Congress of the United States

Washington, DC 20510

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Diane Rowland, Sc.D.
MACPAC
1800 M Street NW
Suite 650 South
Washington, DC 20036

Marsha Gold, Sc.D.
MACPAC
1800 M Street NW
Suite 650 South
Washington, DC 20036

Dear Chair Rowland and Vice Chair Gold,

First and foremost, we would like to thank you for your commitment to Medicaid and the Children's Health Insurance Program (CHIP). The benefit of having a group of independent, dedicated, and diverse experts working to identify opportunities to improve and safeguard Medicaid and CHIP is immeasurable.

MACPAC was established as an independent, nonpartisan commission tasked with providing impartial, evidence-based feedback and recommendations to Congress. In light of a recent letter sent by Chairmen in the House and Senate expressing their interests in MACPAC's future work, we—as Ranking Members of the relevant Committees of jurisdiction—would like to join our colleagues in expressing areas of interest in Medicaid and CHIP to ensure MACPAC has a current, comprehensive and holistic perspective of Congressional priorities.

Over 70 million low-income Americans rely on Medicaid, a joint federal-state program, for comprehensive, affordable health insurance. The Medicaid program has served as a critical safety net for the American public since its creation in 1965, fifty years ago this July. The program is a lifeline for millions of children, pregnant women, people with disabilities, and seniors alike—covering more than one in three children, paying for nearly half of all births, accounting for 40 percent of the nation's total costs for long-term care, covering one in five Medicare beneficiaries, and financing a quarter of all behavioral health services in the United States. Yet, ongoing attacks regarding the structure and financing of Medicaid have made it increasingly difficult to engage in productive conversations about the future of the program.

There is no question that health care spending growth in the United States is an issue that needs to be addressed. Fortunately, since the enactment of the Affordable Care Act (ACA), the overall rate of health care spending growth has slowed reducing projected growth in the Medicaid programs by hundreds of billions of dollars over ten years primarily because of lower than expected growth in costs per Medicaid enrollee. We continue to remain committed to building on the gains made by the ACA, and ensuring taxpayers get the best value for their dollar, now and into the future.

According to the Congressional Budget Office (CBO), in 2012[1], total spending for health care in the United States amounted to about $2.6 trillion, or 16.2 percent of the nation's GDP, with federal spending for Medicare accounting for 22 percent of total expenditures and federal and state spending for Medicaid and CHIP making up 16 percent. We appreciate that when it comes to Medicaid expansion, in the short run, CBO projects spending to increase due to many previously uninsured low-income adults gaining coverage. However, it is also important to recognize that CBO projects Medicaid spending growth to revert to its historical average after this initial ramp up period and that per-beneficiary growth rates will remain modest over the next 10 years. In addition, when employing a holistic lens, one can readily see the short and long-term benefits of Medicaid expansion reverberate throughout the health care system. For example, hospital uncompensated care costs were reduced by $5 billion in Medicaid expansion states in 2014 alone compared to half that in non-expansion states.[2]

Medicaid is a very efficient program, covering the average enrollee at a lower cost with more comprehensive benefits and significantly lower cost-sharing than private insurance. While the federal government can do more to leverage Medicaid dollars to move from paying for volume to value, build system capacity, and extend innovative strategies across Medicaid and throughout the health care system, we are concerned by partisan efforts aimed at undermining this critical entitlement. Accordingly, as a non-partisan, independent commission, tasked with the responsibility to submit reports and make recommendations to Congress on issues related to Medicaid and CHIP, we ask for MACPAC's analytical support in the following areas:

1. Impact of Financing Reforms: MACPAC has been asked to examine a number of financing reforms focused on spending caps including block grants and per capita cap proposals and options related to transitioning Medicaid to a capped allotment financing structure. We are very concerned by such radical attempts to undermine the program, shift costs to states, and harm enrollees and providers. Accordingly, we ask for MACPAC's analysis of the quantitative and qualitative impact of such fundamental financing changes on states, enrollees, and health care providers and plans. Specifically, we ask for MACPAC's help in measuring the likely impact on state budgets and likely corresponding state actions and the impact on enrollment, benefits, cost-sharing, access to care, provider rates and participation, uncompensated care, and overall uninsured rates among low-income Americans. In this same vein, we would also appreciate more in-depth analyses on targeted financing strategies that undermine the mission of the Medicaid program and fail to improve access to care or improve health outcomes such as work requirements for eligible individuals, waivers of non-emergency medical transportation, lockout periods, and increases in enrollee premiums and cost-sharing for emergency and non-emergency services.

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[1] 2012 was the most recent year for which such data were available according to CBO's latest long-term budget outlook. Congressional Budget Office, *The 2014 Long-Term Budget Outlook*, July 2014, at 25.

[2] *See* U.S. Dep't of Health & Human Servs., Office of the Assistant Sec'y for Planning and Evaluation, *Economic Impact of the Medicaid Expansion*, Mar. 23, 2015 ($5.0 billion in expansions states compared to $2.4 billion in non-expansion states).

2. Innovation: A number of state Medicaid programs are leaders in health system innovation. However, we think more can be done to leverage state-level innovation and expand and disseminate state innovations across Medicaid and throughout the health care system. Accordingly, we appreciate MACPAC's support in identifying successful state strategies and demonstration projects through waivers, CMMI demonstrations, and other initiatives that are leading to improved outcomes and decreased costs. For example, states are already undertaking productive efforts to promote work, reduce use of emergency rooms for non-emergent care, and improve coordinated care for people with disabilities and chronic conditions. We also ask for MACPAC's assistance with identifying avenues through which other states and health care systems can employ and replicate such innovations, and examining the role the federal government can play in supporting the diffusion of Medicaid innovation.

3. Chronic Illness and Long-Term Care: It is clear that over the last few decades Medicaid has become the default long-term care system in the United States with 60 percent of nursing home residents covered by the program. In addition, this role is expected to increase with the aging baby boomer population. We are interested in learning more about how Medicaid can use its limited resources to serve this growing population, and examining other resources that may be necessary to meet the needs of our elderly and frail seniors requiring long-term services and supports. We are also focused on how we can support federal and state rebalancing efforts and move away from institutional care toward home and community-based settings for elderly and disabled enrollees alike.

4. Access and Provider Payment Rates: Studies continue to show that provider payment rates can impact access to care for Medicaid enrollees.[3] At the same time, we have seen the expiration of the ACA's Medicaid primary care provider payment increase and the United States Supreme Court ruling that health care providers cannot enforce the Medicaid's Acts payment provision, 42 U.S.C. § 1396a(a)(30)(A), against states in federal court. *See Armstrong v. Exceptional Child*, 135 S. Ct. 1378 (2014). We would like MACPAC's assistance in identifying options through which the federal government can help ensure appropriate provider payment and equal access to care for Medicaid enrollees. We also ask for MACPAC's assistance in identifying policies and practices through which state Medicaid programs can move from paying for volume to value to improve enrollee access and quality of care.

5. Access to- and Integration of- Behavioral Health: In general, Medicaid coverage of mental health services is more expansive than commercial or Medicare with Medicaid, now covering a quarter of all behavioral health services in the United States. We expect the role of Medicaid in the behavioral health space to increase even

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[3] *See, e.g.*, THE COMMONWEALTH FUND, IMPROVING ACCESS TO SPECIALTY CARE FOR MEDICAID PATIENTS: POLICY ISSUES AND OPTIONS (June 2013); NATIONAL ACADEMY FOR STATE HEALTH POLICY, THE EFFECTS OF MEDICAID REIMBURSEMENT RATES ON ACCESS TO DENTAL CARE (Mar. 2008).

further with the recently proposed Medicaid Mental Health Parity regulation and the increase in newly insured adults with disproportionally high mental and behavioral health needs. We are also concerned about the alarming number of children in Medicaid, especially foster youth, prescribed psychotropic medications. Accordingly, we appreciate MACPAC's assistance in identifying barriers and potential options to address enrollee access to quality behavioral healthcare including provider participation, medication management, facility exclusions, and information sharing restrictions. We would also like more information on how the federal government can work to support the integration of behavioral health with physical health to ensure enrollees receive quality, coordinated, integrated care across the care continuum.

6. Data and Transparency: Finally, in order to truly assess the program, we need quality, timely, accurate, and comprehensive data. We appreciate MACPAC's previous work in this space and hope to see more work in this arena soon. The ongoing implementation of T-MSIS is a good first step, but we still have a long way to go. For example, there is insufficient encounter and quality data to allow the federal government to fully assess the program. Transparency around waivers, including covered benefits and services, is also an issue making it difficult for enrollees, providers, and others to access the full scope of their rights under the program while also limiting the ability of other states to learn from waiver successes. Consequently, we ask for MACPAC's help in identifying data gaps and policies to address administrative, capacity, and technical constraints in the program. We would like to learn more about how Medicaid data can be used to improve transparency and the quality of the program. We would also appreciate MACPAC's assistance in identifying tools and policies the federal government may employ to encourage and oversee the reporting of state-level data.

We recognize this is a diverse list of topics and appreciate these issues will take time fully and fairly to evaluate and analyze. We are also confident in MACPAC's ability independently and expertly to address these issues in future reports and recommendations to Congress. Thank you again for your dedicated to Medicaid and CHIP and the 70 plus million Americans they serve.

Sincerely,

Ron Wyden
Ranking Member
Senate Finance Committee

Frank Pallone, Jr.
Ranking Member
House Committee on Energy & Commerce

Debbie Stabenow
Ranking Member
Subcommittee on Health Care
Senate Finance Committee

Gene Green
Ranking Member
Subcommittee on Health
House Committee on Energy & Commerce

CC: Anne Schwartz, PhD, Executive Director, MACPAC