Transcript
BUSPH Public Health Conversation
A Vote for Health: Medicaid

Sandro Galea:

My name is Sandro Galea. I have the privilege of serving as Dean of the Boston University School of Public Health. On behalf of our school, welcome to today's public health conversation. These conversations are meant as spaces where we come together to discuss the ideas to shape a healthier world. Through discussion, debate, and generative exchange of ideas, we aim to sharpen our approach to building such a world guided by our speakers who work towards a deeper understanding of what matters most to the creation of healthy populations. Thank you to the many who helped make this event possible. Thank you to our co-host, the Boston University School Public Health Medicaid Policy Lab and the lab's co-directors, professors Megan Cole, Sarah Gordon, and Paul Schaffer. Thank you to the Dean's office and the communications team, without whose efforts these conversations would not take place. Today's event is part of our fall series, A Vote for Health, where we have been welcoming speakers who will guide our thoughts on issues of consequence for health and the upcoming federal election.

Today we're going to discuss the intersection of 2024 election and Medicaid policy. We're going to talk about how Medicaid policy shapes health at the state and federal level and how policy changes as a result of the election could affect the health of Medicaid and rural populations. I'm very much looking forward to learning from our speakers as we discuss this topic. I'm now pleased to introduce today's moderator, Stephanie Armour, a senior health policy correspondent for KFF Health News. She has reported on the Affordable Care Act, Medicaid, Medicare COVID-19, abortion, health politics and regulations in Washington, D.C. affect patients, providers in the healthcare industry. She's previously worked at Wall Street Journal, Bloomberg, USA Today, and the Des Moines Register in the Daily Tribune, Ames, Iowa. She's a graduate of University of Minnesota. Her journalism awards include earning a First Place National Headliner Award from the Press Club of Atlantic City, first place Sigma Delta Chi Award from the Society of Professional Journalists, and first place Consumer Journalism Award from the National Press Club. Stephanie, it's a privilege to have you with us. Over to you. Thank you for joining us. Stephanie, I think you're on mute.

Stephanie Armour:

Thank you Dean Galea for that introduction. Very much appreciate it. It's a pleasure to be moderating today's discussion. This is a really important issue I think in terms of Medicaid in the election and one that really hasn't gotten enough attention. So it's great that there are people here paying attention and looking at this. I now have the privilege of introducing today's speakers. First we're going to hear from Joan Alker.

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Ms. Alker is the executive director and Co-Founder of the Center for Children and Families and a research professor at the Georgetown University McCourt School of Public Policy. She's a nationally recognized expert on Medicaid and the children's health insurance program and a great source of mine and is the lead author of CCF's annual report on children's healthcare coverage trends. Then we'll turn to Vicki Fung. Dr. Fung is associate investigator at the Mongan Institute Health Policy Research Center of Massachusetts General Hospital and Associate Professor of Medicine at Harvard Medical School.

Dr. Fung is a health services researcher whose research focuses on healthcare financing and insurance policy for socioeconomically disadvantaged populations. Dr. Fung leads multiple federally funded studies that examine the effects of changes in healthcare policy, including in Medicaid and Medicare on healthcare access, quality outcomes and disparities. Third, we'll hear from Kate McEvoy. McEvoy is the executive director of the National Association of Medicaid Directors. An elder law attorney by training, she has 30 years of experience in working with and for people served by Medicaid. Prior to joining NAMD, she was the longtime director of health services for Connecticut's Department of Social Services where she led Medicaid chip long-term services and supports and implementation of the Affordable Care Act's initiatives including Connecticut's Medicaid expansion. Finally, we'll turn to Chima Ndumele, Associate Professor of Public Health at Yale School of Public Health. His research is focused on better understanding factors that influence the way vulnerable populations connect with and access healthcare resources.

Specifically, he conducts work in three areas. The first examines how changes in local policy environment impact the care received by Medicaid enrollees. The second area explores how safety net organizations can improve healthcare services delivery. Finally, he investigates the effect of changes in insurance coverage on the quality of care received by individuals with chronic physical and mental health conditions. He was also a pioneer when it comes to looking at Medicaid roles and ghost providers. Well, as a reminder for our audience following individual presentations, we'll turn to a moderated group discussion. When we have about 20 minutes left in the program, I'll turn to audience questions. Please submit questions using Zoom's Q&A function, which is in the bottom middle of your screen. Joan, I will now turn things over to you.

Joan Alker:

Thank you so much Stephanie, and I'm really thrilled to be here today for many, many reasons, including, first of all, I'm going to note I grew up down the street from BU in Newton, and as a Red Sox fan, which I know y'all are right near Fenway Park, and this is

such an amazing group of speakers today. I'm really excited to hear what they have to say. I think this topic itself has really been not discussed much at all during the elections, even though the consequences and stakes for Medicaid are really, really existential, frankly. And lastly, I'm excited to wear my fancy headset, which I almost never get to wear. So let's turn to my slides, and I want to start by just, if we want to go to the next slide, that Medicaid really, as Idris was talking about, is often kind of a sleeper issue in healthcare debates, both electoral debates but also just in the public discourse.

And of course, I've been working on Medicaid for a long time and Medicaid has certainly come much more to the forefront of public consciousness. It now covers more people than Medicare does, just over one-fifth of the population in the United States and close to half of all children. It's especially important for communities of color and it plays such a key role. It's really the backbone of our healthcare system. It is the largest pair for long-term care. It is making Medicare work for people with low incomes. It is at the forefront of responding to our behavioral health and substance abuse crises. As I mentioned, it's absolutely the most important source of health insurance for children. Also for maternal health pregnancies, it was a leader in responding to the HIV AIDS epidemic, the COVID-19 epidemic. So Medicaid is everywhere in our healthcare system, and if we don't have a strong Medicaid system in place, that has enormous repercussions, and yet we don't hear a lot about it in this election.

We've heard more of course about the ACA, the Affordable Care Act, which relates to Medicaid, but not entirely. And this is also, of course, a major source of state budget financing as well. So let's go to the next slide. Even though a lot of times we don't hear a lot about Medicaid, most Americans know about Medicaid, and they have a connection to the Medicaid program, a personal connection because it is so widespread. So you see here, this is some data from last year from KFF, about two-thirds of adults who were surveyed said they had a personal connection to Medicaid, either somebody in their family or a friend who had been covered by Medicaid. And I know I've done focus groups in certain states and for example, if you talk to women of childbearing age, a lot of folks there have a connection. Folks who have a parent in a nursing home or long-term care, lots of personal connections to Medicaid.

And we can go to the next slide. And the voters like Medicaid. Here, you can see that if you look at social security, Medicare, Medicaid is just right behind them with 75% of voters. And this is a pretty recent data point saying they have a very or somewhat favorable opinion of Medicaid. And that's not very far behind Medicare, 80%, which is really considered social security. And Medicare of course are sort of considered the

third rail of politics, but Medicaid polls almost as well. And it consistently has done so. It polls well across all political parties.

And I should say, for those of you who follow the issue of Medicaid expansion, in every state where that has been on the ballot, even though they've been all red states in recent years, it has passed. So even though as we're going to talk about Medicaid itself may not be particularly popular with Republican politicians, it is popular with the voters. Okay, so let's go to the next slide. So what have we heard in the presidential election? Not much at all. In fact, until a couple of weeks ago, I was saying we haven't heard anything about Medicaid from either candidate, former President Trump or the vice president. Now, that did change last week when the Harris campaign did put out a paper that talked about what might former President Trump mean when he says he has the concepts of a healthcare plan. They explored that topic and highlighted that indeed, we have every reason to believe that Trump has very large and existential cuts in mind for the Medicaid program, and I'm going to talk about that at some length.

We have not heard Trump talk about Medicaid directly. He does frequently say that he would protect Medicare and social security from cuts. Now, he's not a man known for always sticking to what he says. So that's an open question, but it's very conspicuous that he does not say that he's going to protect Medicaid when he makes those comments. So we have been keeping tabs on what are the major proposals that are out there for Medicaid with respect to some key kind of sectors of the Republican Party. Where can we look to see what they intend to do? So as you'll see here, my colleagues made a chart that looks at both some of the proposals that have come out of the house and also Project 2025. Now, I'm guessing everybody probably watching this have heard about Project 2025. It's gotten a lot of attention. What has not gotten very much attention is that it actually has drastic plans to cut and frankly eliminate Medicaid as we know it today.

And I'll talk a little bit more about that. That is part of Project 2025 as well. It just hasn't gotten very much attention. So when we look around at the kinds of proposals that are out there to cut Medicaid, we see commonality emerging. And I should say that some of these proposals that we've seen to cut Medicaid, to cut the ACA subsidies, to cut the children's health insurance program are extremely large. We're talking cuts of a third to a half of their current spending over a ten-year period, extremely large. This would really threaten, as I say, the very existence of Medicaid as we know it. So number one, of course, is this idea has kicked around before. And in fact, when the repeal of the ACA was on the table in 2017, less attention, again, paid to this. But while they were in the neighborhood, the Republicans decided they'd like to block grant and cap Medicaid.

So that's not the same thing as repealing ACA, right? We've had Medicaid for almost 60 years now, but while they're in the neighborhood, they decided that they would cap Medicaid. And I actually think that's one of the reasons that their efforts failed. They overreached. The ACA, of course, is more popular now, but even so, they overreached by trying to cap Medicaid as well while they're in the neighborhood. So we know they want to do this. They've tried before. And as you know, Medicaid is an entitlement program. Medicaid is an entitlement both to the individual, who if you meet the eligibility categories, you have a right to Medicaid and it's an entitlement to states with respect to the financing so that for every dollar that a state spends, depending on the matching rate, they're guaranteed of getting between 50 and 80, or in the case of expansion, 90 cents on the dollar back from the federal government.

That's a guarantee. And that's fundamentally what this proposal would change. It would break that financing structure and have a cap on the federal funding, which would result in enormous cost shifting to states. And the funding for Medicaid would no longer be able to keep up with things like healthcare inflation, new treatments, pandemics, the aging of the population. There are lots of things which right now are just automatically reflected because it is an entitlement program. There are various other proposals around to cut the matching rate, and I won't spend a lot of time because I don't have a lot of time going into detail, but one of the most popular is to cut the 90% percent matching rate for the expansion group. Those are parents and other adults under the Affordable Care Act that states have a choice to cover or not. And 40 states do do that today.

There are other proposals to lower the floor of Medicaid match. Right now, 50 cents on the dollar is the lowest amount that states can get. And so richer states, New York, California are getting 50 cents on the dollar, while poorer states are getting closer to 80 cents on the dollar like Mississippi. Another proposal would lower that floor. And so states with higher per capita income would get less. And oh, what do you know? They're mostly blue states in that proposal that would take cuts. So there are various proposals to fiddle around with the match. Another issue, which gets far less attention but comes up a lot, is to eliminate or restrict state use of provider taxes. Now, states put up their own money of course to draw down Medicaid funds. We just talked about that a little. And almost all states, 47 states I believe today, use provider taxes, taxing hospitals or insurance companies to finance, provide some revenue for their state share.

So if you restrict or even eliminate state's use of provider taxes, they're much less likely to be able to put up their share to draw down the federal dollars, which of course in this scheme would be capped as well. So that's a double whammy. There are, of

course, tied to these cuts are state flexibility. That's how the perennial logic is. States will be able to save money because they can be more flexible, but what that really means is taking away a lot of federal standards that exist, benefit standards, cost sharing protections, income eligibility minimums, those kinds of standards. And then finally, something we hear a lot about are imposing more red tape, other barriers to enrollment. The most famous of these being, we call them work reporting requirements because they're really not about promoting work. They don't promote work, but they do result in a lot of red tape.

Other barriers and limitations as well. Time limits, enrollment caps, harder renewal processes, essentially to just impose red tape, and that keeps people out and that cuts the budget. So these are the kinds of proposals that we consistently see. And of course, if we have a Trump victory along unclear what's going to happen in Congress, that'll be important too. But we would expect to see these kinds of proposals going forward. So let's move to the next slide, and I know I'm probably running out of time, again, voters, Republican voters are basically split right down the middle and whether they would like to block grant the program. But overall, this is also not a popular proposal with voters in general. So this is very high stakes, very high stakes for states too, since this is their largest source of federal funding. So let me just conclude with a few kind of general observations.

I think they would move on this very quickly, and there's a couple of different scenarios where we could see Medicaid cuts in Congress. The first is, of course, that there will be some kind of reconciliation bill. Either way, the Trump tax cuts, some of them are expiring, and of course Trump would like to make them permanent. And so we would expect Medicaid and the ACA subsidies to be the number one source of financing from making those tax cuts permanent. Second, just to remind folks that the debt ceiling agree is due to expire January 1st, 2025. So that's not far away. They will need to lift the debt ceiling again. And last time when this happened a couple of years ago, former speaker McCarthy put on the table a Medicaid work reporting requirement and a SNAP work reporting requirement. That was one of his bargaining chips. Now, he ended up caving on that, but that just, I am going to say, reinforces my point, which is that cutting Medicaid is absolutely top of their list, and that could happen very quickly because they're going to have to deal with that issue very, very quickly.

We've also heard from Russ Vought, who was Trump's OMB chief first time around, former of the Heritage Foundation, very close to all these Project 2025 proposals that he's interested in Trump using something called impoundment, which we really haven't seen since the next administration, although Trump did do it related to Ukraine spending, really broadening their use of impoundment. So that's not spending money

that Congress appropriates, and lots of questions there about the legality of what they could do, but those kinds of approaches, I think they're very eager to really push the envelope and that Medicaid would be a target for those. So I think I'm running out of time. I have more to say and hopefully we can get to some of it in the Q&A. But thanks, I'll hand it back to you, Stephanie.

Stephanie Armour:

Great. Thank you so much, Joan. That was super fascinating. I had completely forgotten about the provider tax issue and the impoundment stuff is really interesting. Up next is Vicki Fung.

Vicki Fung:

Okay, can you hear me? I think I got all the technology sorted. Well, thank you so much. Thanks to Dean Galea and to the organizers of this event. I'm really excited to be part of this panel, and I agree this is a really critically important conversation to have. I'm really happy to follow Joan as well. She gave a really great high-level overview of the potential implications. And what I'm going to do now is really zero in on one sort of specific area, which is to think about Medicaid enrollment and enrollment continuity, and how federal and state policies and procedures can influence these outcomes.

Okay, so why do we care about Medicaid enrollment? There's a really large body of literature that finds that Medicaid coverage and Medicaid expansion specifically have been associated with numerous positive patient outcomes. These include reductions in uninsurance and disparities in coverage, reductions in financial hardship, including incurring medical debts, increases in access to care and utilization, including use of preventive services and improvements in numerous health outcomes.

At the same time, not all individuals who are eligible for Medicaid enroll in coverage, and a study that's led by my colleague Daniel Nelson, we used data from the American Community Survey and found that among individuals who are eligible for Medicaid through income-related pathways, so this includes children, parents, pregnant people, non-disabled working-aged adults. About 71% of adults were enrolled in Medicaid, and a higher proportion about 91% of children were enrolled. As you can see from the graph which plots adult and children participation rates at the state level, there's wide variation across states and participation rates with greater variability for adult participation than child participation.

And on average, adult participation was higher in Medicaid expansion states than states that didn't expand Medicaid. Churn in enrollment, which refers to sort of short-term disenrollments, followed by re-enrollment in Medicaid has also been a major policy concern. Before the ACA estimates were around 30% of Medicaid beneficiaries losing and regaining coverage during the year. Again-

PART 1 OF 4 ENDS [00:23:04]

Vicki Fung:

... beneficiaries losing and regaining coverage during the year. Again, this varies by state also by eligibility groups with groups like children experiencing lower churn on average owing to the higher income thresholds for children compared with other groups. And other groups such as women who gain Medicaid coverage due to pregnancy, facing very high rates of churn before the ACA, with one study finding over half of women with Medicaid coverage at delivery experiencing a gap in their coverage during the year. Churn can be the result of fluctuations in actual eligibility for Medicaid, which is based on monthly income. We know that monthly income fluctuates more widely for lower versus higher income populations, but churn can also be the result of administrative barriers to completing renewals amongst eligible individuals. This can include completing complicated paperwork, returning things within the required timeframes, lost mail due to housing changes. And churn is associated with interruptions and continuity of care, decreases in medication adherence and increases in emergency department use among beneficiaries, and increases in administrative costs for states and managed care organizations.

There's also limited participation in programs for disabled individuals or those age 65 plus who can qualify for Medicaid assistance with Medicare costs. Most of these beneficiaries have incomes below the poverty line and have to meet very stringent asset tests. And Medicare costs, including premiums, cost sharing, deductibles can create major affordability problems for these individuals. Dually eligible beneficiaries also face substantial clinical and social risk factors. Many have multiple chronic conditions, mental health conditions, functional limitations, high levels of adverse social determinants of health, like food insecurity, housing insecurity and transportation insecurity, and yet estimates of enrollment in certain types of Medicaid assistance range from only about half to two-thirds of eligible enrollees, again, with wide variation across states. And importantly in our analyses and others, those who enrolled in Medicaid assistance programs were much less likely to report delaying care due to costs or having problems paying medical bills.

So the ACA included a number of provisions that were aimed at improving the Medicaid enrollment process and easing the administrative burdens associated with enrollment and renewals, particularly for those who qualify for Medicaid through the income-based pathways. These are just a few examples. So one example is that the ACA required states to provide a single application that could be used across insurance affordability programs, including Medicaid, CHIP and the ACA marketplaces. And that could be completed through multiple modalities like phone, online, in-person, mail, and it eliminated the in-person interview requirement. States were also required to adopt a twelve-month renewal period and to ease the administrative burdens associated with re-enrollment. The ACA also required states to use electronic data to verify eligibility to the extent possible before sending renewal forms to beneficiaries which had to be pre-populated with information. I mean, overall the ACA has been found to be associated with declines in the likelihood of having Medicaid coverage disruptions and the length of insurance gaps.

Prior studies examining extensions of renewal periods have found these policies to be associated with improvements in continuous coverage and automated renewals in some studies have been associated with less Medicaid churn during the year. In contrast, during the Trump administration, CMS approved for the first time State 1115 waivers that allowed states to impose various restrictions on enrollment. And most notably, as Joan pointed out, work reporting requirements for Medicaid coverage. So 13 states had approved work requirements, though few were really implemented due to litigation or due to the pandemic. Arkansas was the only state to implement work requirements and actually disenroll individuals for non-compliance. And over a nine-month period, about 18,000 beneficiaries were disenrolled due to non-compliance. Studies have found increases in uninsured rates in this population, but no increases in employment or other community engagement activities that these policies were purported to focus on. And ASPE reports that the decrease in enrollment was likely explained by a lack of awareness and sort of widespread confusion among many beneficiaries about how to conduct the reporting requirements as most of the affected enrollees were already meeting work requirements or would've qualified for an exemption.

In contrast, during the Biden-Harris administration, there's been more of a focus on extending and strengthening the provisions that were in the Affordable Care Act, including those around enrollment and renewal. So as of January 1st, 2024, states are required to provide 12 months of continuous eligibility for children, which is a stronger provision than 12 month renewal periods, and this means that children remain eligible for coverage even if their circumstances like income or household composition change

during the year. The option for states to extend postpartum Medicaid coverage to 12 months was also made permanent and has now been adopted by nearly all states. New rules were also finalized that extend many of the enrollment simplifications and additional enrollment improvement through provisions to those who qualify for Medicaid due to age or disability or blindness. And CMS estimates that this will increase receipt of Medicaid assistance with Medicare costs by about 860,000 beneficiaries, and will save these beneficiaries in estimated 19 million hours in paperwork each year and reduce administrative burdens for state governments by about 2 million hours.

So just to wrap up, I think we're at a really critical point in time for thinking about policies and procedures around Medicaid enrollment. States have now nearly completed the Medicaid unwinding process that followed the end of some continuous enrollment provisions that were enacted during the COVID-19 public health emergency. And about 25 million people have been disenrolled from Medicaid, again with wide variation across states. Notably about a quarter of those who are disenrolled from Medicaid during the unwinding have enrolled in private ACA marketplace plans. And the enhanced premium tax credits for marketplace coverage that allow individuals with incomes between 100 and 150% of the federal poverty level to buy a no-cost benchmark plan are set to expire in 2025. And if these subsidies expire, alternative sources of affordable insurance coverage for those who may be more likely to move in and out of Medicaid coverage will diminish substantially.

In addition, about 70% of those who are disenrolled during the unwinding process were disenrolled due to procedural denials. This is a pretty big bucket and it can encompass many different things, but I think it also serves to highlight how much more work there is to sort of reduce the red tape and barriers to enrollment and renewal. We know that sort of states implement many of these provisions to varying degrees, that there remain a number of barriers to implementation, so I think it's really having more research and evaluation around what's being done, better data collection, and then ultimately understanding how these policies might impact enrollment, continuity and ultimately patient outcomes and spending, are going to be really critically important moving forward. Thank you.

Stephanie Armour:

Great. Thank you so much, Vicki. That was really comprehensive and I had absolutely forgotten how many people had been disenrolled in Arkansas, so that was really a great overview. Next, we are going to turn to Kate McEvoy.

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Kate McEvoy:

Good afternoon everyone. Let me share my slides. I'm so privileged to join you this afternoon and let me just make sure to put this on slideshow. Stephanie, may I just ask, is that observable to you?

Stephanie Armour:

Yes, it looks great to me.

Kate McEvoy:

Excellent. So I am very privileged to join this afternoon. I do want to start by saying I do come from a different frame of reference than do my advocate and researcher esteemed colleagues on the panel. I am the Executive Director of the National Association of Medicaid Directors and we are a nonpartisan organization that represents each of the 56 state and territory programs that are responsible for operating the Medicaid program on a day-to-day basis. We are involved in championing connections and sharing a best practice in our members. Also, innovation and improvement on a kind of rolling basis and work both with the 56 directors and also over 500 senior Medicaid leaders in the domains of finance, eligibility, folks who are involved in communications, folks working on disparities. Really spans the gamut. We are led by a mission focused 14 member board of directors and you see it represents the broad diaspora of Medicaid programs across our country.

I will not dwell here, but I particularly want to affirm and amplify what Joan said about the primacy and importance of the role of Medicaid. Again, as she remarked in her presentation, serving one in five Americans, extremely significant across the age continuum for every age tier. And as she noted really broadly supported from the standpoint of the nexus of nearly every American to someone served by the program which increased exponentially during the pandemic, the COVID-19 public health emergency, and also increasing in favorable view across the ideological continuum. I do want to say I particularly appreciated Dr. Fung's remarks around continuity of coverage. It's an important allusion to the point we are at from the standpoint of the applied practice of Medicaid at the state and territory level. I'll just say briefly, Medicaid programs were absolutely vital during the pandemic, scaling up with incredible rapidity and capability to serve an enormous number of people who are displaced because of unemployment and other reasons during the pandemic.

Also, as has been noted, it has been a watershed year, a year in which programs were required by Congress to resume historically typical eligibility renewal processes, a

Herculean undertaking. It was multifaceted and has been an incredible call to urgency and action, systems change, new means of engagement and many, many partnerships among managed care organizations, advocates and community providers and organizations really to catalyze attention to that renewal process and to examine many, many facets of improving continuity that are pairing with new requirements. For instance, continuous eligibility for children and extension of postpartum eligibility for women, that are important protective pieces in going towards that goal as Dr. Fung described around continuity. From the standpoint of the center point for our member programs right now, overwhelmingly stratifying at the highest level of importance is an attention to behavioral health, with a special point of focus on the high acuity needs of children and youth, and this was something that was starkly illuminated during the pandemic.

Also, a center point of elimination of disparities across various touch points with experience with Medicaid, both from the standpoint of access and utilization, but also outcomes. And there is a notable emphasis on maternal and preventative health here, especially as we know that those are very instrumentally related to longevity itself and the research is very clear about that. As they began to remark eligibility matters, including learning from the unwinding, that's been an incredible learning curve and developmental process, as well as embedding those features around continuity of coverage. And finally and not least important, engaging with the issues that affect people's readiness and capacity to engage with their health goals, housing instability, food insecurity, and also the special needs of individuals who are being released from justice settings. This slide capsules four key examples of that innovation work. Again, eligibility processes, again, automating the eligibility renewals so that we reduce burden both for members and programs.

The community engagement piece that has been so centrally involved in improving the continuity of coverage. And then other pieces, like I said, the continuous eligibility for children and for postpartum women, among other strategies. Many, many initiatives relating to maternal health, extending the care teams beyond the traditional OBGYN, including doulas, lactation specialists, and also coverage through the postpartum period with a special attention on behavioral health needs, as well as substance use disorder for women in those periods. The work around issues that can inhibit engagement with health has particularly centered on supportive housing paired with rental assistance, other strands of government assistance for vouchers and certificates. And finally, very important new opportunities that have been embraced by over half of states, and that is to reach in to [inaudible 00:37:15] settings in advance of release of people and coordinate and assess their needs, bridging to active engagement with

community-based health services and supports. It may surprise you to learn that over 54 of our programs are using at least one research and demonstration waiver.

This is a central innovation tool in Medicaid now and is interpreted, although there are also many creative uses of state plan authority. And I would like to acknowledge KFF as a tracker that is very illuminating of the range of strategies, in a good way, of keeping abreast of how those are progressing. I would be remiss if I did not say that among the administrative challenges perennially faced by states and territories is the lift and the administrative complexity of getting approval from the federal government for these waiver demonstrations. Simply put, the over 80 that are in the pipeline now are overwhelming the capacity of the center for Medicaid and CHIP services. They simply need more staff to handle this influx as we've seen policymakers and state and territory leaders embrace this again as the main vehicle to advance innovation. We also have currently no upfront capital source as we have done at various intervals in the past, and I think there's reasonable discourse around the results and the impact, the sort of breadth of the coverage of this use of capital, but again, that can seed costs that are not contemplated under 1115, and we've spoken about this in a recent health affairs article.

Another really important focal point for all programs is focus on members lived experience, meeting them where they are, and also wrapping around with culturally appropriate and respectful interventions that are going to really move the dial on their experience and outcomes. Briefly, and I will just mostly refer to this from the standpoint of a takeaway, you know Medicaid is a very significant payer. It is also a large component of state spending. Nearly 30% per National Association of State budget officers latest report, 30% of state spending and 18% of general fund spending, second only to K-twelve education. Not surprisingly, the current budget climates for states and territories are fairly serious, and I think some of the factors there include the sunset of the federal pandemic assistance. Also, we've seen pretty broad indication of declining tax revenues. This all told really creates new challenges for state and territory policy makers, not only with respect to the kind of scope of investments in Medicaid, but also the proposition of where to invest limited state resources in various different sectors.

Kind of starkly reminding us of the order of magnitude, the CBO is projecting in the aggregate $58 billion less in Medicaid outlays than they did in 2023. I also want to point to the fact that the territories are uniquely disfavored in this equation by being subject to statutory allotment caps. This constrains their ability and they regularly essentially exhaust their federal funding in any given year. And so I want to really remark on the fact that this is a key consideration, constrained budgets on the

adequacy of financial resources available to programs. It is extremely important from our frame of reference as a nonpartisan association that represents red, blue and purple states and programs to underscore that states and territories have different theories of social change, different perspectives on the structure, breadth and financing of the Medicaid program, and also different views on Medicaid's role in the continuum of payers as we're increasingly looking at bridging to marketplace coverage and employer-sponsored insurance.

Also, very well known to all of us, the very foundation of Medicaid is a federal/state/territory partnership. There is significant latitude in the federal law for states and territories to interpret the program in ways that are locally relevant, and that is a center point of the value to all states across that continuum. Again, with vis-a-vis that budget scenario because states operate typically on biennial budgets, certainty and predictability of what they can receive from the federal government as well as kind of the overall scope and program parameters are important because they're typically projecting quite far ahead in cycles. And I also want to point to the complexity of the current landscape. There haven't been a significant issuance of new federal rulemaking this year, which I think is an important catalyst in terms of core areas like eligibility, access and managed care, but also maybe vulnerable in light of recent Supreme Court and federal court decisions on the administrative procedures act may be subject to legal challenges. I'll just wind up by saying that we do produce a lot of material that is illustrative of the experience of our members, and I look forward to more conversation. Thank you, Stephanie.

Stephanie Armour:

Thanks so much, Kate. That was really helpful. For those of you who haven't read the health affairs article, it's worth reading. Go look it up. I did. It's fascinating, and the information on the bottlenecks too, I think is something that gets overlooked too much, so thank you for sharing that. Next, we will turn to Dr. Ndumele.

Dr. Ndumele:

Thank you Stephanie, and good afternoon to everyone else. I'm thrilled, as the rest of my colleagues have shared, to be here with you this afternoon and to share the virtual stage with my illustrious colleagues. Let me share my screen here. I am going to take the next few minutes to really talk about what's at stake as it relates to the kind of financial viability of Medicaid over the long run. What does this election say and mean for how we design and operate the program long term? But I'm going to start with a little bit of a primer, because I think it's often the case that this can get lost during a

discussion with Medicaid where we are talking about the performance and minutia of the program. Medicaid is transformative for people, and I think my colleagues have done a really wonderful job of articulating some of its benefits, but let me underscore a few.

One, obviously, it's the largest single insurer in the country at this point. It covers services that aren't duplicated elsewhere, and this point is often lost because over 50% of the program and closer to 60% of the program identifies as non-white. It is a singular driver of population level equity. Framed differently there is no meaningful pathway to population level equity that doesn't involve the Medicaid program. In terms of its outcomes, it is also transformative from that standpoint. Relative to being uninsured evidence suggests that Medicaid recipients have greater access to primary care, more financial stability, have higher rates of self-reported health and management of their chronic conditions, and ultimately lower rates of mortality.

Often lost in the discussion of Medicaid, that it's often more than a safety net as well. While it is a program that is there for people who are temporarily down on their luck, in many states, Medicaid is more than kind of secondary and supplemental. It is a primary and long-run insurer for many populations. As a matter of fact, in a study that we conducted a few years ago, we find that in many states, over 50% of individuals that are on the Medicaid program at the beginning of a decade are going to remain on that program at the end of the decade. It has a tremendous capacity to shape long-term outcomes for individuals. It is unbelievably important for the population.

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Dr. Ndumele:

... believably important for the population. But if we are being completely and comprehensively honest here, the reality is that it's expensive as well.

On the left-hand side, let me orient you to a wonderful graph of MACPAC that looks at spending and enrollment over the last 50 years or so of the program. And the good news here is that while Medicaid is getting very expensive, in large part it has been shaped by commensurate growth and enrollment and access to this transformative program.

You might argue that the gap between spending and enrollment has narrowed in the last few years or the last decade or so, leading some to think that there's potential waste in the program that can be accessed.

On the right-hand side, however, is another vantage point. This is a graph of Connecticut major state budget priorities over the last decade. Let me add a disclaimer note that this is not about Connecticut. I think this would be true in Massachusetts or Alaska. I think this would be true in the decade before, and potentially might be true in the decade after. There are a number of important points to highlight here, but I'm going to limit myself to two.

You'll see on the left-hand side of this slide is an increase in total healthcare spending by the state over that decade. And that includes more than Medicaid, but is largely driven by Medicaid. And there are two points to make here about this.

The first is the rate of spending is clearly unsustainable. Even if it's driven by enrollment, it's not something that states can continue with. On the right-hand side of the graph, you will see that the second point that I'll make is that there is no free lunch. States don't print money like the federal government.

Therefore, you'll see that growth in Medicaid, growth in healthcare spending is associated with commensurate either reductions or stagnations in other major priorities: welfare, education, public safety, all things that are arguably more important for health than healthcare spending itself.

So whether you think that this is a function of more access to this transformational program or you think this is a function of waste, the reality is that it becomes really clear that some approach to cost containment is necessary. The question is no longer whether we're going to have cost containment as much as it is how we're going to have cost containment.

And quite frankly, Democratic Party and the Republican Party have two very different visions for how we think about cost containment. On the left-hand side here, I think that the guiding principle of the Democratic approach to cost containment both in this election, and quite frankly beyond, is this notion of innovation via investments. How do we invest in individuals and the program in ways that both improve health and potentially reduce long-term costs?

On the right-hand side, we have a kind of guiding formula that I call Innovation Via Mandates. That is, it is often the case that we are going to impose austerity and presume that if there's waste in the system, that individuals will find pathways towards innovation.

On the left-hand side, the Democratic side, we see things like investments in primary care that are designed to reduce churn and expand access. Expansion of the program, including the 3.5 or so million people who are in the 10 states that have yet to expand Medicaid. Addressing social determinants of health via expansion of waiver programs

and the like of food and medicine, housing waivers and the like. Protecting adjacent safety net programs: SNAP, WIC, and the like.

On the right-hand side, or the Republican side here, we see cost shifting, either cost shifting to states via block grants or per-capita caps, cost shifting to individuals via cost sharing or increased administrative burden on enrollees, or this notion of fraud detection and trying to squeeze any money that we can out of finding individuals who are misusing the program.

There are also areas, however, where we agree. The reduction of long-term services and spending among the elderly population and finding ways for individuals to age in place wherever possible is popular among both parties. Addressing prescription drug costs, whether it be through drug reimportation or negotiation, is also popular among both parties. And fraud detection for providers is something that both parties agree on as well.

Because I am a researcher, I couldn't resist the opportunity to think about where we actually had evidence for some of these proposals. Many of these proposals aren't new, as Joan, Kate and Vicki have all mentioned. And we do have some evidence of what these things do.

So as we look at the GOP cost containment proposals, what is the evidence on spending caps for states? The reality is that this mechanically reduces spending as you put a cap on the program. However, it often happens through a reduction in the number of people or services covered.

What's the evidence on cost sharing? There's mixed evidence on spending. Most of the studies say that there are short-term reductions in the use of all services, both necessary and unnecessary services. And some of these services may be offset by preventable downstream spending. That is, we know something as little as a $5 or $10 copay may stop somebody from going to a primary care doctor or from getting a mammogram. We also know that those people are more likely to show up in the emergency room and get hospitalized for preventable conditions.

What is the evidence on work requirements? Evidence both from Medicaid itself and adjacent programs like SNAP show as much as a 25% reduction in enrollment among targeted groups. Little impact on employment status, disproportionate impacts on the most clinically and socioeconomically vulnerable, and that these policies are often difficult to reverse when they are put in place.

Taken together, the implication for the kind of major GOP cost container proposals suggests the potential for some short-run savings, but at the cost of a diminished program.

What about the proposals on the Democratic side as they relate to cost containment? The evidence on coverage expansion, and the best evidence that we have from the Oregon Health Insurance Experiment, suggests that expanding coverage will increase spending in the short run. But there are some potential for long-run savings both to individuals and to systems.

What is the evidence on investments in social determinants? While we have clear evidence that social determinants matter, we have mixed evidence on whether they impact short-run medical spending. That is when you are providing services to individuals, do you see returns in terms of offsets of medical spending? There's much stronger evidence, however, for protecting the existing adjacent programs such as SNAP.

Finally, evidence on investments in home- and community-based services. Early evidence suggests that incentivizing the right beneficiaries to receive care at home could save short-run costs for individuals. But I will emphasize that it's really difficult to figure out who those right beneficiaries are. This kind of investment-based approach to Medicaid, it's unlikely to yield short-run savings, but may improve the long-run viability of the program.

At its core, that's what we're grappling with here. A short-run view of the program where we need to contain costs right now, or a long-run view of the program where investments have the potential to contain costs and improve health in the long term.

I am thrilled to have an opportunity to have a robust discussion with my panel members now, and I will turn it back over to Stephanie.

Stephanie Armour:

Great. Thank you so much, Dr. Ndumele. The work you have done in your research on this is really groundbreaking, so appreciate your being here. And thank you to all our speakers for their presentations.

Now I'm going to move into a moderated discussion with all of our speakers. As a reminder, we'll turn to audience questions when there's about 20 minutes left in the program. And you can submit your questions using Zoom's Q&A function once again at the bottom of the screen.

One of the questions that I wanted to ask or that I find especially interesting, maybe initially I'll put this question to Joan but would love to hear from others on this as well, is a question about what's going on with Georgia Pathways to Coverage which, as you know, it's the only existing Medicaid work requirement in action.

And Trump approved, Biden withdrew, but a court reinstated. I am wondering, is this a model of what we could expect to see? I could be wrong, but I believe that there were about 10,000 people who applied, but only 2,000 or 4,000 are in the program. So I'd be really interested, Joan, and Kate as well, what your thoughts are on this topic.

Joan Alker:

Thanks, Stephanie. Yeah, that's a great question. And I think there's a couple of themes I want to highlight. First of all, in any presidency, Section 1115 policy is a key feature of what happens with Medicaid.

So Section 115, just to quickly review, they give the Secretary of Health pretty broad authority to negotiate in agreement with states that request authority for changing up federal rules, waiving certain federal rules; that's where they get their names; and potentially using federal money in different ways. And in fact, the majority of Medicaid spending today is operating through Section 1115. So they're hugely important.

In the Trump administration, of course, promoting work reporting requirements was a central feature of their policy. And what happened in Georgia, which also illustrates another theme, which is the growing role of the judiciary in Medicaid policy, which is something we haven't talked about yet today, is that Governor Kemp, who was in a tough reelection battle with Stacey Abrams, who was all in on Medicaid expansion, promoted a much more limited approach called Pathways to Coverage that expands coverage ostensibly for people under the poverty line. But has a very stringent work reporting requirement in place and actually has, for example, no caregiving exemptions.

So I just want to mention in Arkansas, which as we heard is the only state that actually implemented a work requirement during the Trump administration, before the court stepped in and halted it, all parents were exempt. They got a caregiving exemption, but that's not true in Georgia. There's no exemption for parents, so it's a very tough program.

Now, it's interesting. Of course the Biden administration came in and rescinded the authority for work requirements pretty quickly. That was one of their early-on actions, and they'd already suffered in the courts. But Georgia sued, and a judge there reinstated the agreement.

So where we are today, fast-forward is that as you mentioned, while the governor had initially projected that at one point he was up to hundreds of thousands of people would be enrolled, we see under 5,000 people enrolled. Contrast that to North Carolina, which did regular Medicaid expansion and started a few months later, has

almost 500,000 people covered. So we have 5,000 in Georgia and we have 500,000 in North Carolina under traditional Medicaid expansion.

Moreover, because there's so many bells and whistles to this Pathways program, some great investigative reporting turned up. That in fact, 90% of the spending on Georgia's Pathways has been for consultants and IT vendors, the Deloittes of the world and not for providing coverage. That does not include the cost of the lawyers and the litigation. And recently, the governor announced a $10 million outreach campaign related to Pathways.

So the amount of administrative spending here, I call this now Pathways to Profit, not Pathways to Coverage. It is shockingly unsuccessful in covering people, but it's been very good at essentially wasting taxpayer dollars on these kinds of bells and whistles.

And so the value of work reporting requirements, I think is pretty clear could have been a complete bust. And in fact, they're not even enforcing them in Georgia because they're so desperate to have people enrolled.

But next time, I'll tell you how I really feel about it. But we'll see if anyone else wants to jump in.

Stephanie Armour:

Kate, any thoughts on this as well?

Kate McEvoy:

Yes, thank you. I appreciate the invitation to provide a counterpoint to those remarks.

I want to elevate from focus on any one of our member state or territory programs really to say a few things about the reality of where our country's situated.

Again, as I made the comment in my remarks, there are different theories of social change and views around the breadth and scope of the Medicaid program. Definitely different views of pathways to implement expansion across the country.

If we are proponents of expanding Medicaid, it is a necessary phenomenon to examine how that can occur in various environments across the country. The policy features that may accompany expansion may be the vehicles that make that expansion possible. And again, I think it is very important to look at it in that respect of the "why" of the ultimate aim of expansion, and that is coverage of more individuals.

I do also want to say that expansion itself is an expensive proposition at the threshold with the administrative investments. Having served as Medicaid director in

Connecticut, there were enormous upfront costs of preparing our systems, all of the different administrative channels, the nexus to our state-based exchange.

It is not fair to point to one state's experience with expansion as unique in terms of the upfront costs of the administrative processes. Those are always a factor in expanding coverage eligibility groups. And again, examining how we optimize those processes across states is a shared interest of states and territories so that we don't see spending on systems that dwarfs the ultimate utility.

Finally, I will say the language in the federal statute around authorization of 1115 waivers, the research and demonstration waivers, is fairly brief. It has over time been subject to different interpretations by different administrations.

The overwhelming sense of states and territories is that consistent with the structure of Medicaid as an applied equity partnership between the federal and state governments as well as the territories, there is considerable latitude for programs to implement the program in the way that makes sense in their respective environments. And we cannot pretend that there is homogeneity across the country in terms of those features, the policy matters.

And again, those are all very important parts of this discussion as we grapple with differences across programs: but again, honoring the "why" of those.

Stephanie Armour:

Great. Thank you guys so much for your answers. One of the questions, just to move on, because it looks like I think we have about five more minutes left for my questions. And this is something I thought perhaps Vicki and Dr. Ndumele you could speak to a little bit. And that is, what is known about potential disparities in enrollment and continuity? And the implications, the policies that could have on health equity?

Vicki Fung:

Sure. I can hop in first. I mean, I think that Chima really eloquently put it that Medicaid serves disproportionately a population that is comprised of racial and ethnic minorities. So any changes to the Medicaid program are really critical for addressing health inequities.

We know that there are disparities in coverage, Black and Hispanic and American Indian, Alaska Native populations are more likely to be uninsured.

They're more likely to face that issue of churn that I mentioned, particularly concerning if we think people are continuously eligible and they churn in and out of the program and face discontinuities in their care.

We know also that communities of color tend to face more barriers to enrollment, language barriers, fewer resources or social support for enrolling, potential mistrust of government programs.

I think these policies that focus on eliminating unnecessary red tape and streamlining enrollment have a large potential to improve enrollment outcomes, particularly for communities of color.

Dr. Ndumele:

I think Vicki highlights a really important point: that the challenges associated with things like administrative burdens aren't felt equally. They're often felt more by folks that are more vulnerable, however you define that.

In some of our work, we find for example that individuals with diabetes are about two times more likely to be unenrolled for the program due to work requirements. I have [inaudible 01:06:25] often about information and navigating the system, and who can do so effectively.

So there's wide variation across states, but there's also wide variation across populations within states. And it's incumbent upon us to have a functioning Medicaid program as one that tries to reduce the effect of the challenges on all of these individual groups.

Stephanie Armour:

Great. Excellent. Thank you so much. Those are great points.

We also have some fabulous questions that are coming in from the audience, and I wanted to just turn this over to anyone who would like to jump in on this. But I think this is a great question from Cheryl Berenson, which is, "How will the Supreme Court's Chevron decision impact Medicaid?"

Joan Alker:

[inaudible 01:07:18]

Kate McEvoy:

I'm sorry, Joan. Would you like to go first or would you-

Joan Alker:

No, go ahead, Kate.

Kate McEvoy:

Great. I did allude to this in my earlier remarks. The Supreme Court's decision in Loper-Bright, which changed the standard of review for regulations produced by federal agencies, is very significant for Medicaid programs for a number of reasons.

First, it squarely places within courts much more authority to interpret validity, consistency with the enabling statutes than the historical typical deference to federal agencies. It introduces elements of uncertainty for regulations that have already been promulgated. And as I mentioned, we've had a very significant number of those regulations this year around eligibility access, managed care, interoperability, core aspects of the program.

We note that CMS took great pains to include in those rules significant preambles that articulated its view of the relationship to the enabling law as well as severability provisions. But again, there may be and likely will be challenges to at least elements of those rules.

Again, as states are looking ahead; and they have to forecast ahead again across biennial budget cycles and also system cycles that are already overburdened by many legacy projects; the aspects of planning for implementation of the many different facets of these rules are increasingly complex, given the potential for challenges and some of the rules being taken down in that respect.

I also have to mention that their recent federal court decision-

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Kate McEvoy:

I also have to mention that there are recent federal court decisions, interpreting the scope and breadth of the 1115 authority that are also significant operationally in terms of what is permissible and the interplay of the court's decisions with the latitude of approvals by CMS. Again, the bottom line is can states reasonably rely on the auspices of their 1115s and the regulations that they're now being asked to implement?

Joan Alker:

Yeah. I think Kate and I probably have a lot of agreement on this point. I am not a lawyer, but I happen to work with some brilliant legal minds and one of them, Leo Cuello, has blogged on Loper Bright on what the impacts of Medicaid are. I'll try to pop that in the chat. Recently got cited by John Oliver, this blog. It's a great blog, so I'll pop that in the chat. I think couple of points to make that decision of course has

gotten the most attention. There are other decisions, Corner Post, et cetera, that are essentially a tax on the administrative state. That's a problem for Medicaid, an extremely complicated program here that has a great deal of ... almost any program you can think of because Medicaid is a federal state structure, there's just a lot going on in the regulatory environment. This is a big problem. The judiciary is increasingly involved in Medicaid, as Kate was mentioning, the section 1115 decisions, et cetera, et cetera. We have to pay attention to this.

I guess the last point I want to make about this, which is something else I think Kate and I will agree upon, in contrast to this sort of deep state view, CMS, which runs Medicaid, is actually very understaffed. They're not deep at all. This is one of the problems that we have. It takes a long time to process section 1115 waivers. We just saw with the Medicaid unwinding, it was extremely taxing. States are understaffed too. This is a serious problem as we think about in a good election outcome, fulfilling the promise of Medicaid, which I completely agree with Chima, is essential to achieve any goals related to health equity and frankly investing in our children and thinking about our future as a country. We need to have better staffing and support at both the federal and the state level to ensure that Medicaid is running as well as it can and I would add to oversee these managed care companies who really are the ones delivering the services.

Stephanie Armour:

Great. Thanks so much for that. I want to jump into a question from someone who's anonymous and this is for Dr. Ndumele. The question is, "How do we transform the evidence you've synthesized into policy changes? Do we know enough already about pros and cons of the competing approaches or do we need more data?"

Dr. Ndumele:

It's a really, really good question. My sense is that the answer is a little bit of both. There are areas where there's overwhelming evidence. But there are many areas, as Kate noted, where the evidence and the outcome they're going to be related to implementation. States are very different in both their approach to these challenges and their capacity to implement. There's an important and interesting question about when we've hit the tipping point, but the tipping point is directly related to the type of information that you want.

We often have forecasting information about what these policies will do. We rarely have things like return on investment and how those intersect with each state's priorities and populations. There are places where we clearly know that we're going to

do harm and I think we should think about the role of the federal government in helping states avoid those landmines. But there are going to be places where we need to learn on the fly and not because individuals are trying to hurt folks, but because Medicaid is designed to be a series of labs where states work and innovate in ways that respond to their needs and their population's needs. I think it is the case that for many of these things we're going to need a little bit more information.

Stephanie Armour:

Thanks so much. This question is kind of geared toward Joan, but I'd love to hear Vicki's take on this too, or anyone else too, feel free to jump in. This is from Megan Cole-Brahim. "One of the reasons that states give for not expanding Medicaid under the Affordable Care Act is that the concern that the federal government will reduce the match rate and states will be left covering the cost of care for the expansion population. Historically, this doesn't seem likely, but given that Joan mentioned this is potentially one of the GOP federal health policy proposals on the table, I'm curious what the panelists think on this issue. Are states founded to be wary about losing the match rate or do you think that's unlikely to happen regardless of who wins the election?"

Joan Alker:

Okay. Great question. That is absolutely true that this is one of the reasons that opponents of expanding Medicaid will cite. Funnily enough, it's often the same people who support cutting Medicaid and cutting the match rate. So if they're concerned about that, I suggest that they flip their position and lobby against that should their colleagues in the Republican Party wish to do that. But there's a practical way to get around this, which a number of states have done this, which is put in a trigger provision to your expansion law so that if the federal match goes down, the state is automatically going to terminate their Medicaid expansion.

It's somewhat of a disingenuous argument because of whose making it oftentimes. I do want to say historically speaking, we have never seen the Medicaid match rate go down. Okay. We've been through this block grant cap fight. I personally have been through it three times now in my lifetime and I don't know what's going to happen. So far it hasn't happened, but we are in a pretty big change moment in our society right now. We don't know what's going to happen with the outcomes of the election. We just don't know. I would say it's not a good reason not to expand Medicaid, but we just are going to have to see where we're at. We're in a really critical moment. It is an existential moment I think for Medicaid. If we did see a Republican trifecta, I think the

chances is this would be the most difficult fight to fight against a Medicaid block grant that we have ever seen.

Vicki Fung:

Yeah.

Stephanie Armour:

Vicki, any thoughts? Yeah.

Vicki Fung:

I don't have much. I mean, Joan covered that really comprehensively. I don't have too much to add there except for that I think it's worth mentioning that the way that the ACA was originally intended to work was that Medicaid expansion would not be optional at the state level. When I mentioned the ACA marketplace coverage, the ACA also really reformed the individual insurance market for people who don't qualify for Medicaid or Medicare or who don't get coverage through their employers. There's this coverage gap for individuals who live in non-expansion states and who have incomes below the poverty line because the ACA subsidies to buy private insurance coverage on the marketplaces don't extend to that group. There's a lower limit of 100% of poverty. I think that just moving forward in these states that have chosen not to expand Medicaid for whatever reason, and I think there are concerns about what will happen to the match rate and time will tell, but something has to be done to address this major coverage gap for these extremely socioeconomically vulnerable individuals.

Stephanie Armour:

Great. Thanks so much. This question came in from Katherine Mayer-Vanasek. I just think I'll throw this open to everyone because it is an issue that doesn't get a lot of attention, but I think it's a good question. "Are there thoughts regarding oral healthcare coverage? What can be done to ensure access to oral healthcare? Dentists often do not become Medicaid providers due to lower reimbursement rates leading to covered individuals not being able to find a provider."

Kate McEvoy:

I'm happy to jump in on this. I first want to say folks who are producing research in this area have been, I think, very helpful and persuasive in identifying the relationship of oral health to preventive health overall. I think we are in a strong position of examining the why of the coverage. Among other optional services in the Medicaid program, it is

not something I think that is a question of is this of benefit? I think there's widespread view that it is. It really then becomes subject to consideration of this investment or another perhaps equally worthy investment. I would use as an example, that is very material right now, almost all programs are materially investing in behavioral health, especially for young children as I mentioned, and also for maternal health in recognition of the extreme disparities of experience and outcomes, especially around maternal mortality in the postpartum period.

So when you talk about investment in oral health, I think it has to be situated in a context. Again, I described the budget environment is not expansive. It is belt-tightening for the reasons of the sunset of the of the federal pandemic assistance and the tax revenues being down. It's a this or that proposition as well as the considerations of investment in other sectors like education. I think there are many proponents from the preventative health standpoint. But again, this is a relative set of investments and I think we continue to struggle with this. The last piece I'll say is the access rule that was established this year has many features that I think are going to point more attention to the availability, the proximity of preventive health services. Dental was not identified as a core service in that context, but that orientation is really an ask of all programs right now in terms of how people are using those types of services.

Joan Alker:

Yeah, I'll just add to that. As Kate mentioned, it's an optional benefit for adults. It's not an optional benefit for children, it is part of the EPSDT benefit. I agree with Kate, I think with the tight budget climates we're expecting at the state level next year that I worry about the adult benefit being trimmed back. For children, I did want to mention we just had some new guidance issued on EPSDT a couple of weeks ago by the Biden Administration. I would hope in a Harris Administration that they would really continue to dive into this work around EPSDT, the pediatric benefit in Medicaid, which dental is really important component.

But it's really any medically necessary service, a child that's identified in the screening, they are supposed to get treated, but we have a lot of work to do to make this benefit a reality. I think reimbursement rates are a big part of the problem, but I also don't think they're 100% of the problem. I think some dentists just don't want those kids in their office, but I think we've made a lot of progress. I completely agree with Kate, understanding how critical it is to overall health to preventive health. I hope that this is something that we can continue to really make progress on going forward.

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Dr. Ndumele:

I just want to chime in here quickly because I completely agree with both Joan and Kate that this is a really vexing and challenging problem, in part because it's not just a reimbursement problem, right? There are areas of the country, of states where they're just ... this is a workforce challenge, right? There are rural areas where there aren't enough dentists to take care of the folks that we want them to take care of. This is one of those places where states are going to have to think innovatively about how to get this solved because there won't be a one-size-fits-all solution for all states here.

Stephanie Armour:

Excellent. Thank you for those answers. That's really interesting. We're close to out of time, but I did want to throw in one question because we have a couple minutes and that is from James Perrin. His question was, "Managed care organizations provide much Medicaid care with increasingly high denials and limited transparency in state contracts. What changes should affect monitoring of MCO efforts?"

Joan Alker:

I'm going to just ... that I think was teed up. Thank you, Jim. Totally agree with your question. This is a huge, huge issue. I will say from our perspective of the Center for Children and Families, where we do a ton of work on Medicaid, that we really cannot understate the importance of, as a community, focusing on the role of managed care companies, improving transparency about what they're doing, accountability for what they're doing. This is where the money is going. This is the delivery system for most people in Medicaid, particularly on the acute care side. We've got to do better on this. We do have new regulations, as Kate mentioned, and that's something we didn't really get a chance to talk about that a Harris Administration, there's a lot of teed up, new regulations, eligibility, enrollment, renewals, managed care, all of these issues, EPSDT, that hopefully a Harris Administration would really dig into.

But I think all of us need to learn more about what's going on under the hood with managed care. I'll just say finally, a lot of these are for-profit companies, they're well-resourced companies. It is hard for states who are understaffed, as I mentioned, to be able to have good oversight. Even more importantly, it's hard for families and people and their advocates to understand and speak in this foreign language of actuarial soundness and all of these words that get thrown around. But we've got to empower the voice of consumers and providers to be able to really hold these companies accountable, because otherwise, we are not going to be able to achieve our goals for where we'd like to see Medicaid go.

Transcript
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Kate McEvoy:

I'll just wrap around to say states and territories have shared interests in high quality outcomes and experience for members. That new role, I just popped the link to the CMS fact sheet, different domains that I think have potential to be very material with the experience surveys, secret shopper, transparency of rates, the piece around a new quality framework and ratings scheme as we have done for Medicare providers. Also, the piece around access standards. We were just talking about meaningful access to dentists within managed care arrangements. That set of access standards, challenging though it will be, sets a new bar for people who are served by those plans. I think that is the shared commitment of states around improvement and quality and like I said, the experience of people served by the program.

Stephanie Armour:

Excellent. Thanks so much for those answers. One other question, one last question here from Sarah Gordon. I like this question and I want to just throw this open to anyone on the panel. "What would each of your number one federal policy recommendations be for improving Medicaid for the new administration?"

Dr. Ndumele:

I'll take a shot there and it's actually not in Medicaid. I think that often in Medicaid, the case is that we're often looking for our keys under the lamp. That is, we think the most convenient place to look for savings or whatever is where we're going to find them. The reality is that 55% of Medicaid recipients receive care from at least two other assistance programs. There is tremendous room for coordination and engaging with the kind of whole person orientation across the SNAP program, across the WIC program, to collectively design these programs to help people improve their health.

Joan Alker:

I'm going to say on the eligibility side, we have new bill introduced to mandate continuous coverage for children zero to six and then two renewals after. I'd like to see more continuous coverage for adults. So on the eligibility side, that's, I think, an exciting development that a lot of states are pursuing. But let's make sure it doesn't depend on where you live, let's mandate that federally.

Kate McEvoy:

It may surprise you to learn. I will not choose something that is a typical area of policy emphasis, but for me it is the federal government exerting more influence and levers

over system spending for Medicaid. We talked earlier about the high costs of system implementation. The phenomenon of first dollar spending state by state is a real challenge. Because the federal government is paying for 90% of those costs, we are in a position of leading up to say you can do more to illuminate opportunities for scaling practices across states for eligibility systems, for provider payment systems, for call centers, making it possible for states to partner together as collaboratives and also helping our territories. We're at a very naive point of development to partner with states. That's one of the single greatest opportunities to kind of maximize public resources I could point to.

Vicki Fung:

These are all really tremendous answers. I'll just piggyback on all of them just to say that I also agree that coordinating across a number of assistance programs and ensuring that there's more exchange of information that can reduce the burden on beneficiaries who have to go to so many different sources to get the supports that they need would be a really great improvement.

Stephanie Armour:

Great. Thank you for that. One other quick question that came in from Emanuel Nidea, "What can we conclude about the number of Medicaid-enrolled population in 2025?" Joan, I'll start with you.

Joan Alker:

Can you repeat that again? I'm not sure I quite got it.

Stephanie Armour:

Yeah. What can we conclude or what takeaways can we come up with about the number of Medicaid-enrolled population in 2025 just based on its size?

Joan Alker:

I'm not sure how to answer that. The number has gone down recently because of Medicaid unwinding. As Vicki talked about in the beginning, not everybody who's eligible for Medicaid is actually enrolled. We've got to get some more data to see where are we on these participation rates and let's make sure particularly children who are more likely to remain eligible are going to get back into Medicaid if that's really their coverage source. We're in a kind of state of fluctuation and some of those folks that lost got ESI, we hope and went to the Marketplace. So that's okay, but some of

them, particularly the children, should actually be enrolled in Medicaid. We're focused now on let's try to do outreach to families to make sure that those families that lost where they shouldn't have, we need to get those folks back on.

Stephanie Armour:

Anyone else want to jump in on that one? If not, I think we're pretty close, I think we can wrap things up, but I wanted to give anyone a chance if they have any other concluding thoughts to share. This has really been interesting and fascinating so far.

Sandro Galea:

Well, let me jump in looking at the fact that we're at time to say thank you. Wow, what a really interesting conversation, what a really interesting conversation about such an important topic, particularly as we're in October of 2024. I want to say thank you. Thank you to our panelists for teaching all of us. Thank you to our audience. We really had some excellent questions. Thank you to Stephanie for facilitating. Thank you to everybody for everything you do, particularly in a time of flux and a time of change. Everybody have a good afternoon and good evening. Take good care.

Stephanie Armour:

Thank you.