Aid to Families with Dependent Children: Caseload data 1996," U.S. Department of Health and Human Services (2001), <http://archive.acf.hhs.gov/programs/ofa/data-reports/caseload/afdc/1996/1996.xls>.

³² Administration for Children and Families, "Temporary Assistance for Needy Families: Caseload data 2012," U.S. Department of Health and Human Services (2013), http://www.acf.hhs.gov/sites/default/files/ofa/2012_15months_tanssp.xls.

programs that integrate work with health outcomes for individuals with developmental disabilities.

The first pilot, which covers individuals receiving SSI who are on the waiting list to receive home and community-based services, provides assistance with obtaining employment and provides up to \$1,500 per person per month in employment support services.³³ The second pilot focuses on youth and those who would likely meet the criteria for Social Security Disability but are not yet receiving it. These individuals receive employment assistance focused on jobs with employer-sponsored health coverage and receive wrap-around Medicaid services once enrolled in a work-related health plan.³⁴

By integrating employment into Medicaid, Kansas is able to help these individuals gain opportunities to maintain and improve their skills, helping lead to long-term employment and productivity. Given the strong association between employment and better health, integrating employment services also helps to avoid the cycle of poverty, poor health and social isolation stemming from lack of employment. Giving states the flexibility to expand on this integration and implement reasonable work requirements would provide them with more opportunities to move working-age Medicaid enrollees out of poverty and into productivity.

4. In a recent hearing on Medicare benefit redesign, I asked the panel would it be worthwhile to have the government set aside 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 pay 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?

Empowering patients with meaningful choices is critical to designing a Medicaid safety net that works for patients and taxpayers alike. When empowered with the ability to choose, Medicaid patients take more control over their own health. In Florida's Medicaid Reform Pilot, between 70 percent and 80 percent of Medicaid patients are actively choosing their own health plan rather than having the state automatically enroll them into a plan.³⁵ This diversity of plan choices has led to greater competition on value, as plans constantly strive to innovate, improve customer service and maximize the offered benefits and rewards in order to attract more patients. This competitive Medicaid marketplace has produced substantial savings for taxpayers, improved health outcomes and increased patient satisfaction.³⁶

³³ Division of Health Care Finance, "KanCare: Section 1115 demonstration waiver," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_Section_1115_Demonstration_August_6_2012.pdf.

³⁴ Ibid.

³⁵ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

³⁶ Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), <http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf>.

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?

Florida's Medicaid Reform Pilot provided a model for the state to expand choice and competition in its Medicaid program statewide. The Reform Pilot showed policymakers the value of smarter funding, healthy incentives, more choices and stronger competition.

The open-checkbook style of funding Old Medicaid was clearly failing both taxpayers and the patients Medicaid was intended to serve. Replacing that open-ended funding structure with one based on giving health plans a fixed sum of money for each patient ensured that budgeting would be more predictable. Policymakers learned that by risk-adjusting that fixed sum of money based on individuals' health status, they could ensure resources were prioritized to the most vulnerable individuals where care coordination was most needed.

Lawmakers also learned that when given appropriate incentives, Medicaid patients will take even more control over their own health and engage in healthier behavior. By providing patients with financial incentives to enroll in disease management programs, keep appointments, receive regular checkups, and engage in other healthy behaviors, patients will respond. In 2012, nearly 85 percent of the patients in the Reform Pilot actively participated in this rewards program, collectively earning more than \$12 million to spend on over-the-counter items at participating pharmacies.³⁷

Lawmakers also learned that Medicaid patients will take more control over their own health when given meaningful choices and adequate, objective information. Independent choice counselors assist Reform Pilot patients in navigating the plan selection process, providing them with objective information on the 35 different customized benefit packages offered in the Reform Pilot.³⁸ It's no surprise, then, that between 70 and 80 percent of the patients in the Reform Pilot actively choose their own health plans, rather than waiting for the state to automatically assign them plans.³⁹

This robust competition has improved HEDIS health outcomes, increased patient satisfaction and reduced costs to taxpayers. Plans in Florida's Reform Pilot, for example, outperform the traditional Old Medicaid program in 22 of the 33 outcomes tracked by the state.⁴⁰ Better yet,

³⁷ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

³⁸ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 3rd quarter progress report," Florida Agency for Health Care Administration (2013),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_Q3_YR_7_Report_01-01-2013_03-31-2013.pdf.

³⁹ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

⁴⁰ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 2nd quarter progress report," Florida Agency for Health Care Administration (2012),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_Q2_YR_7_Report_10-1-2012_12-31-2012_final.pdf.

Reform Pilot plans are improving far faster than Old Medicaid. Roughly 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.⁴¹

Reform Pilot patients are also more satisfied with their plan choices and the quality of care they receive. For 83 percent of patient-satisfaction measures, Florida's Reform Pilot plans meet or exceed national benchmarks not just for Medicaid, but for commercial insurance as well.⁴²

These patient-centered reforms are also working for taxpayers. Costs in the Reform Pilot are significantly lower than costs for comparable populations in Old Medicaid, those costs remained flat for five years and when Florida launches its reforms statewide, it expects to save \$1 billion annually.⁴³

6. The Administration seems focused on expanding Medicaid. How many people are 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?

The present focus on expanding Medicaid eligibility is misguided. According to an analysis of Census data, there are 25 million individuals who are currently eligible for Medicaid but not yet enrolled.⁴⁴ Of course, not all of these individuals are in need of Medicaid benefits. Nearly two-thirds of these individuals are currently enrolled in private insurance, providing them with higher quality care than received under Medicaid.⁴⁵

Nevertheless, the Medicaid expansion will prioritize a new population of able-bodied adults without children over groups that have traditionally belonged to the social safety net, including the elderly, the disabled and low-income children. Indeed, this new population is not typically considered among the most vulnerable, given that they do not qualify for other types of welfare, such as TANF cash assistance.

Expanding a program that consistently fails to deliver for many patients should never be the priority. Expanding a system often on the brink of collapse will only exacerbate the access and quality problems plaguing many Medicaid programs today. A third of doctors nationwide have stopped taking new Medicaid patients altogether.⁴⁶ In some states, up to 60 percent of physicians

⁴¹ Ibid.

⁴² Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), <http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf>.

⁴³ Ibid.

⁴⁴ Author's calculations, based upon the Urban Institute's estimates of Medicaid take-up rate and take-up counts of potential Medicaid enrollees who are not newly eligible, derived from its Health Insurance Policy Simulation of both the Current Population Survey and the American Community Survey. See, e.g., Matthew Buettgens et al., "Documentation on the Urban Institute's American Community Survey Health Insurance Policy Simulation model," Urban Institute (2013), <http://www.urban.org/UploadedPDF/412841-American-Community-Survey-Health-Insurance-Policy-Simulation-Model.pdf>.

⁴⁵ Ibid.

⁴⁶ Sandra L. Decker, "In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help," *Health Affairs* 31(8): 1,673-1,679 (2012), <http://content.healthaffairs.org/content/31/8/1673>.

have stopped taking new Medicaid patients.⁴⁷ Even the doctors still accepting Medicaid patients will often limit the number they will see. Medicaid patients' access to needed specialists is even worse, with two-thirds of specialists denying appointments.⁴⁸ Even when Medicaid patients are able to schedule an appointment, they often have to wait weeks or even months to see a doctor.⁴⁹

These problems will only worsen as states expand Medicaid and overload a system already failing to meet the needs of our most vulnerable neighbors. Instead of focusing on expanding eligibility to a new group of able-bodied childless adults, state and federal lawmakers should focus their efforts on finally fixing the existing program for those who need help the most.

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?

Each state has had its own experiences with the burdensome waiver process. On August 1, 2011, Florida officials submitted a waiver request to expand their highly successful five-county Medicaid Reform Pilot statewide.⁵⁰ The federal government did not approve this waiver until June 14, 2013, nearly two years after it was submitted.⁵¹

Louisiana submitted its own reform waiver in December 2008, but the waiver request stalled after the presidential administration changed.⁵² Eventually, Louisiana moved forward with their reforms through a state plan amendment, largely because the administration has less control over them, and launched their reforms in 2012.⁵³

For many states, the waiver process is a long, drawn-out and complex negotiation with the federal government. States face a general uncertainty about whether and when CMS will approve their requested reforms, as well as what new strings will come attached to a waiver. Once a waiver has been approved, states face burdensome reporting requirements and subjective deadlines and their reform waivers last just three to five years.⁵⁴ After that time, it must either seek an optional extension of the waiver or submit a new waiver request altogether if it wants to continue its reforms, both of which require new negotiations with the federal government.

⁴⁷ Ibid.

⁴⁸ Joanna Bisgaier and Karin V. Rhodes, "Auditing access to specialty care for children with public insurance," *New England Journal of Medicine* 364: 2,324-2,333 (2011), <http://www.nejm.org/doi/full/10.1056/NEJMsa1013285>.

⁴⁹ Ibid.

⁵⁰ Florida Agency for Health Care Administration, "Florida Medicaid Reform 1115 demonstration, Project # 11-W-00206/4: Amendment request #1," Florida Agency for Health Care Administration (2011), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf.

⁵¹ Centers for Medicare and Medicaid Services, "Florida Medicaid Reform 1115 demonstration, Project # 11-W-00206/4: Approval letter," U.S. Department of Health and Human Services (2013), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Approval_Letter.pdf.

⁵² Bruce D. Greenstein, "Making Medicaid better: Lessons from Louisiana's journey to managed care," Louisiana Department of Health and Hospitals (2012), <http://www.medicaidcure.org/wp-content/uploads/2012/10/Louisianas-Bayou-Health-Making-Medicaid-Better.pdf>.

⁵³ Ibid.

⁵⁴ Section 1115 waivers are generally approved for five-year periods, Section 1915(b) waivers are generally approved for five-year periods and Section 1915(c) waivers are generally approved for three-year periods.

Even reform ideas that have proven successful in their own state or in other states must follow this slow, inflexible process. For example, a state that wanted to replicate Florida's already-approved Medicaid reforms must still submit a waiver and negotiate it with CMS. And states still have no real guarantee that the federal government will grant them permission to implement these proven reforms.

Congress can remove obstacles to reform by granting states the flexibility to turn previously-approved waivers into permanent state plan amendments once the waivers have been proven effective. This would greatly reduce the stress and uncertainty state officials face as their waivers approach scheduled expiration dates and ensures patients' care and taxpayer savings are not interrupted by lengthy renegotiations with the federal government. Congress can also provide states with the flexibility to incorporate reforms that have proven effective in other states into their own state plans without enduring the same burdensome waiver process and scrutiny the reform already received elsewhere. This would allow states to avoid many of the delays for waiver approval, which can last years.

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?

In 2008, Oregon officials wanted to expand eligibility for their Medicaid program, but only had enough funding for 10,000 of the 90,000 individuals wanting to sign up. In response, Oregon held a lottery to see who would receive Medicaid benefits and who would not. Health economists used this unique opportunity to create the first-ever randomized, controlled study of the effect of Medicaid on patients' health. These researchers spent the next two years following those who won the lottery and those who did not to try and measure Old Medicaid's impact.

Their results were astounding. After two years of tracking the participants, the researchers found that "Medicaid coverage generated no significant improvements in measured physical health outcomes" for a variety of conditions.⁵⁵ Despite much higher utilization of health care services, researchers found no significant improvements for the Medicaid group when compared to the control group.⁵⁶ This means that the only randomized controlled study of Medicaid ever conducted failed to find evidence that Old Medicaid significantly improves health. There is already a large body of peer-reviewed evidence that Medicaid patients face larger access barriers and suffer worse health outcomes than the privately insured, and in some cases, fare worse than even the uninsured.⁵⁷⁻⁵⁸

⁵⁵ Katherine Baicker et al., "The Oregon experiment: Effects of Medicaid on clinical outcomes," *New England Journal of Medicine* 368: 1,713-1,722 (2013), <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>.

⁵⁶ Ibid.

⁵⁷ Kevin Dayaratna, "Studies show: Medicaid patients have worse access and outcomes than the privately insured," Heritage Foundation (2012), http://thf_media.s3.amazonaws.com/2012/pdf/bg2740.pdf.

⁵⁸ Avik Roy, "The Medicaid mess: How ObamaCare makes it worse," Manhattan Institute (2012), http://www.manhattan-institute.org/pdf/ir_8.pdf.

This is why it is absolutely critical to reform the existing Medicaid program, rather than move forward with corralling millions of newly eligible individuals into the system.

9. What reforms are needed to help beneficiaries transition off of Medicaid and into private insurance? What are the challenges that beneficiaries face?

Beneficiaries leaving the Medicaid program often face large transition barriers. Current federal restrictions on marketing private insurance plans to individuals transitioning off Medicaid make it more difficult for those patients to know what health options are available to them. When given access to appropriate information, patients can and do make more informed choices about their health coverage. By denying them this information, the federal government is hindering their ability to make educated choices. Removing these unduly burdensome restrictions will allow patients transitioning off of Medicaid to make more meaningful choices over their health futures, and help reduce coverage gaps after leaving Medicaid.

Federal rules and regulations also restrict states from using Medicaid funding in more innovative ways to move individuals out of Medicaid and into private coverage. Even when states are allowed to harness private insurance, they often face huge barriers created by the federal government, limiting their success. With greater flexibility in this area, states would be able to take proactive steps to create an off-ramp for Medicaid, helping ensure that Medicaid patients are not trapped in government dependency and a culture of poverty, but rather help them move from poverty into long-term employment and productivity.

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?

The Medicaid program has long been plagued with wasteful spending. The U.S. Government Accountability Office designates Medicaid as a high-risk program, largely because it is “particularly vulnerable to fraud, waste, abuse and improper payments,” and has inadequate oversight to prevent wasteful spending.⁵⁹ The U.S. Department of Health and Human Services reports an improper payment rate of nearly 10 percent.⁶⁰ Federal officials also estimate that eligibility errors account for most of the improper payments made by the Medicaid program.⁶¹

⁵⁹ Kathleen M. King, “Medicare and Medicaid fraud, waste and abuse: Effective implementation of recent laws and agency actions could help reduce improper payments,” Government Accountability Office (2011), <http://www.gao.gov/assets/130/125646.pdf>.

⁶⁰ Division of Financial Management Policy, “Fiscal year 2011 agency financial report,” U.S. Department of Health and Human Services (2011), <http://www.hhs.gov/afr/2011afr.pdf>.

⁶¹ Ibid.

Some states are moving forward with meaningful program integrity initiatives to ensure that individuals receiving Medicaid benefits are actually eligible. These measures include verification efforts for initial eligibility determinations and annual redeterminations, followed by case cancellation for ineligible enrollees. The Pennsylvania Department of Public Welfare, which oversees the state's Medicaid program, began its Enterprise Program Integrity initiative in 2011.⁶² In its first 10 months of operation, the DPW identified more than 160,000 ineligible individuals who were receiving benefits, including individuals who were in prison and even millionaire lottery winners.⁶³

In January 2013, Illinois followed Pennsylvania's lead and began its own program integrity initiative.⁶⁴ An earlier Inspector General report found that 34 percent of randomly selected Medicaid files contained eligibility errors.⁶⁵ The vast majority of these errors were discovered in the areas of income and other basic eligibility requirements, such as residency and household composition.⁶⁶ A report issued by the Auditor General found that some annual eligibility redeterminations had been delayed for more than five years.⁶⁷ Even when the annual eligibility checks were performed, it was unclear whether eligibility was truly verified. Several audited files were missing evidence that income, citizenship, Social Security numbers and residency had ever been verified.⁶⁸

This sparked a push to use an independent third-party vendor to verify eligibility for Medicaid enrollees. The vendor is using advanced data matching technology to verify income, residency and other criteria for Illinois' 2.8 million Medicaid enrollees each year. So far, the vendor has reviewed eligibility for 210,000 individuals receiving Medicaid benefits.⁶⁹ The vendor has recommended that more than half of the reviewed case be cancelled, meaning that the enrollees appear to be no longer eligible for benefits.⁷⁰ Another 12 percent of enrollees were found to be eligible for some benefits, but enrolled in the wrong program.⁷¹ For example, some individuals enrolled in Medicaid may actually only qualify for programs with greater cost-sharing. This means that of the 210,000 cases reviewed so far, more than 62 percent had eligibility errors of some kind.⁷²

Lawmakers in Massachusetts are also moving toward implementing an enhanced eligibility verification program for Medicaid, TANF cash assistance, food stamps and other public

⁶² Clint Eisenhower, "CSG innovations awards application 12-E-12-PA," Council of State Governments (2012), <http://ssl.csg.org/innovations/2012/2012eastappsinPdf/12e12paenterprise.pdf>

⁶³ Ibid.

⁶⁴ Division of Medical Programs, "HFS and DHS launch enhanced eligibility verification program," Illinois Department of Healthcare and Family Services (2013), <http://www2.illinois.gov/hfs/MedicalProvider/eev/Pages/launch.aspx>.

⁶⁵ Office of Inspector General, "Federal fiscal year 2009 Medicaid eligibility quality control pilot project: Passive redeterminations," Illinois Department of Healthcare and Family Services (2010), <http://www.state.il.us/agency/oig/docs/Passive%20analysis%20092910.pdf>.

⁶⁶ Ibid.

⁶⁷ KMPG, "State of Illinois: Single audit report for the year ended June 30, 2012," Illinois Auditor General (2013), <http://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Statewide-Single-Audit/FY12-Single-Audit-Full.pdf>.

⁶⁸ Ibid.

⁶⁹ Division of Medical Programs, "Illinois Medicaid redetermination project: Summary report, August 5, 2013," Illinois Department of Healthcare and Family Services (2013), <http://illinoispolicy.org/uploads/files/IMRPReport-8-5.pdf>.

⁷⁰ Ibid.

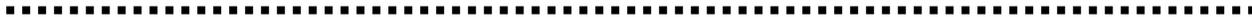
⁷¹ Ibid.

⁷² Ibid.

assistance programs.⁷³⁻⁷⁴ Although more states are starting to move in this direction, wasteful Medicaid spending remains a significant problem in most states. Before even considering adding additional people to the Medicaid program, policymakers should ensure every person already enrolled in Medicaid is actually eligible for coverage. This will help eliminate waste, fraud and abuse, ensuring that scarce Medicaid resources go only to the truly needy. States should consider enhancing their use of federal, state and commercial databases in order to properly and accountably screen applicants and enrollees for eligibility.

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?

It is still unclear what ultimate effect delaying the employer mandate reporting requirements will have on federal health programs, including Medicaid. Reducing the amount of data available to verify eligibility will certainly make that verification more difficult. Indeed, the federal government has scaled back its own eligibility oversight for individuals applying for benefits through the exchanges.⁷⁵ With the federal government scaling back on its verification efforts, states will need to be much more active in verifying eligibility to ensure those receiving benefits are actually eligible for the program.



⁷³ House of Representatives, “House Bill 133,” Massachusetts General Court (2013), <https://malegislature.gov/bills/188/house/h133>.

⁷⁴ House of Representatives, “House Bill 134,” Massachusetts General Court (2013), <https://malegislature.gov/bills/188/house/h134>.

⁷⁵ U.S. Department of Health and Human Services, “Medicaid and Children’s Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, premiums and cost sharing; Exchanges: Eligibility and enrollment,” Federal Register 78(135): 42,160-42,332 (2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

Response to the Honorable Kathy Castor

During the hearing, Congresswoman Kathy Castor asserted that Florida's Medicaid Reform Pilot was "known as a real disaster." According to Ms. Castor, studies produced by the State of Florida "condemned the results" after finding that patients were "unable to gain access" to needed care. As a result, Ms. Castor claimed that "everyone across the board condemned what has happened" in the Reform Pilot.

The state has produced and submitted more than 30 quarterly and annual reports to the federal government, as well as numerous reports studying whether the Medicaid Reform Pilot improved quality, increased satisfaction, incentivized healthy behaviors and saved taxpayers money. These reports have one thing in common: they show that the Medicaid Reform Pilot has been a decided success.

Rather than create access problems, the Reform Pilot helped alleviate the access problems plaguing patients in Old Medicaid. Plans in the Reform Pilot have outperformed Old Medicaid on access to preventive care every single year it has been measured.⁷⁶ Indeed, Reform Pilot plans outperform Old Medicaid on 22 of the 33 quality measures tracked by the state.⁷⁷ Quality also improved more rapidly in the Reform Pilot than in Old Medicaid, and has continued to rise. Approximately 94 percent of regularly-tracked measures have improved since 2008.⁷⁸

Medicaid patients are also more likely to have a personal doctor in the Reform Pilot than they were before the reforms began.⁷⁹ In fact, patients in the Reform Pilot are half as likely to report difficulty finding a personal doctor as they were before the reform.⁸⁰ It's no surprise, then, that patients were less likely to resort to emergency room care following the reform.⁸¹

Reform Pilot patients are also more satisfied with their plan choices and the quality of care they receive. For 83 percent of patient-satisfaction measures, Florida's Reform Pilot plans meet or exceed national benchmarks not just for Medicaid, but for commercial insurance as well.⁸² In 2012, the Florida agency overseeing the Medicaid Reform Pilot received just six complaints for every 10,000 patients.⁸³ The plans also successfully resolved these complaints quickly, as no unresolved grievances were filed during the entire year.⁸⁴

⁷⁶ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 3rd quarter progress report," Florida Agency for Health Care Administration (2013),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_Q3_YR_7_Report_01-01-2013_03-31-2013.pdf.

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), <http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf>.

⁸³ Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012),

http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.

⁸⁴ Ibid.

Independent researchers at the University of Florida confirmed these results, finding that the Reform Pilot introduced innovative tools, increased accountability, improved quality and reduced costs, in more than 100 evaluation reports produced during the six years of the Reform Pilot.⁸⁵

Ms. Castor may have confused the Florida Reform Pilot's documented record of success with a 2007 report filed by the Office of the Inspector General on the very early implementation of Florida's reforms. The Congresswoman did not identify the report to which she was referencing in her comments before she left the hearing, but the Inspector General's report most closely aligns with her statements.⁸⁶

However, this report was based on the first year of implementation, when performance, quality and cost data was not yet available to evaluate the Reform Pilot's results.⁸⁷ Instead, the Inspector General conducted interviews and surveys of agency staff, providers, advocates and plan representatives.⁸⁸ The review was focused largely on improving internal communication, increasing information sharing, and designing future evaluation processes to measure success.⁸⁹ The Inspector General noted that the challenges it identified were largely the result of an expedited implementation timeline and agency staffing, rather than issues with the Reform Pilot itself.⁹⁰ These transition issues were long-ago corrected and reviews of actual performance, quality and cost have shown the Reform Pilot to be a model for successful reform. Independent experts have since concluded that, although Florida's implementation timetable was ambitious by any standard, it did a "commendable job of project implementation and management" of the Reform Pilot.⁹¹

In short, Florida's Medicaid Reform Pilot is a bipartisan reform success story. The legislation establishing the Reform Pilot passed the Florida Senate by a vote of 39-1 and passed the Florida House of Representatives by a vote of 88-24.⁹²⁻⁹³ The waiver was initially approved by President George W. Bush's administration and was extended under President Barack Obama's.⁹⁴⁻⁹⁵ The Obama administration recently approved Florida's plan to expand that waiver statewide.⁹⁶

⁸⁵ R. Paul Duncan et al., "Evaluating Florida's Medicaid reform demonstration pilot: 2006-2011 summary report," University of Florida (2011), http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/contracts/med027/FL_1115_Final_UF_Eval_Report_12-15-11.pdf.

⁸⁶ Office of the Inspector General, "Program review of the Medicaid Reform Pilot project," Florida Agency for Health Care Administration (2007), <http://dl.dropboxusercontent.com/s/6s51rota4ij6v8a/Medicaid-Reform-IG-report-2007.pdf>.

⁸⁷ Ibid.

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ R. Paul Duncan et al., "Evaluating Florida's Medicaid reform demonstration pilot: 2006-2011 summary report," University of Florida (2011), http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/contracts/med027/FL_1115_Final_UF_Eval_Report_12-15-11.pdf.

⁹² Faye W. Blanton, "Journal of the Senate," Florida Senate (2005),

<http://archive.flsenate.gov/data/Historical/Senate%20Journals/2000s/2005/sj050605.pdf>.

⁹³ John B. Phelps, "Journal of the House of Representatives," Florida House of Representatives (2005),

<http://www.myfloridahouse.gov/FileStores/Adhoc/Journals/data/session/2005/2005%20RS%20-%20Journal%2031.pdf>.

⁹⁴ Centers for Medicare and Medicaid Services, "Florida Medicaid Reform 1115 demonstration, Project # 11-W-00206/4: Special terms and conditions," U.S. Department of Health and Human Services (2006), http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf.

Similar reforms enacted in other states have also received approval from the Obama administration, including Louisiana’s state plan amendment to implement Bayou Health and Kansas’ Section 1115 waiver to implement KanCare.⁹⁷⁻⁹⁸

Ms. Castor’s comments describing these pro-patient, pro-taxpayer reforms a “real disaster” ignore a nearly decade-long reform of healthier, happier Medicaid patients, and substantial budget savings.

⁹⁵ Centers for Medicare and Medicaid Services, “Florida Medicaid Reform 1115 demonstration, Project # 11-W-00206/4: Approval letter,” U.S. Department of Health and Human Services (2011), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/CMS_Approval_Letter_12-15-2011.pdf.

⁹⁶ Centers for Medicare and Medicaid Services, “Florida Medicaid Reform 1115 demonstration, Project # 11-W-00206/4: Approval letter,” U.S. Department of Health and Human Services (2013), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Approval_Letter.pdf.

⁹⁷ Centers for Medicare and Medicaid Services, “State Plan Amendment Transmittal No. 11-21,” U.S. Department of Health and Human Services (2011), <http://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/LA-11-21-Ltr.pdf>.

⁹⁸ Centers for Medicare and Medicaid Services, “KanCare 1115 demonstration, Project # 11-W-00283/7: Approval letter,” U.S. Department of Health and Human Services (2012), http://www.kancare.ks.gov/download/KanCare_CMS_Signed_Approval_Letter.pdf.