KFF

Headquarters
185 Berry Street
Suite 2000
San Francisco, CA 94107

650.854.9400
650.854.4800 fax

Washington Office &
Barbara Jordan
Conference Center
1330 G Street, NW
Washington, DC 20005

202.347.5270
202.347.5275 fax

November 14, 2023 | Virtual Event Transcript

A Look at Medicaid Enrollment and Spending Trends and an Array of Policy Issues Amid Unwinding of the Continuous Enrollment Provision

Robin Rudowitz: Good afternoon. I'm Robin Rudowitz from KFF, and I want to thank you all for joining us for the release of our annual survey of state Medicaid programs. Medicaid currently provides comprehensive coverage to about 90 million people, or over one in five low income Americans, and the program is the primary payer and provider of long-term services and supports. At the time we were conducting the survey, states were heavily focused on the unwinding of pandemic related policies, including the continuous enrollment provision. However, states were also focused on a multitude of other priorities as well, from core operations to developing and implementing new initiatives, including provider reimbursement policies, new benefits, delivery system reforms, and initiatives to address health disparities and social determinants of health. Today we will hear more about trends in Medicaid policy, and there is indeed a lot going on.

In collaboration with Health Management Associates, or HMA, we fielded our 23rd annual Survey of Medicaid Programs last summer. In this presentation, we will discuss key findings from two reports we released today, our analysis of National Medicaid enrollment and spending trends and our detailed look at Medicaid policy and programmatic changes across the states for state fiscal years 2023 and 2024. That report is jointly released with the National Association of Medicaid Directors. As I am sure many of you already know, Medicaid is a complex program with significant variation across states. Changes in Medicaid policy can have profound effects on state budgets, providers, health plans, and of course the millions of enrollees served by the program. Over 23 years, this report has certainly evolved over time as the program has evolved, but it has continued to provide a snapshot and overview of the many issues facing state Medicaid programs each year.

Next slide. We have a packed agenda today, so here is the roadmap for the next hour. First, Liz Williams from KFF will set things up with some context on national Medicaid enrollment and spending trends. We'll then turn to Libby Hinton, from KFF, and Kathy Gifford, from HMA, to highlight some key findings from the policy report. Next we will hear from Kate McEvoy, who is the Executive Director of the National Association of State Medicaid Directors, who will provide a national perspective on Medicaid policy trends. And then finally

we'll turn to a discussion with two leading Medicaid directors to hear more of what is happening on the ground in the states.

We are so excited to have Amir Bassir, who is the Medicaid director in New York, and Jennifer Strohecker, who is the Medicaid director in Utah joining us today. I really want to thank all of our panelists in advance as well as the report authors and all the other staff from both KFF and HMA, who have helped with these reports and there are many involved. I also want to thank NEMD and all of the Medicaid directors, and the Medicaid staff who took time to complete the surveys so we can provide such a robust picture of what is going on with state Medicaid programs across the country. We know that Medicaid directors and their staff are extremely busy and pressed for time.

And finally, before I dive into the content, I want to remind you again that we'll save some time at the end for questions, so please enter any questions in that Q and A function, and with that we'll get started and I will turn things over to Liz Williams. Next slide.

Liz Williams: Great, thanks Robin.

I'm now going to share some key findings from our analysis of national Medicaid enrollment and spending trends. For a three year period, following the onset of the COVID-19 pandemic, states provided continuous enrollment in Medicaid in exchange for an increase in the federal share of Medicaid spending. The Consolidated Appropriations Act ended the continuous enrollment provision and allowed states to begin dis-enrolling individuals for Medicaid starting in April, 2023. Although many states did not start dis-enrollment until May, June or July of this year. The law also phases down the enhanced federal matching funds through the end of the year. As a result, states expect national Medicaid enrollment to decline by 8.6% in state fiscal year 2024, as state Medicaid agencies continue to unwind the continuous enrollment protections. These estimates reflect a dramatic year-over-year decline in program enrollment after reaching record highs during the continuous enrollment period.

It is important to note that these estimates reflect new enrollments as well as coverage losses due to the unwinding, but they also assume some individuals losing coverage will re-enroll in Medicaid within the year, or what we call churn. Since enrollment is the primary driver of total spending growth, we can see here, that states were also projecting slower total spending growth in state fiscal year 2024. Most Medicaid officials indicated that both their enrollment and spending projections reflect what is assumed in their state's adopted

budgets though estimates are uncertain, and the effects of the unwinding are continuing to evolve with significant variation across states. Next slide please.

The state share of Medicaid spending typically grows at a similar rate as total Medicaid spending growth unless there is a change in the federal match rate, or what we call the FMAP. During periods of fiscal relief, state spending typically declines, and then increases sharply when the fiscal relief ends. This pattern occurred with the fiscal relief during the Great Recession and is expected to repeat itself, as you can see here.

State spending on Medicaid declined during the first two years of the pandemic due to the enhanced federal funding, but is expected to increase sharply in state fiscal year 2024 due to the phase out and eventual end of the enhanced federal Medicaid matching funds. In addition to the enhanced FMAP, state cited the expiration of one-time funding, especially American Rescue Plan Act funds for home and community-based services and changes in their regular FMAP formula as additional factors affecting state spending increases. Increases in state spending come at a time when states are starting to experience some uncertainty in their fiscal outlook after somewhat strong fiscal conditions in the recent years. With that, I will now turn things over to Libby Hinton, to highlight other key Medicaid policy issues covered in our report. Next slide please.

Libby Hinton: Thanks Liz. I'll turn now to some of the key findings from the policy report. We won't have time to cover everything in the report today, so we hope you'll access the report on the KFF website to learn more about the array of Medicaid work underway across the country.

The report addresses policy changes in fiscal year 2023 and changes implemented or planned for fiscal year 2024, across a variety of policy areas including provider rates and taxes, delivery systems, benefits, pharmacy, and telehealth. I'll turn first to provider reimbursement rates. Next slide please.

The number of fee-for-service rate increases greatly outnumbered fee-for-service rate restrictions in both fiscal year 2023 and fiscal year 2024. As you can see in figure eight, rate increases for nursing homes and home and community-based services were the most common, as many states acted to address direct care workforce shortages. Some states reported double-digit increases for these provider types. We also saw an uptick in primary care physician rate increases compared to surveys in the past few years. While the survey only captures changes in fee-for-service reimbursement rates, these rates are important benchmarks for managed care payments in most states, often serving as the state mandated payment floor. Next slide.

Capitated managed care remains the predominant delivery system for Medicaid in most states. As of July, 2023, there were 41 states, including DC, that contract with Medicaid managed care organizations, or MCOs. This number is unchanged from last year. This count will change to 42 states in fiscal year 2024 when Oklahoma implements capitated managed care. Medicaid MCOs provide comprehensive acute care, so most physician and hospital services, and in some cases long-term services and supports to Medicaid enrollees. MCOs are paid a set per member, per month payment for these services. A smaller number of states operate primary care case management programs, or PCCM for short, which retain non-risk based fee-for-service provider payments, but enroll beneficiaries with a primary care provider who's paid a small monthly fee to provide case management services in addition to primary care. Next slide please.

The COVID-19 pandemic caused major shifts in utilization across the healthcare industry that affected state's ability to set managed care per member, per month payment rates which are typically set prospectively for a 12-month period. Because of this uncertainty, CMS encouraged states to implement risk mitigation strategies in MCO contracts for rating periods impacted by the public health emergency. In this year's survey, we asked states about pandemic related risk corridors. Risk corridors allow states and health plans to share profit or losses if spending falls above or below specified thresholds. Nearly two-thirds of states that contract with MCOs reported implementing a pandemic related MCO risk corridor. Among these states, more than three-quarters reported that recruitments for MCO payments had already occurred or were expected for 2020, 2021 or 2022. Next slide, and I'm going to turn it over to my co-author Kathy Gifford from HMA to continue with the findings.

Kathleen Gifford: Thank you, Libby. So benefits, consistent with survey results over the past decade, almost all benefit changes reported this year were expansions. In both 23 and 24, service expansions across the behavioral healthcare continuum were the most frequently reported, followed by pregnancy and postpartum service expansions, preventive service additions, dental service improvements, and new services to address unmet social needs like housing instability, homelessness, and nutrition insecurity. Several states also reported benefit changes to support access to culturally competent care, including coverage of community health workers. Next slide please.

As you've probably heard, a new class of drugs to treat obesity has hit the market, and all payers public and private are examining their coverage policies to determine who should be covered for these expensive therapies. Now, unlike most other drugs, however, a longstanding statutory exception allows states to

choose whether to cover weight loss drugs under Medicaid. So in this year's survey, we asked states to tell us whether they covered weight loss medications for adults under fee-for-service when prescribed for the treatment of obesity, and if so, whether a comorbid condition was required. 16 state Medicaid programs reported covering at least one weight loss medication as of July, 2023, and at least five other states noted that coverage was under consideration. Now, we did not ask about utilization controls, but at least three states commented that coverage was limited to only one drug at this time, and a few state mentioned BMI or other prior authorization requirements. Next slide.

Reducing health disparities has become an important priority for the federal government and many states. And many states leverage their Medicaid managed care contracts to help address health disparities. In this year's survey, we asked states with MCO contracts whether certain contract requirements, those shown on figure 13, were in place for planned. 36 MCO states responded to this question, and as you can see in this slide, a similar number of states, about half, reported that they required MCOs to train staff on health equity or implicit bias, or meet health equity reporting requirements in fiscal year 2023. Over one-third of responding MCO states reported requiring MCOs to have a health equity plan in place or seek enrolling input or feedback to inform health equity initiatives. But fewer states reported requiring MCOs to have a health equity officer or achieve NCQA's Multicultural Healthcare distinction or Health Equity Accreditation. The number of MCO states with at least one of these requirements has grown significantly, from 16 states in fiscal 22, to an expected 29 states in fiscal year 2024. Next slide please.

Now, every year we ask states about the challenges they expect to face and their top priorities for the year ahead. And at the time of the survey, as we already noted, all states were heavily focused on Medicaid redeterminations, but they also identified other pressing challenges and a wide range of key priorities. At the very top of the challenge list, three-quarters of states highlighted workforce challenges for the healthcare provider workforce and the state workforce, or both. For example, states reported that shortages of nurses, direct care workers, and behavioral health providers often resulted in access challenges. States also cited the difficulty of recruiting and retaining state staff with specialized technical expertise. More than half of responding states identified behavioral health and long-term services and supports as key priorities or challenges, and specific LTSS related challenges that they cited included workforce shortages, the aging of the population generally, LTSS access, and provider financial challenges for either nursing facilities or HCBS providers.

Now states also reported other key priorities related to delivery system or value-based payment initiatives, addressing enrollee social needs, improving provider reimbursement rates, and implementing initiatives to improve maternal and child health. Finally, while most states reported favorable state fiscal conditions at the time of the survey, more than half of states commented on a more uncertain, longer-term fiscal outlook. Some states mentioned the expiration of enhanced federal funds, and others commented on the budgetary impacts of inflation, the workforce challenges, and provider pressures to increase reimbursement rates. As always, a very exciting and challenging time to serve as a state Medicaid Director, and I'm very much looking forward to hearing the perspectives of the directors who have joined us today.

And at this point I will hand it off to Kate.

Kate McEvoy: Thank you so much, Kathy. I am so pleased and excited to join this incredible forum today. Heartfelt thanks to Robin and our KFF colleagues. This report is really both a remarkable longitudinal resource, it represents an incredible historical archive, but also an of-the-minute capsule of Medicaid policy and operations, and we deeply appreciate the longstanding partnership with KFF on this work and their continued leadership and investment encapsulating this phenomenal work.

I also want to thank, again from my heart, all of the folks who are serving in Medicaid leadership right now. Two extraordinary examples of whom are joining us this afternoon, Jen and Amir. We at NMD represent the 56 Medicaid state and territory leaders, and we're so proud of their exemplary leadership during the intense and taxing period of the public health emergency, but also this watershed year, where the program is embedding learning gleaned during the PHE, dynamically responding to the very complex and herculean task of the unwinding, but also taking up, again, the mantle of the priorities that were never abandoned during the PHE, significant areas of mutual interest and concern across the country, around access to primary preventative services, integration of behavioral healthcare, improvement in the urgent disparities that are manifest in maternal healthcare, and also opportunities for rebalancing of long-term services and supports, and true choice and integration for older adults and people with disabilities.

This is indeed a watershed year, where so much of that activity is now being emblemized across the country. And I know you'll hear from Jen and Amir around that continued responsivity to the needs and interests of the over 91 million folks who are served by Medicaid and SHIP. And again, that process, the constant evolutionary curve that this program is on, never essentially laying

down the responsibility to engage, to learn from, and to improve both the experience, access, and outcomes of people who are served by Medicaid and SHIP. So let me turn now back to Robin for more detail from our directors.

Robin Rudowitz: Great. Thank you so much to everyone who has already spoken, to Liz, Libby, Kathy and Kate. It was a really great overview, and I'm now really excited to turn to our panel and hear from two states. So welcome Amir and Jennifer to the panel. And we are going to just dive right into a conversation. We heard some, a little bit about our national enrollment and spending trends, and I'm wondering if you could share some perspectives from your states about how those ring true, or don't, and your experience with unwinding and those trends. And maybe also if there are broader fiscal issues that are affecting what's happening in your states that would have implications for Medicaid. So maybe I'll turn to Amir first, and then you can start us off.

Amir Bassiri: Sure. Thank you Robin.

What I would say is that a lot of the findings from the Kaiser survey, the 50-state survey, are very consistent with the experience in New York, both from the enrollment projections to the state Medicaid spending growth and the challenges that lie ahead.

The unwind is still our number one priority amongst these other challenges, and thus far we are seeing a decline in enrollment that is relatively consistent with what we projected, around 15 to 20% of our Medicaid enrollees. But we have encountered challenges that have resulted in risk mitigation strategies that may impact those estimates at the end of the unwind period. But all in all, retention of coverage gains is our number one priority, and still where primary of our focus has been. With respect to spending, Governor Hochul in New York has made provider reimbursement and workforce a top priority, as well as behavioral health. And over the last two years, we have increased our state share of Medicaid spending by about 10 to 15%, driven by investments in primary care reimbursement, hospital and nursing home reimbursement rates, and then behavioral health investments to the tune of $1 billion over the next five years. So there's been a considerable investment in services, and we are exploring benefit changes in our pending 1115 waiver.

Robin Rudowitz: Great. Jennifer, do you want to jump in?

Jennifer Strohecker: Yeah, I will. Thank you.

So our experience in Utah is complicated by some things that have happened in our state, and I'd like to cover three things. First of all, Utah's overall job growth is consistently the best in the nation, and as a result it's really translated to an economic strength, as we've exited the public health emergency with very low unemployment and a very strong economy. Second to this, Utah has experienced a significant amount of migration into our state through the public health emergency. And this is different for us, where 61% of people moving into our state are from other states. And actually, what this has also caused over the last 10 years, is that our demographic has changed dramatically. So we had, back in the 1990s, about 10% of a multicultural background. Today, we're sitting at about a 30% change. So this in the context of continuous Medicaid enrollment and the requirements from the PHE on Medicaid programs, has actually resulted in an interesting environment where our Medicaid program at this time, grew at a faster rate than we'd ever seen.

It actually grew by 71% during the time of the PHE. So here we are looking at a unique environment of huge growth in Medicaid, but in also a statewide environment of population growth and economic stability. So it's really made it incredibly challenging for us to forecast enrollment and spending projections for 2024. We did planning like many other states did, trying to prioritize our unwinding work. We actually looked at individuals who were not utilizing and services that were maintained on the program, tried to look at reviewing these first with the idea that the rate of decline of dis-enrollment would kind of taper off as we move forward in our activities of unwinding. However, our dis-enrollment has actually continued at an aggressive pace since unwinding started seven months ago, so this was not expected. And as a result that steeper dis-enrollment projection actually has been challenging with some of our forecasting. Actually, we recently surveyed about a thousand Medicaid members to figure out, those who had dis-enrolled, what was happening, to try to understand what their outcome was.

About two-thirds of them, actually, said that they had other insurance coverage, but about 30% reported that they were uninsured. And so, of course this is really challenging for us and concerning to us as we consider what this means on the population. I also think too, as we've approached looking at forecasting and setting budgets, that there is a process we undergo as a state that we call consensus, where our legislative fiscal analyst, or governor's office, as well as our Medicaid program, do meet together and talk through changes in enrollment trends, impacts to the program, including FMAP changes and other things. And we've been doing this for a long time. We do this twice a year, and I'd say that in our meeting in October, there were still several unknowns, and we're really looking forward to what February data will show us so we have a

better understanding of our dis-enrollment and what that looks like with regard to our fiscal forecasting and things like that.

One other aspect, that I'll just touch on, is that we had set our managed care rates based off of what we expected our dis-enrollment to be earlier on before we actually began this. Actually, the activities of unwinding as we anticipated what they would be, and because our unwinding actually has exceeded our projected dis-enrollment, we are doing mid-year rate adjustments with all of our managed care plans and our providers, in order to cover some of those changes and expenditures that have happened and where our models haven't quite matched up. So that's the state of Utah today and it's been challenging. I'm sure others are experiencing this as well. But yeah, it's been an interesting year, and that is certainly a major area of focus for us as well.

Robin Rudowitz: Thank you both for that. I think that really highlighted so much of the complexity and uncertainty of doing some of these projections and anticipating what is happening. I want to turn a little bit more to some of the policies that are going on, and I think, Amir, you started to talk about some of these, but we did notice a lot of activity around reimbursement rates, even more so than previous years, and states doing rate studies and various tension on different increasing rates in different areas. And I'm wondering if you can talk about how you're using rates to address, potentially, some workforce issues, and where you've been focused on some of those rate changes. We could start again with Amir, and then we'll switch it up.

Amir Bassiri: Absolutely. Yeah.

As many states have likely heard from their provider communities, the reimbursement rates and our base rates, fee for service base rates, have not kept pace with some of the rapid changes in inflation and workforce costs, particularly that were exacerbated throughout the pandemic. And so we have explored any and all options to address those issues through our base rates, paying all the way up to what is allowable under the upper payment limit rules for those provider categories like hospitals, nursing homes, clinics, et cetera.

And then we've used the ARPA program, the enhanced home and community-based services funding, to try and shore up some provider workforce payments in our waiver programs and elsewhere. And then in managed care, we've really been leveraging the directed payment authority to, in our best way possible, drive funding towards provider groups that are experiencing those wage increases. But we're always sort of playing catch up, and I would say that there are limits to what we can do under the various authorities and we are beginning

to run up against those limits in the fee-for-service program due to the upper payment limit, which is really based on historical data. So it's very hard to stay current with what is happening in the ever-changing delivery system, but we have explored any and all opportunities, and continue to do so.

Robin Rudowitz: Great. Excuse me.

Jennifer Strohecker: I'll just chime in as well, for Utah. We're in a similar place as New York. One of the pieces that we've looked at considerably statewide is that really Utah has a considerable workforce shortage across our state, but really particularly in primary care, dental, mental health, we are experiencing a health professional shortage. Really across many, many and most regions of our state, we've seen so many professionals just leave their roles and do other jobs, and even retire early.

And it's created such a concern for us, which we've actually done at a department level, as we've been able to put together, through a legislative effort, a committee that's really looking at workforce shortages and think about novel ways to do this. And just a couple things we've done outside of the rates and reimbursement that I thought worth noting, was first of all, looking at incentive loan programs. And some of you may be doing this, but just in our rural and frontier areas where it's really greater challenge for access and making sure people have timely access to services and the types of services that they need, even from a primary care standpoint, really pushing out loan repayment models and some service-oriented in these areas.

Additionally, we're doing a study around looking at licensing, and how we're looking at this as its impact on the behavioral health workforce ourselves. What we're finding is that our lower, really looking at new licensing requirements for lower-trained behavioral health staff, and looking at their scope and reassessing that in order for them to be able to have the ability to work through this. Like I mentioned, this is a statewide effort, a work group run through the department that's really been able to evaluate and look at things from a staffing perspective, not just a rates and reimbursement, but also from our Medicaid program. Similar to what Amir mentioned, we certainly have areas that struggled across the board, but in significant areas around HCBS, behavioral health, home health providers, ARPA was critical in these areas. We've been able to really get some funding put in some key places, and then fortunately because our economic state in Utah has done well this past legislative session, we were really able to continue some of those essential ARPA covered benefits forward into the future.

And these are areas that we've been able to look at for our HCBS providers as well. We've also issued multiple infrastructure grants. These are sort of non-traditional funding streams that have been really helped providers look at some unorthodox solutions to challenges they're facing. This investment really helped with other things that doesn't just come from rates and reimbursement, looking at things like transportation to meet the settings rule, for example, training and ability to meet EVV requirements, or even how to really improve their physical settings to make them more compatible with what we want to see for our Medicaid population.

Another piece that was really critical for us through the duration of the PHE was family caregiver compensation. It's been transformative, truly, for our state and for our service delivery system, through this service that's been funded through ARPA. This allowance, as you all know, families and caregivers, guardians, to be added to the array of service providers, and we've been able to continue this forward through legislative funding that we've been able to receive post-PHE and we have waivers that have been submitted now. Additionally, our last legislative session, we were able to give behavioral health providers a mandated annual 2% inflationary increase.

This matched, and kept at parity what the ECOs are experiencing, and this allows our behavioral health providers to receive those similar benefits and help catch up with some of the rate disparities that we've seen there. One last thing I'd like to touch on is dental services, as it was called out as an area of concern from many states. We've had a really wonderful partnership in our state, in Utah, with our University of Utah School of Dentistry. And in recent years, this partnership where the school of dentistry really covers the state share of our services for adult dentistry, they've enabled us to build a stable network of dental providers across our state. Through this partnership, we've been able to address important reimbursement issues in the areas of specialty care, like endodontics, and other places where dental providers have been able to weigh in and to say this is an area like we can't cover Medicaid members. And we've been able to really put funding in that area through the facilitation and the work that we've done in partnership with the School of Dentistry.

Last, I will say that we did just complete a comprehensive rate study for most provider types. This was really important for us because we've been able to support certain areas but not others. And it seems some have gone 10 years or more without a rate increase, so this study was really important to create a greater level of transparency and visibility around what that gap is compared to other states, as well as comparisons to Medicare. And this is an important tool for our legislature to use as they get funding requests. We're looking at funding

key areas and to support these different areas that are really critical areas of access for Medicaid members. So we have lots of work going on just like Amir does, and a commitment, of course, from our legislature and our governor's office to understand the needs of the Medicaid program, and certainly some support and action that we've seen over the last year.

Robin Rudowitz: Again, that was really helpful, and we know that these workforce issues transcend just the Medicaid program, but super helpful to hear the particular issues that Medicaid is addressing, or trying to address, and the particular challenges as well. I know, I mean, New York and Utah are both doing so much in terms of, and we already have some questions coming in, I see, on the panel related to social determinants of health and how your states are using Medicaid to try to address some of those issues related particularly to housing and food. So I'm wondering if you could spend a little bit of time talking about what both of you are doing and your programs are doing in that area. And maybe we'll start with Utah this time.

Jennifer Strohecker: Certainly. Thank you.

We have two key areas we've really been focusing on with regard to work in the behavioral health and social determinant space. And I think like many other states, Utah is very invested in justice involved reentry initiative. We actually had submitted a waiver to CMS more than three years ago, where there was really, as we were moving into adult expansion, this was a key area of focus from our state, from the legislature, as an opportunity. And as we've now had further guidance from CMS, we are enhancing that look, and we're really excited about the opportunities this allows for improvements in that connection of care and continuity of care through pre-release services. With the rate of mental illness in Utah, jails being six times higher than the general public, and certainly substantial gaps in care is what we're noticing, is incarcerated individuals who may have a substance use disorder, who have untreated mental illness and really moving through the system and having gaps, they're not receiving that level of care we want.

This is a prime area of focus for us now, is we're coordinating and working with our prisons and our jails, to really stand up the infrastructure for this in anticipation that these conversations with CMS will be moving towards approval of this essential service soon. This is certainly a high priority item for us.

And in the context of this, certainly looking at housing related support services, this was another waiver that was submitted a number of years ago, but received approval about a year ago. This benefit underneath the 1115 waiver provides

housing transition support to an eligible member who meets this needs-based criteria. We, of course, have this housing related support services, offers a variety of services to address social determinants and essential needs of housing. We've had hundreds and hundreds of individuals, just this past year, really benefit from this. And as we look at the connections of housing and justice-involved work and how they support the overall work of the Medicaid program, I would say that these are two key areas that we are focusing on as our state, as ways to lift and address social determinants, racial disparities, and address the needs of vulnerable populations.

Robin Rudowitz: Great, thanks.

Amir Bassiri: Yeah, and I would echo what Jen mentioned on those that are being discharged from incarceration. I mean in New York, we have had, and been very, very focused on prioritizing health equity through the integration of social care services in our managed care benefit. And that's really the underlying goal of our pending 1115 waiver.

We have had prior initiatives in place in managed care, through in lieu of services, that we were not seeing a massive hiccup on from health plans and from providers. And there were a lot of challenges, and it really informed what we're proposing to do in our 1115, which is to integrate the health-related social needs services into the benefit package with community-based organizations. And we intend to build that out for the transitional housing services, the food and nutritional services, and ongoing case management. And in the interim, what we have done is sort of make a down payment in our state plan through enacting and pursuing authorities to expand our community health worker program statewide with a focus on the high risk and high need individuals, expanding our funding for supportive housing programs, knowing that there's a shortage of available housing slots for those that are being discharged from an institutional setting, or at risk or suffering from homelessness.

And we've also made a big focus on behavioral health and maternal health, expanding our doula pilot statewide, making a big focus on the Nurse-Family Partnership program, and expanding that and looking at ways to really strengthen the wraparound and supportive services for a lot of our members. So our waiver is our health equity strategic plan, but we try to take interim steps to formalize some of these benefit changes and service expansions in our state plan. And then as I mentioned before, behavioral health, huge priority, everything Jen mentioned in terms of the gaps in care and workforce issues, are evident in New York. And we have severe workforce shortages in areas like child psychiatrists and other mental health practitioners, nurse practitioners that

we've been trying to focus on through a range of initiatives. But it's very challenging, and we have engaged with our partners in the state education department because we do think there needs to be some changes to [inaudible 00:41:48] scope of practice to really address some of the access issues that we're seeing in New York.

Robin Rudowitz: Great. I think I'm going to turn now to just ask you if you want to look into the future a little bit and just give us a little bit of an overview of what you think the biggest issues that are coming up in this current fiscal year, as well as a few years out. Again, we touched on a bunch that are part of what we collected from a more national picture, but I'm curious what you're experiencing, maybe the what keeps you up at night kind of issues. And again, we could start with Utah.

Jennifer Strohecker: Yeah, thank you.

What keeps us up at night? Gosh, our current state is just so incredibly busy trying to understand unwinding and the context of member flow, and things like that, is certainly a key concern for us as we move through this phase. And even in the context of applying so many new policies, it's really encouraging as we look at the future of some of the proposed rules around access eligibility, the managed care rule, and we're certainly contemplating what this does to our current environment, and how we keep up. Certainly I think that these proposals are amazing, they're transformative. They reach a level of care and provision of services for our Medicaid population that we know is essential to achieving that great quality of care that we want for a very vulnerable population, resolving gaps, addressing equity issues. And as a state agency, we are on board with this work, but consequently, it's also a whole lot of work to take on.

And I think as we lay out, while we have priorities, I mentioned we're looking at 12-months continuous for children, 12-months postpartum, our justice work and the work we want to do, layering on much of the quality work, the access and eligibility and enrollment standards that are being rolled out. You do have to consider A, the cost as that is this is not coming, these are significant state dollars to invest in these programs.

But additionally, workforce as well. And I'm saying our workforce. We have workforce that I certainly think about from the access standards. How are we going to meet these with our current enrollment and the ability of providers to cover care. But also for staff, how are we going to manage all of this? How can the workforce keep up? How are we going to keep our staff engaged? So I think

about all of these things in the context of change, how we drive and be transformative in our work, how we embrace the future of where we're going, and actually be leaders in these areas, but bring our staff along and bring our programs along in a way that create a sustainable, long-lasting change.

And it certainly, there's a lot on our plates these days. There's a lot for us to think about. It's complex for some of us who may not be as far along on this health equity journey and some of the work that's been done in other states, and Utah isn't as far along. So for us, that journey is a little bit longer than others. And so those are the things we think about and we process. It's an exciting time, it's a challenging time, it's an opportunity. And I think the folks we have now are really committed to improving the best level of care and providing the greatest services to our members. I'd say those are the things that really keep us up at night and have us thinking about the future of Medicaid as it's kind of created week by week, month by month here.

Robin Rudowitz: Great. And how about New York?

Amir Bassiri: Yeah, I mean Jen, really a lot of the comments Jen made very much resonate with me. And I want to hit on to not only the provider workforce issues, but as Jen mentioned, the state workforce challenges. There is not a single state Medicaid director that will not tell you this is as busy as the Medicaid program has ever been. There are converging, major policy changes that are being implemented at the same time. Programs have grown tremendously over the past few years, and we have people retiring from state service, a lot of institutional knowledge that is moving on or ready to move on, not necessarily with succession plans behind them. And there's not a day that goes by that I don't think about our internal staff, and also the local staff for our counties that jointly administer parts of the Medicaid program.

The workforce challenges are truly across the board, and they're very, very challenging from a state government perspective. And so that is really something that keeps me up at night because I know how hard everyone is working across the country, and particularly in New York, to fulfill some of the federal obligations, and then obviously to ensure we have some continuity and coverage, and that we retain as many people as possible that have been enrolled over the past three years. And there's only so many hours in a day and state staff to fill some of these jobs, so that is definitely my number one concern moving forward amongst the other challenges that we're facing.

Robin Rudowitz: Great. And at this point, I want to invite Kate back on to see if she has any national perspectives to share on the same question, looking forward, and then we have a bunch of Q and A that have come in that we'll turn to.

Kate McEvoy: Thank you so much, Robin. And I do want to say, I think Amir and Jen just did such an extraordinary job of representing their peers, talking about the learning that was gleaned from the very intense time of the PHE, applying that, the opportunities for systemic change and improvement, really in every facet of the program, the access and eligibility standards, really the scope and breadth of coverage, the integration of services and supports, and of greatest and most foundational importance is really looking to the lived experience and preferences and values of the people served by the program. And I think that programs have been so self-actualized around that, as a kind of carryover from the demands of the PHE, really looking to embed that in very exciting ways across the country. I would say wrapping around both of them, a piece that is very significant for all of us is that Medicaid is foundationally an applied federal and state equity and territory, equity and operational partnership.

So I think in addition to the pieces that can be owned by states and optimized, there are numerous opportunities for further work by the federal government, really around rules of operation of the program. This kind of critical aspect of what among the elastic authorities of the pandemic can be carried forward, looking at not only the eligibility rules, the E-14 opportunities that we're using to great effect during the unwinding, but also the other types of elastic opportunities that were represented by Appendices K and the like. So that piece around signaling permanency there, I think, is very significant. Opportunities around systems improvement, which is top of mind for so many directors right now. But the role of the federal government in exerting influence on specifications, not just the desired goals, but the kind of parameters for doing that work, scaling solutions across states, so it is not a sort of first dollar investment in each and every state and territory.

Jen and Amir talked so cogently about workforce. Again, opportunities for the federal government to coalesce across disciplines with a focus on the pipeline on immigration, consideration of drawing people into this work through promotion of the value of it. The issue of resources, the core aspect of the Medicaid match from the federal government and opportunities to use enhanced match to capitalize innovation, but also to look at the need for seed dollars. We do not have a vehicle like a DISRIP or a SIM right now, so looking at that ongoing, and I just wind up by saying that the shared interest among all of us in promoting the very significant value of the Medicaid program, we know conclusively from longitudinal research that this has lifetime benefits for

children, in terms of developmental readiness, school participation, adult job retention, prevention of acute healthcare needs, and integration and choice for older adults and people with disabilities. And at a time where we're grappling with the overall federal budget and those mechanisms, again, everything we can do to champion this incredibly important program, I know we'd all value. So thank you, Robin.

Robin Rudowitz: Great. And then I'll invite other folks back on. And we have a lot of questions that have come in. We're not going to get to all of them, but I think one area, some of them touch on things that we've already covered, but one question that we haven't spent a great deal of time on, that we know is a big issue for states is related to pharmacy. So we know that cost control and implementing initiatives around prescription drug costs are a key priority. I know, again, both Utah and New York particularly have efforts going on around these issues, and we have some information from the survey, so I'm wondering if anyone wants to jump in and talk about any issues related to prescription drugs.

Amir Bassiri: Well, Jen is a pharmacist, so I'm happy to let her start because I talk to her about this regularly.

Jennifer Strohecker: Yeah, Amir and I have certainly had several conversations around pharmacy. Certainly I think on many people's radar is our cell and gene therapies, as they really completely rewrite the landscape of how we look at pharmacy drug costs and certainly the impact they're going to have on all state budgets. I'd say there are two ways that we've been looking at this as a state. First, I think it's important, we've spent a lot of time educating our legislature, and also stakeholders in our state, to look at our communal interests in optimizing the care that individuals receive as these drugs come onto market. We know by 2030, I believe 40 to 50 of these cell and gene therapies that are two to $3 million price tag will be available for people. And there's a lot of interest in this when it comes to people's own advocacy for a cure. And certainly that's one piece from a larger landscape.

We've led the way in those discussions, knowing that Medicaid is a primary payer. An important piece I'd say that I just looked at from cell and gene therapies and cost containment, but also through that equity lens in Medicaid, is developing the most rigorous sort of continuum of care around a person's access and availability of getting these treatments, and actually what it means for that person along their lifespan to be able to access that in a timely way, to have the right assortment of services around them to make sure that when that pharmacy solution is delivered, that they are managed and monitored correctly.

And so we've been looking both through at least with cell and gene therapies, the larger global impact stakeholder input, as well as partnerships with our hospitals, with our commercial payers, things like that. But also, really bringing it down to a policy level to make sure that it's very clear that when a Medicaid member is eligible, that there is a very clear path for that individual to receive this service timely, and make sure that their outcomes are achieved in receiving this. So that's where I'll say our focus has been with regard to cell and gene therapies.

Amir Bassiri: And that has certainly been a focus of ours in New York. Everything Jen said, with respect to the pipeline is very much on our radar. In New York, we did pursue the value-based contracting authority. We do have that in place, and we are executing agreements for some of those gene and cell therapies. I will say it is incredibly resource intensive, and with the range of new therapies that are coming on the market for differing underlying conditions that are very specific to the Medicaid population, like hemophilia and sickle cell, I do worry about our ability to manage some of the complexity of these arrangements that are based on outcomes, which is a good thing, but are very hard to measure and standardize across various drug types.

I would also be remiss to say we have been pursuing, and finally did implement, a transition of our pharmacy benefit from managed care back to fee-for-service. That took effect earlier this year. It has been another big undertaking, but one that we felt strongly in. And a lot of this stemmed from our concern with how the pharmacy benefit managers were acting on behalf of health plans, and some of the underlying opaque reimbursement practices. And thus far that transition has gone well. But some of the cell and gene therapies that Jen mentioned are on both the medical and the pharmacy benefit, which adds some new complexity as to how we enter into agreements with drug manufacturers.

Robin Rudowitz: Great. And we only have a few more minutes, so I'm combining a lot of questions into one. Kate touched on this federal state partnership, and we know that there's a lot of pending regulations that have... I'm wondering how states are potentially preparing for what's coming down the pike in terms of regulations, and also speaking of the Federal State partnership, if anyone has any comments about the implications of a potential federal shutdown as we are approaching that date again, and then that will probably wrap us up.

Amir Bassiri: I can start. No comments on the shutdown. I would say we are working very closely with CMS on a range of things, and I think that generally it's been very hard to manage, as I'm sure it has been for them. But overall, we've had very good discussions on a range of different issues that we're working on, from our

waivers to fee-for-service based payments. And sometimes it's been a challenge having and working across different areas of CMS that may need to talk with one another, to really wrap their head around the underlying policy change we're pursuing, but the unwind has certainly been a priority in some of those discussions. But overall, I think we've had a very good relationship with our federal partners in administering the program and we're working towards addressing some of these challenges, but I can appreciate some of the workload that is imposed on them and that they're facing the same challenges that we are.

Robin Rudowitz: Anyone else? Final word. It's amazing how fast an hour flies by when there is just so much going on and so much content, but that was just such a really rich and informative discussion of so many issues. I feel like sometimes when we have Medicaid discussions, we're focused on a very narrow slice of what's happening, and I always feel like this report and this discussion really highlights the multitude of things that are going on at the same time.

So I really want to thank our panelists and everyone who tuned in to listen. There were many questions, again, that we didn't get to, but hopefully we could try to follow up, or follow up with us. And a reminder that the reports and a recording of the webinar will be posted on kff.org later this afternoon. So I thank everyone for joining us and have a great day.