Amid Unwinding of Pandemic-Era Policies, Medicaid Programs Continue to Focus on Delivery Systems, Benefits, and Reimbursement Rates

Results from an Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024

Executive Summary

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Executive Summary

The COVID-19 pandemic profoundly affected Medicaid enrollment, spending, and policy. The pandemic also focused policy attention on longstanding issues resulting in new efforts to reduce health disparities, expand access to care through the use of telehealth, improve access to behavioral health and home and community-based services, and address workforce challenges. Serving more than 90 million low-income Americans and accounting for one-sixth of health care spending (and half of long-term care spending) and a large share of state budgets, Medicaid is a key part of the overall health care system. While the unwinding of the pandemic-related continuous enrollment provision and enhanced federal match rate were the dominant Medicaid policy issues at the end of state fiscal year (FY) 2023 and headed into FY 2024, states were also focused on an array of other priorities that range from core program operations and the unwinding of other pandemic-related emergency policies to developing and implementing new initiatives (Figure 1).

This report highlights certain policies in place in state Medicaid programs in FY 2023 and policy changes implemented or planned for FY 2024, which began on July 1, 2023 for most states.¹ The findings are drawn from the 23rd annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by KFF and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAM). Overall, 48 states responded to this year’s survey, although response rates for specific questions varied.² States completed this survey in mid-summer of 2023. Given differences in the financing structure of their programs, the U.S. territories were not included in this analysis.

Figure 1

The 2023-2024 Medicaid Budget Survey Reveals Key Themes Beyond Unwinding in These Topic Areas

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SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2023
KEY TAKE-AWAYS

Provider Rates and Managed Care

- States had implemented (in FY 2023) and were planning (in FY 2024) more fee-for-service (FFS) rate increases than rate restrictions. States reported rate increases more often for nursing facilities and home and community-based services (HCBS) providers than for other provider categories, with several states reporting substantial increases—likely in response to ongoing workforce or staffing-related challenges. In addition, nearly half of states (23) reported increasing primary care physician rates in FY 2023 and nearly two-thirds of states (30) reported plans to do so in FY 2024, representing an increase relative to surveys in recent years. More than three-quarters of states also reported rate increases for behavioral health (mental health and substance use disorder) providers. While the survey only captures changes in FFS reimbursement rates, these rates remain important benchmarks for managed care payments in most states, often serving as the state-mandated payment floor.

- Nearly two-thirds of states that contract with managed care plans reported implementing “risk corridors” to manage pandemic-related uncertainty, and most of these states recouped or expect to recoup funds from managed care plans as a result. Capitated managed care remains the predominant delivery system for Medicaid in most states. As of July 2023, 41 states were contracting with managed care organizations (MCOs). To help respond to utilization shifts and uncertainties in setting capitation payments, the Centers for Medicare & Medicaid Services (CMS) encouraged states to implement two-sided risk mitigation strategies, including risk corridors, for rating periods impacted by the public health emergency (PHE). Risk corridors allow states and health plans to share profit or losses if spending falls above or below specified thresholds. Nearly two-thirds of responding MCO states (23 of 37) reported implementing a pandemic-related MCO risk corridor since March 2020; more than three-quarters (18) of these states reported that they have or will recoup funds from managed care plans.

Benefits and Prescription Drugs

- Most states continue to implement benefit enhancements, particularly for mental health and/or substance use disorder (SUD) services. In addition, to improve maternal and infant health outcomes and address racial/ethnic health disparities, states continue to expand and enhance pregnancy and postpartum services. States dramatically expanded the use of telehealth during the pandemic, and while telehealth coverage policies have now largely stabilized, states continued to report telehealth coverage expansions in FY 2023 and FY 2024.

- Sixteen states reported Medicaid FFS coverage of at least one weight-loss medication for the treatment of obesity for adults as of July 2023. While Medicaid programs must cover
nearly all Food and Drug Administration (FDA) approved drugs from manufacturers that have entered into a federal rebate agreement, a long-standing statutory exception allows states to choose whether to cover weight-loss drugs under Medicaid. Some states may be re-evaluating their coverage of weight-loss drugs due to the emergence of a new group of highly effective anti-obesity or weight-loss agents known as GLP-1 (glucagon-like peptide-1) agonists, including Ozempic, Rybelsus, Wegovy, and Mounjaro. (Ozempic, Rybelsus, and Mounjaro are drugs approved to treat diabetes, and covered by Medicaid for that purpose in all states; off-label coverage for weight loss in Medicaid may be limited.) Expanding coverage of weight-loss drugs under Medicaid would increase access to these medications that remain unaffordable or inaccessible for many but, at the same time, would likely contribute to increases in Medicaid drug spending. Rising prescription drug costs are an ongoing concern for states and over two-thirds of states reported at least one new or expanded initiative to contain prescription drug costs in FY 2023 or FY 2024. Efforts to implement or expand value-based arrangements (VBAs) with pharmaceutical manufacturers were the most frequently mentioned cost containment initiative across states.

Social Determinants of Health and Reducing Health Disparities:

- A number of states are expanding or enhancing Medicaid coverage to help address enrollee social determinants of health (SDOH) or associated health-related social needs (HRSN). In 2022, CMS released a new framework for covering HRSN services under Section 1115, expanding flexibility for states to add certain short-term housing and nutrition supports as Medicaid benefits and subsequently approved waivers in four states (Arizona, Arkansas, Massachusetts, and Oregon). In 2023, CMS approved additional HRSN waivers in Washington and New Jersey. Looking ahead, one quarter of states cited addressing health-related social needs as a key priority.

- States are implementing strategies to reduce racial and ethnic health disparities, including through changes in managed care contracts. Some state MCO contracts incorporate requirements to reduce health disparities and states may also tie MCO financial quality incentives (e.g., performance bonuses, withholds, or value-based state directed payments) to reducing health disparities. States must require MCOs to implement performance improvement projects (PIPs) to examine access to and quality of care, and these projects often include analysis of health disparities.

Heading into FY 2024, states were focused on unwinding of the continuous enrollment provision in Medicaid but also on addressing other key priorities. States were employing a variety of strategies designed to maintain coverage for eligible individuals and mitigate “procedural” terminations that occur when individuals do not return or complete renewal forms or respond to requests for information. In addition to managing the enormous undertaking of unwinding, states highlighted addressing provider and state workforce shortages, expanding access to behavioral health and long-term services and supports
(LTSS), and implementing broader delivery system and value-based initiatives as both key priorities and challenges. A smaller number of states mentioned addressing health-related social needs, improving provider reimbursement rates and/or performing rate studies, implementing initiatives to improve maternal and child health, and expanding eligibility as key priorities. While most states are in a strong fiscal position, many Medicaid directors expressed concern regarding their longer-term fiscal outlook due to the expiration of pandemic-era federal funding and economic factors including slowing revenue growth, inflationary pressures, and workforce challenges.
Endnotes

1 State fiscal years begin on July 1 except for these states: New York on April 1; Texas on September 1; Alabama, Michigan, and District of Columbia on October 1.

2 Florida, Minnesota, and South Carolina did not respond to the 2023 survey. In some instances, we used publicly available data or prior years’ survey responses to obtain information for these states. However, unless otherwise noted, these states are not included in counts throughout the survey.
The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country and territories. NAMD supports Medicaid Directors in administering the program in cost-effective, efficient, and visionary ways that enable the over 89 million Americans served by Medicaid to achieve their best health and to thrive in their communities. NAMD does this by offering programs for Medicaid Directors, elevating the consensus issues of Directors in the federal policy process, and serving as the trusted source for data and information about Directors. Learn more at medicaiddirectors.org.