Highlights of the MACPAC June 2015 Report to Congress on Medicaid and CHIP

Overview

The Medicaid and CHIP Payment and Access Commission (MACPAC) submitted its June 2015 Report to Congress on Medicaid and CHIP on June 15th. The June report, the second and final statutorily-required report this year, begins with a discussion of Delivery System Reform Incentive Payment (DSRIP) programs and continues with chapters on access to dental care and services for Medicaid-covered adults, Medicaid's role in providing access to health care for certain vulnerable populations (e.g. low-income children served by the child welfare system), and, in closing, focuses on the use of psychotropic medications among Medicaid beneficiaries. What follows below are summaries, the key points, and arguments of each chapter in the June 2015 Report.

Chapter 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform

In this chapter, MACPAC explores a new type of Medicaid supplemental payment to "sustain safety-net providers in their communities," or the DSRIP programs, which operate under Section 1115 waiver authority. To date, six states have received CMS approval to implement a DSRIP program: California (2010), Massachusetts (2011), Texas (2012), Kansas (2013), New Jersey (2014), and New York (2014). MACPAC, in collaboration with the National Academy for State Health Policy, conducted a series of interviews with state and federal officials, including site visits to selected states, revealing that many states currently view DSRIP as a form of supplemental payment as opposed to CMS's view of the program as an approach to transform the overall Medicaid delivery system. MACPAC believes "DSRIP programs would benefit from clear and consistent federal guidance to promote more effective oversight." MACPAC will continue to analyze DSRIP in the context of broader delivery system transformation, the role of Medicaid in such transformation, and Medicaid supplemental payments, ultimately hoping to understand DSRIP's effectiveness and how programs are being implemented in states.

Key Findings:

- MACPAC defines DSRIP as "financing mechanisms for states to make supplemental payments that would otherwise not be permitted under federal managed care rules and as tools for states to invest in provider-led projects designed to advance statewide delivery system reform goals."
- States faced many challenges in implementing DSRIP programs, including finding a source of non-federal share to finance the program. Aggregate data demonstrating improved health outcomes or cost savings in addition to program evaluations are not yet available and/or are challenging.
- In the six states that have received approval to implement DSRIP, in 2015, up to $3.6 billion in federal DSRIP funds are projected to be available to eligible providers, which are mostly limited to hospitals, though some states include physician groups and community mental health centers, for example.

Chapter 2: Medicaid Coverage of Dental Benefits for Adults

MACPAC, in this chapter, discusses dental benefits for Medicaid-covered adults and why access to regular dental care is challenging for many adult Medicaid beneficiaries across the country. Federal law does not mandate minimum dental coverage for adult Medicaid beneficiaries, and according to MACPAC's analysis, substantial variation exists among Medicaid dental benefits and services provided to beneficiaries across state Medicaid programs. For example, the report finds that in 2015 for non-pregnant, non-disabled adults, 15 states covered 5 or more dental services, 17 states covered 1 to 4 services, and 18 states only offered emergency dental services or covered no dental services. MACPAC plans to study Medicaid enrollee use of the emergency room for dental services and adequacy of the dental workforce in addition to sites of care for the Medicaid population.

Key Findings:

- Adults with incomes below 100 percent of the federal poverty level (FPL) are three times more likely to have untreated dental caries – commonly known as cavities – than adults with incomes above 400 percent FPL.

- Thirty-seven percent of adults age 65 and older with incomes below 100 percent FPL had complete tooth loss compared to 16 percent of those with incomes at or above 200 percent FPL.
- Medicaid programs are required to cover dental services for children and youth under age 21 but there are no minimum coverage requirements for adults. As a result, adult dental benefits vary widely across states. For example, as of February 2015:
    - 19 states provided emergency-only adult dental benefits for non-pregnant, non-disabled adults; 27 states covered preventive services; 26 states covered restorative services; 19 states covered periodontal services; 25 states covered dentures; 25 states covered oral surgery; 2 states covered orthodontia, and; 9 states placed an annual dollar limit on covered dental services.

Chapter 3: The Intersection of Medicaid and Child Welfare

In the third chapter of the June report, MACPAC analyzes the relationship between low-income children served by both Medicaid and the child welfare system. Child welfare-involved children and youth are eligible for Medicaid if they receive child welfare assistance or have low family incomes. Additionally, children enrolled in Title IV-E programs such as foster care or guardianship assistance are automatically eligible for Medicaid. All Medicaid children under age 21, regardless of their status, have access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. MACPAC "supports continued federal oversight and guidance in this area and encourages states to evaluate how Medicaid policy changes could help to improve the health and well-being of child welfare-involved children and youth." MACPAC also showcased several policy issues, including concerns around the implementation of the new pathway to Medicaid eligibility for youth that have aged out of the child welfare system, the complexity of coordination and collaboration among services between child welfare agencies and state Medicaid programs, as well as financing and data sharing.

Key Findings:

- In Fiscal Year (FY) 2011, MACPAC found that nearly 1 million children were eligible for Medicaid based on their receipt of child welfare assistance. Children eligible for Medicaid based on their receipt of child welfare assistance account for less than 1% of all Medicaid enrollees and about 3% of all children enrolled on a basis other than disability.
- Children served by both Medicaid and the child welfare system have significant health, behavioral, and social needs and often require more complex and specialized services to meet those needs.
- Spending on Medicaid benefits for children enrolled based on child welfare assistance totaled $5.8 billion in FY 2010, or about 2% of benefit spending for all enrollees and 9% of spending for non-disabled children.
- In 2010, the share of children eligible for Medicaid on the basis of foster care assistance who used any type of Medicaid service was 89.3%, which is comparable to the 85% share of other children enrolled in Medicaid, though the amount and type of services used differ significantly.

Chapter 4: Behavioral Health in the Medicaid Program – People, Use, and Expenditures

MACPAC, in this chapter, highlights the critical role played by Medicaid in serving beneficiaries with behavioral health diagnoses. MACPAC analyzed the prevalence of behavioral health conditions, the enrollee use of health services, and expenditures for these services. Medicaid, MACPAC notes, is the single largest payer of behavioral health services in the country, and approximately one-in-five Medicaid beneficiaries has a behavioral health condition, for whom services accounted for almost half of all Medicaid spending in 2011. The chapter represents MACPAC's first of many inquiries into how Medicaid pays for and delivers behavioral health services.

Key Findings:

- Medicaid beneficiaries enrolled on a basis other than disability still have unmet needs for behavioral health screening, treatment, and referrals. Early intervention and treatment could help delay or prevent loss of function and allow beneficiaries to manage problems before they become disabling.

- In 2011, more than 4 million of the 29 million children and youth under age 21 who were enrolled in the Medicaid program had a diagnosis of a behavioral health condition.
- About half of non-dually eligible enrollees under age 65 (including children) who qualified for Medicaid on the basis of disability had a behavioral health diagnosis in 2011. This population's expenditures accounted for approximately two-thirds of total Medicaid spending.
- Among adults not dually eligible for Medicare and Medicaid, about 3.8 million adult Medicaid enrollees had a behavioral health diagnosis in 2011.
- Adult Medicaid enrollees not dually enrolled in Medicare and Medicaid with behavioral health diagnoses were considerably more likely to have a number of concurrent chronic medical conditions than adult enrollees with no behavioral health diagnosis, regardless of eligibility basis.
- About 20 percent of the full-benefit Medicaid enrollees that MACPAC identified as having a behavioral health condition using Medicaid data alone also qualify for Medicare.

Chapter 5: Use of Psychotropic Medications among Medicaid Beneficiaries

In the last chapter of the June report, MACPAC highlighted the extent to which Medicaid beneficiaries are receiving prescriptions for psychotropic medications, which play a key role in treatment for enrollees with behavioral health conditions. Considering the risk associated with such drugs, MACPAC is concerned about the high rate of psychotropic medication use (and therefore, also spending) in Medicaid, especially for children in the child welfare system and older adults. MACPAC notes that psychotropic medications accounted for 18% of all fee-for-service (FFS) and managed care Medicaid drug claims and 30% of overall FFS Medicaid drug expenditures in 2011 prior to the application of drug rebates. MACP discussed ongoing federal and state activities to ensure proper use of psychotropic medications, including numerous CMS initiatives and prior authorization, utilization management, and education efforts. MACPAC, in preparation for future chapters and analysis, will continue to focus on issues relating to the use of psychotropic medications by Medicaid beneficiaries, including whether providers are appropriately prescribing such medications.

Key Findings:

- About 14% of Medicaid beneficiaries used a psychotropic medication during calendar year 2011. In 2011, Medicaid spent about $8 billion in FFS for psychotropic medications, or about 30% of the program's total FFS drug spending.
- Almost half of children and adults who qualified for Medicaid on the basis of disability used psychotropic medications. Although such individuals accounted for about 10% of Medicaid enrollees, they accounted for more than 50% of the psychotropic drug claims and 60% of FFS spending on these medications.
- Nearly 25% of children eligible based on child welfare assistance used a psychotropic medication, almost five times the rate of children eligible on a basis other than disability or child welfare assistance.

Viohl & Associates will continue to monitor, analyze, influence, and report on the work of MACPAC. Please let us know if you have any questions, concerns, or would like to discuss further.