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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

July 7, 2015

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Medicaid at 50: Strengthening and Sustaining the Program"

On Wednesday, July 8, 2015 at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Medicaid at 50: Strengthening and Sustaining the Program."

This month marks the 50th Anniversary of the passage of the Medicare and Medicaid programs. The hearing will take a broad look at the past, present, and future trends in the Medicaid program. Witnesses from the Centers for Medicare and Medicaid Services, U.S. Government Accountability Office, and Medicaid and CHIP Payment and Access Commission will testify.

I. BACKGROUND

Established along with Medicare by the Social Security Amendments of 1965, Medicaid today covers more than 71 million Americans.[1] Medicaid plays a significant role for children, the disabled, and the elderly. Most Medicaid enrollees are children, but a majority of Medicaid spending is for the elderly and people with disabilities. In contrast, spending on parents and non-elderly childless adults represents a much smaller proportion of the program; states have historically provided more restrictive eligibility for parents than for children, and prior to passage of the Affordable Care Act (ACA), nondisabled childless adults under age 65 were categorically excluded from Medicaid by federal law.

[1] Nearly 71.1 million individuals were enrolled in Medicaid and CHIP in March 2015. This enrollment count is point-in-time (on the last day of the month) and includes all enrollees in the Medicaid and CHIP programs who are receiving a comprehensive benefit package (online at http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/2015-march-enrollment-report.pdf0).

The Medicaid program finances nearly half of all births nationwide, and covers more than 1 in 3 (33 million) children. In fact, 75 percent of children living below the poverty line are covered by Medicaid.[2]

The Medicaid program is also a critical component of care for seniors; 1 in every 7 elderly Medicare beneficiaries are also Medicaid beneficiaries.[3] For the elderly and those with disabilities, Medicaid plays a particularly important role.[4] In FY 2012, elderly and disabled enrollees accounted for 21 percent and 42 percent, respectively of Medicaid expenditures. And, 200,000 additional enrollees aged 65 or older signed up for Medicaid from 2014–2015.[5] Medicaid is also the primary payer of long term services and supports (LTSS), which represented slightly more than half (51 percent) of total national LTSS spending in 2013.[6]

The Medicaid program is the second-largest item in state budgets, after elementary and secondary education, and the third-largest federal domestic program, after Social Security and Medicare. In FY 2014, combined state and federal Medicaid spending totaled $494 billion; the federal government paid $299 billion (about 61 percent of that total), which was the largest share of federal funds made to the states.[7]

Medicaid's hybrid structure, which involves a mix of federal and state financing and control, is in many respects the defining feature of the Medicaid program. States must follow broad federal rules in order to receive federal matching funds, but they have flexibility to design their own version of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs regarding who and what services are covered and how those services are provided and paid for.

Each state has a Medicaid state plan that outlines Medicaid eligibility standards, provider requirements, reimbursement methods, and health benefit packages among other program design criteria; however, a number of these requirements can be waived, per the approval of the Secretary

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[2] Kaiser Family Foundation, *Medicaid at 50* (May 6, 2015) (online at http://kff.org/medicaid/report/medicaid-at-50/).

[3] *Id.*

[4] HHS, FY2016 Budget in Brief: CMS Medicaid Services (online at http://www.hhs.gov/about/budget/budget-in- brief/cms/medicaid/index.html#services).

[5] *Id.*

[6] Kaiser Family Foundation, *Medicaid and Long-Term Services and Supports: A Primer* (May 8, 2015) (online at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/).

[7] Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid – CBO' s March 2015 Baseline* (March 9, 2015).

of the U.S Department of Health and Human Services (HHS). As such, Medicaid authorizes several waiver and demonstration authorities to provide states with the flexibility to operate their Medicaid programs. Under the various waiver authorities, states may try new or different approaches to the delivery of health care services, or adapt their programs to the special needs of particular geographic areas or groups of Medicaid enrollees.

States incur Medicaid costs by making payments to service providers (e.g., for doctor visits) and performing administrative activities (e.g. making eligibility determinations), and the federal government reimburses states for a share of these costs. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).[8] The FMAP varies by state and is inversely related to each state's per capita income. For FY2015, FMAP rates range from 50 percent (13 states) to 74 percent (Mississippi).

Medicaid is a highly efficient program. Medicaid's costs per beneficiary are substantially lower than for private insurance and have been growing more slowly than per- beneficiary costs under private employer coverage. A recent analysis of Medicaid expenditure data shows that in 2005, for people with similar health status, Medicaid cost 27 percent less for children and 20 percent less for adults than private insurance.[9] Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. And over the past decade, costs per beneficiary grew much slower for Medicaid than for employer-sponsored insurance. Medicaid also is expected to grow no more rapidly through 2023 than spending per beneficiary for people with private insurance. Moreover, the Congressional Budget Office (CBO) now projects that Medicaid spending between 2011 and 2020 will be $335 billion, which is 10 percent lower than what the Office projected in August 2010, largely due to slower expected growth in per-beneficiary costs.[10]

A. Medicaid and Managed Care

Approximately 70 percent of Medicaid enrollees are served through managed care delivery systems.[11] Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between managed care organizations (MCOs)

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[8] *See* CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell; For more information about the FMAP rate (overview of Medicaid financing issues).; CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014* (further explanation on and information about FMAP rate).

[9] *See* Medicaid is Cost Effective, June 15, 2015 (online at http://medicaid.gov/medicaid-50th-anniversary/overall-medicaid/overview-medicaid-anniversary.html).

[10] *See* Center on Budget and Policy Priorities, *Frequently Asked Questions About Medicaid*. (Updated June 29, 2015) (online at http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid).

[11] *See* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html (information on Medicaid managed care, individual state profiles, and a summary of key Medicaid managed care regulations).

and state Medicaid agencies. MCOs accept a set per-member, per-month (capitation) payment for these services. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

On May 26, 2015, CMS released the first comprehensive proposed regulatory guidance for Medicaid and CHIP managed care in more than a decade. The proposed rule would make a number of changes designed to align Medicaid managed care operating standards with those used in other markets. In particular, the regulation proposes to align appeals and grievances standards with those used in Medicare and the health insurance marketplaces, institutes a Medical Loss Ratio (MLR), mitigates the Medicaid IMD (Institutions for Mental Disease), exclusion, puts new standards in place for calculations of actuarial soundness, and provides a number of consumer protections around prescription drug access and long-term care services and supports (LTSS).[12]

II. AFFORDABLE CARE ACT

The Affordable Care Act (ACA) made significant changes to Medicaid. While Medicaid expansion is the most well-known reform, the ACA also included extensive Medicaid provisions related to program integrity and transparency, and delivery system reform – particularly in long-term care. These reforms and other major ACA Medicaid provisions are summarized below.

A. Medicaid Expansion and Enrollment

Historically, Medicaid eligibility has been limited generally to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. As of January 1, 2014, however, states have enjoyed the option to extend Medicaid coverage to most nonelderly, low-income individuals. The ACA established 133 percent of the federal poverty level (FPL) (effectively 138 percent of FPL with an income disregard of 5 percent of FPL) as the new mandatory minimum Medicaid income eligibility level for most nonelderly individuals.

Twenty-nine states, at present, have opted to expand Medicaid, with several additional states at various stages of debating an expansion.[13] On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, effectively making ACA Medicaid expansion optional for states.

Most states have expanded Medicaid through a traditional expansion of their state's Medicaid program, but a handful of states have implemented their expansions through 1115

[12] *Id.*

[13] *See* http://www.cbpp.org/health-reforms-medicaid-expansion for more information on individual state expansions.

waivers.

The ACA provided enhanced federal Medicaid matching rates for the individuals who receive Medicaid coverage through the ACA Medicaid expansion. The ACA added two FMAP exceptions called the "newly eligible" FMAP rate and the "expansion state" FMAP rate. States receive 100 percent FMAP rate (i.e., full federal financing) for the cost of providing Medicaid coverage to "newly eligible" individuals, from 2014 through 2016. For "newly eligible" individuals, the FMAP rate will phase down to 95 percent in 2017, 94 percent in 2018, 93percent in 2019, and 90percent afterward. The FMAP rate per year is set by law, so a state that expands in 2017, for instance, will have missed the 100 percent FMAP rate time period.

The Congressional Budget Office (CBO) estimates that ACA insurance coverage provisions will increase Medicaid and CHIP enrollment of nonelderly individuals by 14 million in FY2025.[14] A vast majority of the increase in enrollment for Medicaid and CHIP is due to the ACA Medicaid expansion. Projected enrollment increases will also be driven by other ACA reforms, such as the expansion of Medicaid eligibility for foster care children and children ages six to 18.

The federal government will cover an overwhelming percentage (94 percent) of the costs that CBO attributes to the ACA's Medicaid and CHIP insurance coverage provisions. CBO estimates these provisions will increase federal Medicaid and CHIP outlays by a total of $847 billion from FY2016 through FY2025, while states' cost of these provisions is estimated to be $46 billion over the same period of time.[15]

B. Program Integrity and Transparency

The ACA included a number of provisions with the objective of strengthening Medicaid program integrity. Some of the most important provisions shift the traditional "pay and chase" model to a preventive approach that seeks to keep fraudulent suppliers out of the program before they can commit fraud. On February 2, 2011, CMS issued final rules that dramatically changed how providers and suppliers participate in the Medicaid and Medicare programs. The new regulations implement Section 6401 of the ACA, which requires the HHS Secretary to establish procedures to conduct risk-based screenings of Medicare, Medicaid, and CHIP program providers and suppliers.[16]

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[14] Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act – CBO' s March 2015 Baseline,* March 9, 2015.

[15] *Id.*

[16] Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers* (Feb. 2, 2011).

The final regulations require that all participating providers in the Medicaid and CHIP programs be screened and revalidated at least every five years. Based upon this requirement, state Medicaid agencies must complete the revalidation process of all providers by March 24, 2016.

Additional anti-fraud provisions in the ACA affecting Medicaid include:

- **New and enhanced penalties for fraudulent providers.** The ACA adds new civil monetary penalties for individuals who

    - fail to grant timely access to information required for audits or investigation;
    - have been excluded from federal health care programs;
    - order or prescribe services provided by that program;
    - make false statements on enrollment applications or bids, and
    - know of, but do not return, overpayments from Medicare and Medicaid.

    New provisions also allow the Inspector General to exclude from Medicare and Medicaid any provider that makes false statements on an application to participate in these programs.[17]

- **Withholding payments.** The ACA requires state Medicaid agencies to suspend payments to a provider of services or supplier pending an investigation of a credible allegation of fraud, unless good cause exists not to suspend such payments.[18]

- **New funding to fight Medicare and Medicaid fraud.** The ACA significantly increases funding for the HCFAC Fund, indexing the program's mandatory baseline and funding to inflation, and providing additional mandatory HCFAC funding of $105 million in FY 2011, $65 million in FY 2012, $40 million in FY 2013 and 2014, $20 million in FY 2015 and 2016, and $10 million in FY 2017-2020.[19]

1. Medicaid Waiver Approval Process

Congress took major steps towards improving transparency of the Medicaid waiver approval process. These steps were consistent and in-line with longstanding GAO recommendations to allow for public input at the state and federal levels, standardize approval documentation, and make waiver proposals and supporting material publicly available. The

[17] Congressional Research Services, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview* (Sept. 8, 2014).

[18] Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers* (Feb. 2, 2011).

[19] P.L. 111-148, Section 6402(i) (2010).

recommendations flowed from GAO findings that were made over the course of several reports, that the public did not have sufficient opportunities to learn and comment about pending waivers at the federal level, and that public input at the state level varied substantially.[20]

The specific provision, requiring these added transparencies to the Medicaid waiver approval process — Section 10201(i) of the ACA — came about following more than a decade of bipartisan efforts. The ACA also requires that Section 1115 waivers be evaluated on a periodic basis and that states submit reports on the implementation of their demonstration projects. On February 27, 2012, CMS published a final rule implementing new transparency and public input requirements for Medicaid 1115 demonstration waivers.

C. Delivery System Reform

Implementation of Medicaid expansion and streamlined eligibility and enrollment reforms generate the most public attention. Due in part to the program's flexible nature and framework, the states have initiated some of the most innovative health delivery projects in the country with the support of Medicaid. From a delivery system reform perspective, the ACA included many provisions to Medicaid with the goals of improving quality of care and controlling costs. Those that targeted delivery reforms include:

- **Healthy infants.** The Strong Start for Mothers and Newborns initiative aims to reduce early elective deliveries as well as test models to decrease preterm births among high-risk pregnant women in Medicaid and the Children's Health Insurance Program (CHIP). As part of this initiative, clinicians at some hospitals have reduced their early elective deliveries to close to zero, meaning fewer at-risk newborns and fewer admissions to the neonatal intensive care unit. From 2010 to 2013, there was a reduction of 64.5 percent in early elective deliveries, reflecting the collaborative efforts of providers, private sector organizations, and government toward the shared goal of improved birth outcomes.

- **Integrating care for individuals enrolled in Medicare and Medicaid.** Many of the ten million Medicare-Medicaid enrollees suffer from multiple or severe chronic conditions. Total annual spending for their care is approximately $300 billion. Twelve states (California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia and Washington) have entered into agreements with CMS to integrate care for Medicare-Medicaid enrollees.

- **Money Follows the Person Program.** The Money Follows the Person Program helps states rebalance their long-term care systems in part by transitioning Medicaid beneficiaries from institutions to the community. As of December 2013, over 40,650 individuals with chronic conditions and disabilities have transitioned from institutions back into the community through Money Follows the Person Program. The 44

[20] Kaiser Commission on Medicaid and the Uninsured. The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers, March 2012 (online at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf).

participating States and DC have proposed to transition an additional 25,816 individuals out of institutional settings through 2016.

- **Balancing Incentive Program.** Nineteen states are participating in the Balancing Incentive Program, which gives states incentives to increase access to non-institutional long-term services and supports and provides new ways to serve more Medicaid beneficiaries in home and community-based settings.

- **Health Home State Plan Amendments**. Sixteen states have approved Health Home State Plan Amendments to integrate and coordinate primary, acute, behavioral health, and long term services and supports for Medicaid beneficiaries.

- **Promoting care at home.** An Affordable Care Act demonstration, Independence at Home, tests whether providing chronically ill beneficiaries with primary care in the home will help them stay healthy and out of the hospital. Fourteen primary care practices and three consortia of physician practices are participating in the Independence at Home Demonstration.

- **Medicaid Innovation Accelerator Program.** CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014, to further support states' efforts to accelerate new payment and service delivery reforms. While complementing other federal-state delivery system reform efforts such as the State Innovation Models (SIM) initiative, IAP will provide additional federal tools and resources to support states in advancing Medicaid-specific delivery system reform and by sharing lessons and best practices.

III. MEDICAID: FUTURE TRENDS AND CHALLENGES

The U.S. Government Accountability Office (GAO) and the Medicaid and CHIP Payment and Access Commission (MACPAC) will testify at the hearing on future trends and evolving challenges for the Medicaid program.

A. GAO Recommendations

GAO has identified, based on its body of prior work, four key issues facing the Medicaid program: 1) access to care; 2) transparency and oversight; 3) program integrity; and 4) federal financing.

- **Access to Care.** The GAO has found that Medicaid enrollees report experiencing access to medical care that is generally comparable to that of privately insured individuals.[21] For example, according to national survey data, few enrollees covered by Medicaid for a full year—less than 4 percent—reported difficulty obtaining necessary medical care or

[21] Government Accountability Office, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance* GAO-13-55 (Nov. 2012).

prescription medicine in 2008 and 2009, which is similar to the rate amongst privately insured individuals. However, particular populations may face challenges obtaining care, and access to specialty care remains an issue. GAO has recommended that CMS take steps to address access issues, such as enrollees' access to dental care. GAO acknowledges that CMS has taken important measures to improve dental provider networks, such as by working to ensure states gather information on the provision of Medicaid dental services by managed care programs, but believes more must be done to identify and strengthen inadequate networks.[22] GAO has also recommended that CMS work with states to improve reporting on Early Periodic Screening, Diagnostic, and Treatment Services (EPSTD). CMS has taken steps to improve the accuracy and completeness of this data, but GAO believes that additional steps are required, such as requiring states to report on the receipt of services separately for children in managed care and fee-for-service delivery models.[23]

- **Transparency and Oversight.** GAO has identified three main areas in which greater transparency would improve federal oversight: better collection of data on states' payments to individual providers under supplemental payment programs, better collection of data on state financing sources, and improved transparency with respect to HHS's policy, process, and criteria for approving state spending under section 1115 waiver authority. GAO made a number of additional recommendations to improve CMS's oversight of Medicaid payments, and CMS concurred with all of the recommendations.[24] Regarding state financing, HHS acknowledged that it does not have adequate data on state financing methods for overseeing compliance with the 60 percent limit on contributions from local governments, and that it will examine efforts to improve data collection to this end. HHS did not concur with the specific GAO recommendations that this data be collected through the annual UPL reviews or through the T-MSIS system.[25] With respect to GAO's recommendations regarding 1115 waivers, CMS agreed with the GAO's recommendations regarding improved documentation, but only partially agreed with an additional recommendation regarding the issuance of more specific approval criteria.

- **Program Integrity**. In its recent work, GAO has focused on two areas where CMS could

[22] Government Accountability Office, *Oral Health: Efforts Under Way to Improve Childrens' Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns* GAO-11-96 (Nov. 2010); Government Accountability Office, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain* GAO-09-723 (Sep. 2009).

[23] *Id.*

[24] *Id.*

[25] Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* GAO-14-627 (July 29, 2014).

improve Medicaid program integrity: 1) efforts to improve oversight of managed care payment rates; and 2) efforts to ensure only eligible individuals and providers participate in Medicaid. The recently issued Medicaid managed care proposed rule would make significant changes to Medicaid managed care rate setting, such as requiring more consistent and transparent documentation of the rate setting process to allow for more effective reviews of states' rate certification submissions.[26] GAO has acknowledged that CMS has taken important steps to strengthen Medicaid beneficiary and provider enrollment processes. The February 2011 provider enrollment regulation requires state Medicaid agencies to implement new screening procedures for enrolling and revalidating all Medicaid providers. GAO acknowledges that this rule, if properly implemented, "will address some of the issues that we found in our analysis of fiscal year 2011 data, such as screening of excluded providers."[27] The agency has also concurred with two additional further recommendations that GAO has made in this area.[28]

- **Federal Financing**. GAO found that Medicaid's federal-state partnership could be improved through a revised federal financing approach that better addresses variations in states' financing needs. GAO's recent work focuses on two areas for improvement: how federal assistance should be adjusted in times of economic distress and how the FMAP formula calculates variations in levels of assistance to states.[29] First, GAO recommends that Congress pass legislation to automatically increase federal financial assistance for states affected by national economic downturns. GAO provides a prototype formula to address these changes.[30] Second, GAO has found that federal Medicaid funds provided to states could be more equitably allocated to better account for the states' ability to fund Medicaid. GAO found that the current FMAP formula's basis on per capita income does not adequately address variations in states' demand for services, geographic costs, and available resources.

B. MACPAC Recommendations

[26] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions to Related Third Party Liability* (May 25, 2015) (online at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-12965.pdf).

[27] Government Accountability Office, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls* GAO-15-313 (May 2015).

[28] *Id.*

[29] Government Accountability Office, *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States During Economic Downturns* GAO-12-38 (Nov. 2011).

[30] *Id.*

Established in 2009, the Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the HHS Secretary, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). Similar to its Medicare counterpart, MedPAC, MACPAC issues two reports to Congress per year, one in March and one in June. It also publishes issue briefs, comments and data reports throughout the year. MACPAC's areas for study are outlined by statute and include payment, eligibility, enrollment and retention, coverage, access to care, quality of care, and the programs' interaction with Medicare and the health system.[31]

The first half of the March 2015 report to Congress focused on Medicaid's impact on children's health coverage and financial implications for low-income families had Congress not extended the CHIP program in a timely manner.[32] The second half of the March report offered detailed perspectives on Medicaid payment, including an analysis of premium assistance waivers — an approach currently approved in Arkansas and Iowa for adults, newly eligible for Medicaid to purchase exchange coverage.

The report also provided new data giving rise to possible implications for access to care based wholly or in part on conflicting Medicare/Medicaid policies. Today, almost 20 percent of Medicare beneficiaries receive Medicaid assistance through Medicare premiums or cost sharing. MACPAC cautioned that current cost-sharing policies, as well as the complexity involved in processing claims across these two programs, may reduce access to care for beneficiaries. The March report also outlines a new payment framework for analyzing how payment and delivery systems meet statutory principles of economy, quality, access, and efficiency. Finally, MACPAC continued tracking whether the primary care payment increase measurably had an impact on Medicaid beneficiaries' access to primary care, but as of yet, data is not fully developed enough to show any such impact.

The report released by MACPAC to Congress last month appropriately acknowledged the 50th anniversary of Medicaid. Thus, the June 2015 report focuses on several aspects of Medicaid's longstanding mission to ensure access to high quality health services for the most vulnerable Americans and looks to the program's future as a major health care payer driving health system change towards value. Specifically, MACPAC looked at Delivery System Reform Incentive Payment (DSRIP) programs operating under waivers in several states. Although finding a great deal of potential in many of these programs, MACPAC found that the programs could benefit from more clarity and consistency in federal guidance as well as an examination of lessons learned across states to underpin future expansion. The report also reviews access to dental care for adults covered by Medicaid, an area also of interest to the GAO. MACPAC's analysis shows that state

[31] *See* https://www.macpac.gov/about-macpac/ (for further explanation of MACPAC and access to complete reports).

[32] *See* https://www.macpac.gov/wp-content/uploads/2015/03/March-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf (for further explanation of the matter).

Medicaid programs vary considerably in the dental services they offer adults, and that access to regular dental care is challenging in many areas of the country.

MACPAC also plans extensive future work into behavioral health and Medicaid. As a first step in examining how Medicaid pays for and delivers behavioral health services, this report also provided a detailed picture of Medicaid beneficiaries diagnosed with mental health conditions and substance use disorders. Ranging from young children in need of early intervention services to adults with serious mental illness to frail elders affected by depression and dementia, this report looks at these individuals' need for and use of Medicaid services. MACPAC plans an extended inquiry into identifying targeted policies and practices for improving care for Medicaid enrollees with different behavioral health needs. Finally, the June report also examined the use of psychotropic medications among Medicaid beneficiaries, highlighting promising federal and state activities to ensure safe and effective prescribing practices.[33]

IV. WITNESSES

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[33] *See* https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf (for further explanation of the matter).