

**Statement of
Anne L. Schwartz, Ph.D., Executive Director**

**Medicaid and CHIP
Payment and Access Commission**

**Before the
Subcommittee on Health
House Committee on Energy and Commerce**

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Summary

Medicaid is a major part of the U.S. health care system, covering 72 million people, almost half of the nation's births, and paying for more than 60 percent of long-term services and supports (LTSS), and more than a quarter of treatment for mental health and substance use disorders. It accounts for about 15 percent of national health spending, 8.6 percent of federal outlays, and 15.1 percent of state spending.

While we often compare Medicaid's performance with other sources of coverage, it is important to recognize its unique roles. It provides health insurance to individuals who otherwise may not have access to coverage and is a major source of revenue for safety net providers serving both Medicaid beneficiaries and the uninsured. It covers LTSS and enabling services which help beneficiaries access needed health services, and wraps around other sources of coverage, including employer-sponsored insurance and Medicare.

Since the early 1990s, the Medicaid program has changed in significant ways. During this time period, the country weathered two economic recessions. States responded by undertaking modernization efforts and cost containment strategies. Managed care is now the dominant delivery system with about half of all beneficiaries enrolled in comprehensive risk-based plans. The Olmstead decision requiring that persons with disabilities be served in the least restrictive environment resulted in a major shift in the provision of LTSS from nursing facilities to home and community-based settings. Congressional action in the 1990s broadened children's coverage through Medicaid and the State Children's Health Insurance Program (CHIP), and encouraged states to reach out to people eligible but not enrolled in coverage. More recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created new dynamics, allowing states to expand coverage to certain non-disabled adults, as well as providing new delivery system options to states and allowing for one-stop shopping for individuals seeking health care coverage.

The 20 years ahead are likely to be similarly dynamic as states experiment with new approaches to delivery system design and provider payment, and seek to provide care more effectively and efficiently for high-cost, high-need individuals, such as those with behavioral health conditions and beneficiaries who are dually eligible for Medicare and Medicaid. Pressure on federal and state budgets create challenges to ensuring both the sustainability of the program and that beneficiaries have access to high-value services that promote their health and ability to function in their communities.

MACPAC's analytic agenda for the year ahead reflects these challenges. We will extend our work on Medicaid's role for people with behavioral health disorders, focusing on how to improve the delivery of care. We will continue to focus on understanding the impact of value-based purchasing initiatives and the extent to which these bend the cost curve and improve health. In the area of access, we will examine how to effectively measure access, the extent to which different groups of beneficiaries are at risk of access barriers, and the extent to which such barriers can be addressed through Medicaid policy. Our analyses on the impact of the ACA will, as required by Congress, model the impact of disproportionate share hospital payment reductions. At the request of members of this committee and others in Congress, we will analyze and evaluate various policy options to restructure the program's financing. We will move to the next chapter in our work on children's coverage, looking ahead to recommend policies to assure adequate and affordable coverage for low- and moderate income children before CHIP funding expires in FY 2017. Finally we will continue to highlight the importance of having appropriate data for both policy analysis and program accountability. MACPAC has also commented on administrative capacity constraints that affect the ability of federal and state administrators to meet program requirements, provide oversight, promote value, and integrate Medicaid and CHIP into broader delivery system and financing reforms.



Statement of Anne L. Schwartz, Ph.D., Executive Director

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Green, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission.

As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and State Children's Health Insurance Program (CHIP) policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on issues affecting these programs. Its 17 members, led by Chair Diane Rowland and Vice Chair Marsha Gold, are appointed by the U.S. Government Accountability Office. The insights and expertise I will share this morning reflect the consensus views of the Commission itself. We appreciate the opportunity to share MACPAC's recommendations and work as this committee considers the future of Medicaid.

Medicaid is a major and important part of the U.S. health care system, covering 72 million people in fiscal year (FY) 2013, more than 20 percent of the U.S. population. The program covers almost half of the nation's births, pays for more than 60 percent of national spending on long-term services and supports (LTSS) to frail elders and other people with disabilities, and accounts for more than a quarter of national spending on treatment for mental health and substance use disorders. In total, it accounts for about 15 percent of national health expenditures, 8.6 percent of federal outlays, and 15.1 percent of spending from state-funded budgets, including state general funds, bonds, and other state funds (which for Medicaid includes provider taxes and local funds that flow through the



state budget). It should be noted that while Medicaid has grown as a share of the federal budget, increasing from 1.4 percent of federal outlays in FY 1970 to 8.6 percent in FY 2014, annual growth in Medicaid spending per enrollee has been lower or comparable to Medicare and private insurance since the early 1990s.

While we often compare Medicaid's performance as a payer with other sources of coverage, such as Medicare and employer-sponsored insurance, it is important to recognize Medicaid's unique roles. In addition to providing health insurance to individuals who otherwise may not have access to coverage, it is also a major source of revenue for safety net providers serving both Medicaid beneficiaries and those without insurance. It covers enabling services such as non-emergency transportation and translation services that help beneficiaries access needed health services. Moreover, it wraps around other sources of coverage, including both employer-sponsored insurance and Medicare in its role for 10.7 million dually eligible beneficiaries. Notably, despite the fact that Medicare is the major source of medical coverage for the nation's elderly, it does not cover LTSS. For those in need of long-term care, Medicaid coverage for ongoing nursing facility or other institutional arrangements, home health, personal care, and other home and community-based services (HCBS) is vital to their daily lives.

Looking Back

Since the early 1990s, the Medicaid program has changed in significant ways. During this time period, the country weathered two economic recessions. States responded to budgetary pressures by undertaking modernization efforts and cost containment strategies. As a result, the program has moved from a traditional fee-for-service model to one in which managed care has become the dominant delivery system. More than half of all beneficiaries are now enrolled in comprehensive risk-based plans, and another 20 percent receive some of their benefits



through a non-comprehensive managed care arrangement, including primary care case management and limited benefit plans. While initially managed care covered primarily children and their mothers, increasingly managed care is being extended to populations with more complex health needs. Managed care is also transforming the delivery of long-term services and supports. In 2004, just eight states had managed LTSS programs. By the end of this year, more than half of the states are expected to be using managed care models for such services.

The Supreme Court's 1999 decision in *Olmstead v. L.C.* requiring that persons with disabilities be served in the least restrictive environment resulted in a major shift in the provision of long-term services and supports from nursing facilities to home and community-based settings. In FY 1995, 18 percent of Medicaid LTSS spending occurred in a non-institutional setting; by FY 2012, the figure had risen to nearly half.

In the 1990s, congressional action broadened children's coverage through Medicaid and CHIP, and encouraged states to reach out to people eligible but not enrolled in coverage. These actions substantially reduced the share of children without health insurance. In 1997, 22.4 percent of children below the federal poverty level and 22.8 percent of those with family incomes between 100 and 200 percent FPL were uninsured. By 2014, these percentages had dropped to 6.9 percent and 8.9 percent respectively.

More recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created new dynamics, allowing states to expand coverage to previously ineligible childless adults and parents. Twenty nine states and the District of Columbia have now expanded their programs, and other states are examining their options. Streamlined eligibility and enrollment processes, including the adoption of modified adjusted gross income (MAGI) as the standard for income determinations, now allow for one-stop shopping for individuals



seeking health care coverage. The law also created new options for states for delivery of HCBS, including the Community First Choice program for individuals who are eligible for Medicaid and have incomes below 150 percent FPL but who may not meet institutional level-of-care criteria, or those with such needs whose incomes exceed 150 percent FPL, the Health Homes option, extension and modification of the Money Follows the Person demonstration, and establishment of the state Balancing Incentive Payments program.

Looking Ahead

The 20 years ahead are likely to be similarly dynamic as states experiment with different approaches to delivery system design and payment, including the delivery system reform incentive payment (DSRIP) programs described in MACPAC's June 2015 report to Congress. States are also seeking to provide care more effectively and efficiently for high-cost, high-need individuals such as those with behavioral health conditions and beneficiaries dually eligible for Medicare and Medicaid, also the subject of analysis in our 2015 reports.

Pressure on federal and state budgets creates challenges to ensuring the sustainability of the program and making certain that beneficiaries have access to high-value services that promote their health and ability to function in their communities. These challenges are not unique to Medicaid. Between FY 2014 and FY 2022, annual growth in Medicaid spending per enrollee is projected to average about 4 percent, similar to the rate for Medicare and lower than the rate for private insurance.

MACPAC's Agenda



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MACPAC's analytic agenda for the year ahead reflects several of these challenges. We will extend the work published in our June report on Medicaid's role for people with behavioral health disorders, focusing on how to improve the delivery of care and better understand models of integration for various subpopulations such as those with serious mental illness. We will also continue to focus on the impact of value-based purchasing initiatives including accountable care organizations, bundled payments, and patient-centered medical homes, and the extent to which these bend the cost curve and improve health.

In the area of access, we will be strengthening and extending our longstanding efforts to measure access to care, an issue now more salient than ever given the Supreme Court's decision in *Armstrong v. Exceptional Child Center* which will put new pressures on the federal government to ensure that Medicaid payment rates are sufficient to ensure access comparable to that of the general population. In addition, we will be examining more closely the extent to which different groups of Medicaid beneficiaries are at risk of access barriers and for which services (for example, specialty care) and the extent to which such barriers can be effectively addressed through Medicaid policy.

Our analyses on the impact of the ACA will include a major effort, as required by Congress, to model the impact of disproportionate share hospital (DSH) payment reductions. Our first report examining the impact that such changes will have on hospitals is due February 1st of next year. In addition, building on our March 2015 report chapter examining premium assistance models in Arkansas and Iowa, we will be also be considering how different approaches to Medicaid expansion affect expenditures and use of services.



At the request of members of this committee and others in Congress, we will analyze and evaluate various policy options to restructure the program's financing. We will be moving to the next chapter in our work on children's coverage, looking ahead to recommend what policies should be in place to assure adequate and affordable coverage for low- and moderate-income children before CHIP funding expires in FY 2017.

Finally we will continue to highlight the importance of having appropriate data available for both policy analysis and program accountability. Since its inaugural report to Congress in March 2011, the Commission has continually called for improvements in the timeliness, quality, and availability of administrative data on Medicaid and CHIP, noting the importance of these data in answering key policy and operational questions that affect beneficiaries, providers, states, and the federal government. As noted in our June 2013 report, given that plans to modernize federal data systems currently rely on a patchwork of program integrity, quality measurement, health information technology, and CHIP reauthorization funds, the Commission is concerned whether available resources are sufficient for this purpose.

MACPAC has also commented on administrative capacity constraints at the federal and state levels that affect the ability to meet program requirements, provide oversight, and take on broader delivery system reforms that promote value and contain costs. As noted in the Commission's June 2014 report, there are few clear performance standards or metrics to assess state capacity, identify gaps in performance, prioritize investments, and identify appropriate responses. This is an area where we plan to work with state officials and experts in performance management to shed light on promising approaches.



Again, thank you for this opportunity to share the Commission's work with this subcommittee and I am happy to answer any questions.

