Responses to Questions for the Record
Medicaid at 50: Strengthening and Sustaining the Program
Hearing before the Health Subcommittee of the
Energy and Commerce Committee
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The Honorable Representative Pitts

Q1: Recently, the nonpartisan Congressional Budget Office formalized a policy to protect against conflicts of interests from their outside advisors (see: https://www. cbo. gov/about/objectivity/employee_policy). Obviously, MACPAC Commissioners are appointed because of their Medicaid and CHIP expertise and their experience representing stakeholder groups. However, given MACPAC's role as an independent source of information for Congress, similar protections against material or perceived financial or advocacy conflicts of interest may also be important for your Commissioners. In addition to the steps that GAO takes to assess potential conflicts of interest when appointing Commissioners, does MACPAC have other policies or standards for its Commissioners related to disclosing and preventing potential conflicts of interests?

a. If so, please describe the policies or standards, including those related to the appropriate role of Commissioners in doing related but outside work or advocacy regarding Medicaid?

b. If not, has MACPAC considered adopting conflict of interest standards? If this has been considered, please describe the Commission's plans.

A1: MACPAC's statutory language requires the Comptroller General of the U. S. to establish a system for public disclosure by members of MACPAC or financial and other potential conflicts of interest. In addition, Commission members are required to be treated as employees of Congress for the purposes of applying Title I of the Ethics in Government Act of 1978. As a result, Commissioners are required to disclose information on financial and other interests to GAO as part of the appointment process and annually thereafter. This disclosure includes information on earned income, assets and holdings, gifts and nonfederal travel reimbursement, liabilities, positions, and agreements or arrangements—requirements that are more expansive than those CBO requires of its advisors. Given the comprehensive nature of GAO's review, MACPAC has not adopted additional requirements.

Q2: MACPAC's work has reviewed some of the literature between low reimbursement rates and poor access for patients in Medicaid. Do you worry that, left unchecked, the easiest thing for legislatures to do to rein in Medicaid spending would be to cut reimbursement rates, which would have a direct negative impact on our most vulnerable patients?

A2: States have considerable flexibility under current law in the strategies they may employ to curtail Medicaid spending. These include reducing provider payments, limiting benefits,

and enrolling fewer people. None of these choices are easy and all have the potential, as you note, to have a negative impact on our most vulnerable patients.

Recently, states have been engaged in a variety of activities to re-engineer the delivery system with the goal of making it more efficient while maintaining or improving quality of care or health outcomes. Over the past year, MACPAC has been examining different approaches to value-based purchasing including the use of episode-based payments in Arkansas, accountable care organizations in Minnesota, and enhanced primary care case management in Oklahoma. We also recently published findings from a review of safety-net accountable care organizations for Medicaid enrollees. In our June 2105 report, we included a chapter on the role of delivery system reform incentive payments (DSRIPs) under certain states' Section 1115 demonstrations.

While there is considerable interest in the potential of these innovations to bend the cost curve, for the most part these initiatives are still too new to have yielded clear evidence of success. Over time, we hope to get clearer answers about which approaches lead to better outcomes while moderating spending, and we look forward to keeping you informed of our work in this area.

Q3: The Commission was created five years ago. What is the most recent funding level MACPAC received, and how many staff are currently employed there?

a. To my knowledge, the Commission does not produce annual reports that list its staff, budget, travel expenditures, overhead, research contracts, and other spending. So, in the interest of helping the Committee better understand how MACPAC is spending taxpayer dollars, would you please make some of that data available to the Committee?

A3: MACPAC submits an annual budget justification to the House and Senate Committees on Appropriations, in accordance with their requirements. We also make that information available to the staff of MACPAC's committees of jurisdiction, including the Committee on Energy and Commerce.

In fiscal year 2015, MACPAC received an appropriation of $7. 65 million. We have requested $8. 7 million for fiscal year 2016 in order to have sufficient resources for the growing demand for technical assistance to Congressional staff and to fulfill new Congressionally mandated requirements such as our upcoming report on disproportionate share hospital (DSH) payments.

Major categories of spending include staff salaries and benefits (56 percent), external contracts for research and data analysis (21 percent), general operations (17 percent), meetings (including commissioner travel) (3 percent), and commissioner stipends (3 percent). We have a staff of 28 including analysts with experience working in state and federal governments, private sector consulting, congressional support agencies, and academia. A complete list of MACPAC staff with biographical information is included in our statutorily mandated reports and is also available on our website at https://www.macpac.gov/about-macpac/commission-staff/

MACPAC staff would be pleased to brief you or your staff on our budget and staffing, or any aspect of MACPAC operations, in more detail at your convenience.

The Honorable Representative Bilirakis

Q1: When this Committee receives a policy recommendation from MedPAC, we routinely receive the Commission's best recommendation on accompanying policies to offset the recommendation. Does MACPAC have any timeframe to adopt a similar process, providing the Committee both with recommended policy AND a recommended offset?

A1: As the transcripts of our public meetings highlight, the Commission is extremely mindful of the federal and state budget effects when making recommendations to Congress. (Note: transcripts are available at https://www. macpac. gov/public_meeting/). Indeed, consistent with MACPAC's statutory language, the Commission must examine the budget consequences of proposed recommendations. Further, recommendations must be accompanied by a report of federal and state budget implications.

I would note that, according to the Congressional Budget Office, six of the twelve recommendations MACPAC has made have been estimated to have no federal budget effect. Many of the other recommendations have been estimated to have an extremely modest budget effect—the smallest non-zero category of spending used by CBO.

The Commission will continue to consider the federal and state budget effects of recommendations they propose and consider options to mitigate budget effects, if any.

The Honorable Representative Ellmers

Q1: I'm concerned that lack of access to appropriate care often times leads to more significant costs to beneficiaries and the program, especially those with chronic conditions such as diabetes. Have you examined the impact of access to care on cost, care needs and mortality?

A1: Issues of access have been a focus of MACPAC's work since we began our work, and of course the word "access" itself is part of the Commission's name. We have examined measures of access to care for children, nonelderly adults, and populations with a disability, with results published in its annual reports to the Congress and in presentations at our public meetings. See, for example:

- Examining Access to Care in Medicaid and CHIP (March 2011) https://www. macpac. gov/publication/ch-4-examining-access-to-care-in-medicaid-and-chip/

- Examining Access and Quality in Managed Care (June 2011) https://www. macpac. gov/publication/section-e-access-and-quality-in-managed-care/

- Access to Care for Children Enrolled in Medicaid and CHIP (March 2012)

https://www. macpac. gov/publication/ch-2-access-to-care-for-children-enrolled-in-medicaid-or-chip/

- Access to Care for Non-Elderly Adults (March 2012)
  https://www. macpac. gov/publication/section-b-access-to-care-for-non-elderly-adults/

- Access to Care for Persons with Disabilities (June 2013)
  https://www. macpac. gov/publication/ch-3-access-to-care-for-persons-with-disabilities/

- Medicaid Primary Care Physician Payment Increase (June 2013)
  https://www. macpac. gov/publication/ch-2-medicaid-primary-care-physician-payment-increase/

- Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care (March 2015)
  https://www. macpac. gov/publication/effects-of-medicaid-coverage-of-medicare-cost-sharing-on-access-to-care/

- Provider Networks and Access: Issues for Children's Coverage (March 2015)
  https://www. macpac. gov/publication/provider-networks-and-access-issues-for-childrens-coverage/

- Behavioral Health in the Medicaid Program—People, Use, and Expenditures (June 2015)
  https://www. macpac. gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/

In general, controlling for factors such as income, age and health status, persons enrolled in Medicaid do not differ substantially from those with private insurance in their use of health services. Medicaid enrollees have better access to medical care than those without health insurance, again controlling for many sociodemographic characteristics. Medicaid enrollees use more emergency room visits and have longer wait times than those who are privately insured, but fewer concerns over costs of care. After accounting for differing enrollee characteristics, children with Medicaid or CHIP and those with employer-sponsored insurance report similar rates of delayed medical care.

Because Medicaid populations are on average poorer and less healthy than privately insured populations, it is difficult to independently assess the effect of having Medicaid on health outcomes. Moreover, lack of available data make it difficult to assess the relationship between use of specific services and health outcomes associated with use of those services.

Looking at access to care at the national level does not answer the question of whether specific groups of Medicaid enrollees face barriers to accessing specific services. MACPAC's work plan for its 2016 reports includes additional analysis of access to care for specific

populations, including children, nonelderly adults, older adults, and persons with disabilities. We are particularly interested in learning whether Medicaid beneficiaries are using recommended services that have been shown to improve health outcomes, such as preventive screenings, dental care, and behavioral health care. We are also interested in learning how such use compares to privately insured persons in similar income and age groups. The Commission is also specifically interested in barriers to treatment for persons with behavioral health conditions and whether there are ways to organize the delivery of care, such as programs to integrate mental health and medical care, which have been shown to reduce expenditures and provide better outcomes.

Q2: Have you examined the published evidence of Medicaid patient access barriers to podiatrists and the experience of state Medicaid programs that have ensured access to podiatrists?

A2: States may, but are not required, to provide podiatry services under Medicaid programs. In addition, such services may be limited to specific populations or specific conditions. For example, in California, podiatry services are limited to pregnant women and institutionalized adults. Other limitations vary by type of service and include limits on the number of services covered per month (KFF 2015). In the state of Nevada, Medicaid only cover podiatry services for dually eligible Medicare and Medicaid enrollees and children who are referred based on screening (Nevada Department of Health and Human Services 2015).

Although MACPAC has not independently analyzed how coverage of podiatry services affects outcomes and costs, we are familiar with several recent studies demonstrating that podiatry services may reduce subsequent morbidity and mortality, particularly among persons with diabetes. A 2011study found that patients who visited a podiatric physician had $13,474 lower costs in commercial plans and $3,624 lower costs in Medicare plans during two-year follow-up (Carls et al. 2011). A study of Medicaid enrollee costs before and after the podiatric benefit was removed in the Arizona Medicaid program in 2009 found an increase in hospitalizations and costs among diabetic enrollees (Skrepnek et al. 2014).

References

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