

The Honorable Michael Burgess

1. Low provider reimbursement rates are a large factor in 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?

The best solution to encourage provider buy-in is to fundamentally reform Medicaid by moving towards a defined contribution model where the government sets contribution level which could vary by category of eligibility and allows physicians to negotiate with the private insurers for participation.

2. As you are aware, the ACA attempted to address Medicaid's low reimbursement rates by offering a short-term increase in payments to primary-care physicians. Do you know who is responsible for paying for these increased reimbursement rates? Who would pay for these increased rates past 2015? How will this increased cost affect future funding levels for Medicaid and state budgets? Do you believe these increased primary-care rates have increased the number of participating physicians in the Medicaid program?

Federal taxpayers are responsible for funding the increased reimbursement rates included under the ACA. After 2015, when the additional federal funding ends, state would choose whether or not to maintain the higher payment levels. At the time of enactment, the Congressional Budget Office estimated the federal payments would be \$8.3 billion between 2010-2019 while the Center for Medicare and Medicaid Services estimated the cost at \$11 billion between 2010-2019. Of course if states were to maintain the higher payment level, states would have to budget for that increase. With delays in implementation, the impact of the provision is still unknown.

The Honorable Gus Bilirakis

1. 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?

Diversity of plan option would be a good idea especially in light of the diversity in Medicaid beneficiaries – children, pregnant women, the disabled, low income elderly, and in some cases also parents and childless adults. Moreover, it would allow plans to tailor benefit packages to better meet the unique needs and manage the care for enrollees.

2. 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?

Determining an exact figure of people who are Medicaid eligible but not enrolled is difficult. One study suggests that there are 4.5 million uninsured adults who Medicaid eligible but not enrolled (Kenney, et al, 2012) and another study found an estimated 5 million uninsured children are Medicaid or CHIP eligible but not enrolled (Kenney, et al, 2010).

The priority should be to focus on improving the care for those *currently enrolled* in Medicaid before seeking out eligible-but-not-enrolled individuals and certainly before expanding eligibility to new groups.

Physician participation in Medicaid has long been a challenge for the program. A recent study found that 1/3 physicians were not accepting new Medicaid patients and it is unclear whether the temporary boost in federal funding for primary care physicians in the ACA will change this trend. The increase in individuals dependent on Medicaid as well as the increase in the number of newly insured individuals as a result of the ACA may likely increase the demand for physician services.

3. How much has this administration embraced experiments in Medicaid? Florida recently got 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?

States have existing authority to experiment, but some experimentation needs federal waiver approval and the process for obtaining a waiver can be laborious. While I am familiar with the

Questions for the Record Responses
Ms. Nina Owcharenko, The Heritage Foundation

Florida waiver and the basic parameters of the waiver process, I have not followed the waiver process for specific states.

4. 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?

The recent Oregon Medicaid study offers new insight into the impact of Medicaid on patients. Heritage analysis by Kevin Dayaratna has also documented the quality of care issue facing Medicaid as does a March 2011 opinion piece in *The Wall Street Journal* by Scott Gottlieb, MD.

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

Current beneficiaries face an outdated, one-size-fits-all program that is unable to meet the unique needs of enrollees. To help beneficiaries transition off Medicaid, there should be additional flexibility to adapt Medicaid benefit packages to more closely reflect private insurance, to allow more tailor benefits based on need and ability, and to better integrate private insurance options into Medicaid.

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?

While some efforts are being pursued to ensure better eligibility verification, I have some concern with policies to streamline eligibility requirements within Medicaid. Such efforts may potentially save money, but may not be focused on vigorous 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?

The delay of the employer mandate is yet another indication that the Administration is not ready for implementation. The challenges facing this new system go beyond employer reporting requirements which will likely result in people being improperly enrolled, rejected and displaced throughout the whole ACA coverage network.