STATES OF HEALTH: INNOVATION BEYOND WASHINGTON DC

Kody Kinsley

Well, good morning, everyone. It's wonderful to see folks. My name is Kody Kinsley. I am the retired and recovering health secretary from the state of North Carolina. And we are happy to invite you to our little secret dinner conversation among friends to talk about some tough and exciting things right now. I'll have folks introduce themselves the first time they speak, just to keep it easy. And I think you know everyone up here, but we're going to go ahead and dive in. So, I want to start here, which is that we had an election last week. 36 states had gubernatorial elections, 21 new governors. We've got folks up here who have had their hand on the tiller for several years and will continue to have their hands on the tiller, navigating through some of the most choppy times in health policy broadly. We also know that the federal government often looks to states to find their best ideas for innovation, and it's these leaders that are sparking those innovative things. Last point, which is, we heard from voters, 60 percent of them ranked health care as one of their most top concerns for the economy and something they were concerned about, tied with gasoline prices and groceries. Now, I don't know about you, but I'm kind of surprised that Americans are caring about health-care prices as much as they care about gas and groceries, and I think it tells you the frame of mind that voters are in. So, I want to start here, which is, Tracy, I'm going to pull you in. I waited until you took a sip.

Tracy Gruber

Dinner, it's dinner.

Kody Kinsley

That's right. You're allowed to drink. Is it water? So, we had 10 states, I think, in the last year have a budget deficit, many others project a budget deficit. That's created a bit of a burning platform for state conversations to embrace policy ideas a little bit differently. Can you talk to us about your budget deficit in Utah, how you guys are navigating it, and how you're trying to start to tackle that challenge?

Tracy Gruber

Sure. Yes, and thanks. Great to be here. Tracy Gruber. I'm the commissioner at the Utah Department of Health and Human Services, have been in my role since 2021 when Governor Cox became governor. And we don't have a statewide budget deficit. Utah's economy is really recognized as among the strongest. It's very diverse. It continues to keep growing, knock marble. But we do have a Medicaid deficit. And what we know is about two-thirds of the states have a Medicaid deficit that we're all trying to tackle, and the trends that created that are very similar. Utah had one unique issue that we thought it was a good idea to launch

our Medicaid management payment system, our new system that was 10 years in the making, replacing a 40-year legacy system at the same time as unwinding, which made it very difficult for us to forecast. So, to the extent states are able to take the opportunity, I think you've called it a “crisisutinity”, if I'm not mistaken, and finally have the time to kind of reset and reevaluate. I think what we've seen, at least in the Medicaid space, is that Medicaid has become the program to address a lot of issues that have been underfunded, whether it's food or housing, certain other things, and that has created a lot of pressure and has really moved away from some of the core elements of the Medicaid program. And we think this is a great opportunity to look at the Medicaid program holistically. And also, quite honestly, address some foundational challenges that kind of, over time, increase the complexity of the program that I think all of us were surprised by. And when I say all of us, I think I would include our actuaries who we rely on for rate settings, not being able to see that. So, we're in the process of trying to think differently about the program, how we administer the program, of course, program integrity, how to make sure that the population can actually get access to health care, to bend that cost curve without jeopardizing or making their health outcomes worse.

Kody Kinsley

Medicaid's pretty much one of the top expenditures in most states. And so, it's got... *[inaudible]* But Gloria, pulling you in, can we solve health-care costs by focusing just on Medicaid?

Gloria Sachdev

That would be nice. That would be easy. I'm Gloria Sachdev. I'm secretary for Health and Family Services in Indiana, cabinet secretary to Governor Mike Braun. Prior to this, I've been in government for almost two years. I was president CEO of the Employers’ Forum of Indiana. In that role and in this role, now I think I have a 360 lens on health care. And, Medicaid is just one of our payers, right? It is the biggest state government payer, but we have commercial. All of us, I'm assuming most of us are working. And so, we have commercial, Medicare, and cash paying patients. So, those are the only four payers. And most of us in the commercial space have high-deductible health plans, as a state. So, you have a deductible, but then you have a max out-of-pocket. That max out-of-pocket could be $15,000 or more. And so, essentially, transparency now and competition are part of the forefront. We have to focus on transparency because it's not just the uninsured that are cash paying. The majority of us are paying cash until we hit some sort of threshold. And even if you're not one of those, your employers are picking the rest of it up, and that comes out of your paycheck by way of premiums. So, either way, you're paying for it. You're also paying for Medicaid and Medicare. So, I think to look at it holistically, both public-private partnerships, as we are trying to address affordability is really key. But focusing on transparency and competition has been what we've been focusing on at the state.

Kody Kinsley

Meena, I know you've been really focused in Maryland about making sure you're getting your value for every dollar. And using your data and the transparency to see that where those investments are playing out. Talk to us about that a bit.

Meena Seshamani

Yeah. Well, I echo the thanks for getting to be here and join my esteemed panelists. I'm Meena Seshamani, secretary of health for the state of Maryland. I actually want to pick up on where Secretary Sachdev left off on the fact that you do have different payers in the mix. And as we think about what are the things that people want, as you started with, Kody, having affordability, having a market that actually works, where you have choice, where you have competition, and where you have investment in health care, where it really matters to people, which is not when they're already sick and now going to the emergency room, right? And so, what we're able to do in Maryland is align all of the commercial, the Medicaid, all of the buckets of payers together in a system that has cost containment, where hospitals have a global budget that is

irrespective of what their payer mix is. It's based on what their population is, and if they keep people healthy and out of the hospital, then that's more money for them. Coupled with aligned quality metrics. And I think this is where the data really comes into play because we can spend all of our time chasing down data metrics that are different for different programs, right? When I was working in a health system, we had a spreadsheet of, like, 800 metrics for all these different programs. And instead, where we can really align on several key measures that can really drive improvements, and where you can utilize a health information exchange like we have in Maryland with CRISP, so that everybody has access to that data across all of the venues that somebody goes for their care. And I think that has really been important for us. So, looking not only at whether diabetes is controlled, high blood pressure is controlled, follow-up after a hospitalization for mental health, but then pairing that with unnecessary hospital visits, readmissions, ED utilization, and finally, what is the total cost of care? So, by bringing all of those metrics that start with those health metrics and then expand to the utilization and then ultimately, to the cost, you're able to then invest in aligned initiatives across populations that can really drive meaningful improvements in the health of people in communities, and that ultimately spends the dollar in a smarter way.

Kody Kinsley

Yeah. I hear this through line of how are we drawing the line through the fragmentation of purchasers, and then also how are we drawing the line through the fragmentation of the ecosystem of providers to make sure we're all rowing in the same direction? And I think it's really beautiful in the seats that you all in to do that. I want to start to dive into that sense of how we're aligning around a goal and bring a particular goal to the conversation, which is maternal health. This is a space where we've seen states like Arkansas, North Carolina, Maryland—a number of—really try to reach across, especially some of our health disparities issues. Dan, you've been on this issue for some time in Mississippi. Talk to us about where you're hopeful on progress, how you've been getting alignment across this issue, and where there's still more work to be done.

Daniel Edney

Yeah. Thank you. There's an awful lot of work yet to be done. And, just to level set expectations, in Mississippi, I'd be the equivalent of the commissioner of health. We don't have a super agency. But I don't report to the governor. I report to the Mississippi State Board of Health, who has all public health authority in our state. And that is what allowed me to declare the public health emergency for infant mortality. It was, in particular, related to African American infant mortality, where in 2024, we had an explosion that none of us could explain. And it was very discouraging that despite all the work that everybody in Mississippi had been doing on maternal infant health issues, we had a really bad year, and our babies had a really bad year in 2024. And so, I didn't realize how innovative that policy decision would be when I declared it, because we're the only state that's ever done that. And then the question I immediately asked was, why? Because we're not the only state with a problem, are we? And, every state represented up here has a problem with maternal infant health issues to one degree or another. We are scoring the poorest with our babies. But there are many states that are just barely ahead of us, and now, they hear the hoofbeats behind them as Mississippi is working very hard to achieve our goal, which is to reduce our infant mortality rate to below the US average. And I'm 65 years old, been doing this work a long time. I'm anything but naive. But I know, from the science, that we can do this. This is achievable. And if Mississippi can do it, good grief, we all can do it. So, what I'm very… And declaring that emergency was a much bigger splash than I realized, in the state and outside of the state, and it was not a gimmick. It was something we needed to do, and it got state government out of our way at the state department of health—

Kody Kinsley

Yeah. What did it free up? Tell us what you're doing and *[inaudible]*

Daniel Edney

It is an agency state emergency, which got state procurement laws out of our way, got state personnel restrictions out of our way. The first thing that we did, we knew that we had safe sleep issues in the state, especially with our high-risk vulnerable families that just did not have cribs. So, we got, in the last year, 800 cribs out, and that are Pack and Plays to vulnerable families at no cost, tied to safe sleep education. And I was able to buy those cribs in a couple of weeks instead of eight months. And we got those cribs out and continue to get those cribs out. We had been working on our state's fourth statewide system of care, the obstetrical system of care, which is a modeled after our trauma system, so that high-risk moms and babies get to the right level of care as quickly as possible. Not the closest care, but the right care at the right time, the right way. And when we complete that, which will be about another 12 months, we'll be the only state in the country that has a comprehensive obstetrical system of care starting at 911 all the way to discharge. That just attacks one of our problems. But it accelerated the implementation of that program by a year.

Kody Kinsley

Again, this theme of drawing this line through the fragmentation around a specific issue. So, Marvin, you, relatively new in your role in Virginia. That's wonderful. And you've come into the role at a time when everything's been pretty quiet. *[Laughter]* And there's not been a lot of change. You've got all these issues. Everybody's talking about how they're focusing. Talk to us a little bit about the headwinds here and what's changing in the midst of all this around various H.R. 1 public programs, and how you're tackling that as well.

Marvin Figueroa

Yeah. Happy to. And good morning, everyone. I want to also thank Milken for inviting me to this dinner party. Pair alignment fragmentation is exactly what I talk about at dinner.

[Laughter]

Kody Kinsley

I mean, it is. I bet it is.

Marvin Figueroa

It actually is. Look, I think where—I came in in January, a lot of issues to deal with, and what I've been focusing on is sort of the basics. There's a lot going on. There is a need to look at all the things that are immediate, but also think about more long-term. And the way that I've been able to do that is to think about my mother and growing up in the Bronx, and how frustrating it is to go and get the services that you need in order to stabilize your family. The amount of time that you have to wait for that Medicaid determination, the fact that you have to explain your story to someone multiple times before you get access to SNAP. And so, while there's all these policies that you have to consider when you're administering these programs, I always start with that family that has decided that they need help, and they come to government for that assistance or that helping hand. And what you discover is that we make it very complicated for people to get what they need at that moment. And so, I've been working from there. Right? So, we always tell people, "Come to our website to sign up." And then you go to the website yourself, and it takes multiple clicks before you get to the place that you need to be. So, we're working to make sure that you don't have to go for WIC in one place, SNAP in the other place, and Medicaid determination another place, but unify that. Work with your contractors to be able to get that in one place. I've also realized that how people talk to you when you go to a local social services is something that we need to change, because the person could be waiting there or spoken about in a way that is so derogatory or in a way that doesn't recognize their humanity, and they leave and never come back. And we lose our opportunity to be able to help that person out. Yes, H.R. 1 provides us a number of new challenges, but it's going back to the basics that allows us to meet those head-on.

Kody Kinsley

Marvin, last I checked, I think the federal government spends about $12 billion a year on Medicaid eligibility systems. Is that the right number?

Marvin Figueroa

I don't know if that's the right number, but I can tell you we spend a lot. And the thing that frustrates me the most is that even then, we don't have it right. When you look at our system in Virginia, and Virginia is structured in a very decentralized way. We have social services that does one part of the job, then we have our Medicaid office that does another part of the job. And then we also have about 120 different social services offices, which means that you have 120 ways of doing things, even though there's one way that we're instructing them to try to do it to the extent possible. So, you get a different experience if you're in Norfolk versus when you're in Tazewell, whether you're in Loudoun or whether you're in Arlington. And so that decentralization creates variability in outcomes. And so, the system is the system. The legacy systems are not great, but it's also the fact that we decentralize so much that we don't know exactly what we're going towards.

Kody Kinsley

I want to invite everybody into the conversation for a few minutes around SNAP. And Tracy really brought this up at the beginning in your comments, as folks were continuing to think about different ways to invest in medicine. North Carolina had big Food Is Medicine pilot. I know, Marvin, you're thinking a lot about SNAP, and as you think about people coming into those social service offices, and how do we serve them in this moment. So, welcome anybody to jump in on how are we improving the experience for individuals who need food assistance as a driver of health? How can we take advantage of that better? Meena?

Meena Seshamani

I mean, I can start.

Kody Kinsley

Meena, hop in.

Meena Seshamani

Yeah, sure. Why not? You're looking right at me.

[Crosstalk]

Oh, okay. We all thought. You have this glare—it's everyone. I actually will come back to you Kody, where you started about how the federal government often looks to states as labs of innovation. Just by listening to the answers of my colleagues here, I think it's so obvious why, right? It's that through line, as you put it, of the fragmentation and the ability when you're closer to the ground at a state, that you're more agile and you can see what's going on to be able to address. I mean, the example of the cribs and getting cribs to address infant mortality, right?

Kody Kinsley

Yeah.

Meena Seshamani

Cribs is not a health-care expense, right? And I think that ties into the conversation around food. To Marvin's point, we in Maryland also have one application, where you go to one place, mobile app on your phone, where you can do your eligibility process for Medicaid, SNAP, TANF, LIHEAP, all of these programs. And really being able to leverage that in the time that we're in now, where people now have to, in Medicaid, redetermine every six months potentially, and have to meet new requirements. But also making sure that you are cross-pollinating the data. So, if someone is applying for SNAP, why do they have to turn around and submit the exact same information to then apply for Medicaid? So, I think that point that Marvin made was really important. And you mentioned the Food Is Medicine, and I think that comes back to where we are connecting the through line, not just among the fragmentation that exists within the health system, but also more broadly, with our economy and our communities. Right? So, one of the things that we're doing in Maryland is we are able to take money that traditionally is in the health system, in preventable ER visits and preventable hospitalizations, and we are instead funding medically-tailored meals for diabetics who come in to our hospital with a preventable ED or preventable inpatient admission. So that you are taking those dollars and spending them in a more effective way outside of the traditional health-care venue, and pairing that with money we're getting from Rural Health Transformation from the federal government to invest in our local farms so that they're the ones who are supplying those meals. So that you have—and this is what I think you're hearing from all of us—that you have that opportunity to connect the dots, not just within the health-care sphere, but even more broadly, so that you are raising economic well-being more generally for communities. And we know that economic well-being, one of the main drivers of health.

Tracy Gruber

One of the things that I would just say, we all are running these agencies, and so we are, on the government side, able to do some things. But as the health industry writ large, we can't do everything. And some of our states aren't going to be doing as much social determinant of the medicalization of social services. But I think that that is incredibly important when you're talking about prevention and improved health outcomes that the health system itself is not necessarily thinking about in the same way that I think everybody's like, "Well, that's a social service, so government should be dealing with the social service." And I think that there is a bigger trend and a bigger drumbeat for our health systems to be thinking about this stuff, too. Why is it only a governmental entity? Maybe not only, but to Dan's point of buying cribs, of course, there's a population that we serve, but the government alone is not going to be able to afford to address all of these issues. And at the end of the day, we all want improved outcomes for the people that we serve, and health systems want to be able to save money. And we're investing too late in the health outcomes of our population. And everybody turns to us to say, "Well, why aren't you fixing it?" And our deficits are a good reason. Everybody needs to be involved in ensuring that our populations are getting what they need, and the health systems are seeing people as soon as they're born in the ideal circumstance.

Kody Kinsley

Gloria, jump in.

Gloria Sachdev

So, one thing we've been doing is we call it Smart SNAP. And Smart SNAP is you get your dollars on your EBT card, and you can't use it for sugary drinks. You can't use it for candy. And shout-out to Milken, they, I think, released a report yesterday on this, looking at what all the states are doing in this space. So, we were one of the first states to do that. And then, we also have something called Double Up, which is you can, what Secretary Seshamani was saying, bringing in your local farmers so you can double up, or your dollars that are on your SNAP card are worth twice as much if you get them from a farmers' market for fruits and vegetables. So, it really helps them make the right choices. Another opportunity that we're looking at right now—so while those are in place, and we just launched those this year, another opportunity that we're looking at, we all want rewards. I think oftentimes we think of punitive things. Like, "If you don't do this,

blah, blah, blah, blah." So, we are trying to think of how can we reward folks? There are some grocery stores that actually have cards where if you make good choices, you can get an app. You can look and say, "Oh, gosh, this barbecue sauce sure does have a lot of sugar in it." But literally, it will say if you go on that same shelf two bottles down, here's a better choice for you. And then they score it in your grocery cart on the checkout way. So, if your scores improve, like you're picking healthy foods, it's your foods, and you're learning, and you're getting educated along the way how to make smarter choices, you get bonus points added, like dollars added to your card. So that's something we're looking at right now. I think a couple of states, or maybe one or two states are doing that, but some of the grocery stores are really doing that. So, I think it's an opportunity for us, again, just think about FinTech and retail and how we can bring pharmacists into helping with chronic disease management and prevention as well. So total sidebar if you wanted to dive into it.

Kody Kinsley

No, well, I want to pull more on this public-private partnership thread and looking both to Dan and Marvin to kick us off. I think, Dan, as you've worked on maternal health issues and public health broadly, I think we saw during COVID and continuing that really our employers as partners held a lot of trust among their employees as we navigated really tumultuous times. Talk to me on maternal health and broadly, how are you doing public-private partnerships around public health issues?

Daniel Edney

Well, it's such a critically important issue, and the SNAP conversation is just a great example of how all the states have different challenges and different resources. I'm responsible for improving population health outcomes in the state with the most intense poverty, fewest resources, and started off with by far the poorest outcomes. I'm happy to say four and a half years in, that's no longer true. Instead of being 60th in the country, we're 48th. And the way I've—

Kody Kinsley

He's a rosy person.

Daniel Edney

And the way we've been successful in Mississippi has been framing it in terms of economic development as we improve the health of the population. So, poor health in Mississippi cost our state's economy $25 billion a year. Maternal infant death, not health, but death, cost our economy $3.2 billion a year. Those are real dollars. And so that's the return that I put in front of our decision-makers, and they're very receptive to that. But in Mississippi, you know, it's great everybody that qualifies for SNAP is getting it, but if the closest grocery store is an hour and a half away from your community, and the closest access to food is a convenience store or a gas station, what kind of food do you think they're buying with SNAP? So, we're doing the same thing with our waivers in terms of restricting unhealthy foods. But we have areas of our state, especially Mississippi Delta, where it's ironic there aren't even farmers markets in the richest farmland in the world. And yet, the people in Mississippi Delta struggle to access healthy food. So, these are all things that are really important. The public-private partnerships, and all-government approach is how we're doing it. I'm really proud. The legislature, I asked for an endowment for public health two sessions ago. I thought it would take me three years to get it so that we could bring private sector resources into the public health space, and partnering with government resources. And we got it right out the bat, and the trust is steadily growing, and that trust is dedicated to the challenges that we're talking about this morning, and things to improve the health of the population of Mississippi. So public-private partnerships are very important for us.

Kody Kinsley

Dan, you're describing this economic flywheel opportunity, and I think all of you are thinking about this broader picture. Marvin, I'm curious, as you're thinking about social services and access to that safety net, to that springboard, are you thinking about it similarly or different in Virginia?

Marvin Figueroa

It's similar, and I'll go back to some of the stuff that Meena mentioned. There's two different buckets I think I would put it into. I think in terms of SNAP, we lost about 125,000 Virginians for procedural issues from July 2025 to July 2026 from our SNAP program. And so, you start digging into the information, and then you start to figure out what is the intervention, right? So, when people are expected to be at our social services office is also when they're supposed to be at work. And so, a person that needs social services is making the decision between going to work—and they're wage workers—going to work, and they're having to figure out how to make ends meet at the end of the month. Make it make sense, right? Or going to get the services that they need. And so, we're experimenting with having extended hours so that people can get out of work and then go to their interview, because we saw that a lot of the times folks were missing their interview. Also true during the pandemic, folks were not required to go and do an interview. And so, a lot of the folks that we hired during that period don't know how to interview. And so, we are creating AI tools and other tools to be able to, for that person to ask a question, "Hey, what is the documentation that I need for X, Y, and Z?" And then it gives them an answer. And so, we're doing that. Right? Again, I think I go back to what are the basic things that need to happen for the system to work better because of that frustration that I mentioned to you earlier in my opening. On the other—

Kody Kinsley

Just real quick, 33 minutes into the panel before AI was mentioned.

[Laughter]

Marvin Figueroa

Had to get it in there.

Kody Kinsley

That's kind of impressive. Okay.

Marvin Figueroa

I want you to call us innovative, so I had to.

Kody Kinsley

That's right. Lean in. Go.

Marvin Figueroa

So, there's that piece. And then, Tracy mentioned this is, what are the limitations of government, right? And so we are working with this thing that we call Keep Virginia Covered, which we're figuring out what are the other groups that are doing things that we need to bring them in, because one of the biggest superpowers of a secretary is the power of convening. So being able to bring in Feed More, being able to bring the food banks, being able to bring the hospital systems and say like, "If you were to create a system, I'm not telling you to align on everything, but I do need you to figure out what can we do together." And you'll find that when you invite people to the table, they actually have solutions that could be scalable, depending on what region of the Commonwealth you're in.

Kody Kinsley

How about Tracy? AI. Go.

Tracy Gruber

AI. Oh.

Kody Kinsley

Good or bad?

Tracy Gruber

Well, I mean—

Kody Kinsley

Go or no go?

Tracy Gruber

Yes. It's a go. It's a big go. Utah has this pro-human AI initiative that was launched in 2025. As I like to say, you can either put your head in the sand and pretend it's not happening, but I think a KFF report said that 30 percent of adults every month are using AI for health. I'm one of them. And so, we've decided in our state, rather than wait, and see what happens and be pulled along in AI, and have our population pulled along in AI, that we were going to lean in to being able to study some of these tools in an AI regulatory sandbox. And that term is not uncommon in the bureaucracies of regulation that you study a particular issue, you see what regulations need to be waived or adjusted in order for an innovation to come forward. So, they did add, recently, a health-care arm to this pro-human AI work, which I'm very proud to be representing and learning a lot. And they didn't have that originally because they just missed that health care would be the area that was going to need it the most. We've got people who can't afford health care, rural communities without enough health-care providers. People are demanding access to some semblance of health care. And so, studying these tools, it started with a prescription AI tool last year. The doctors lost their minds. They had a little bit of reset, and they're like, "I think we need health and human services at the table." And we have some really interesting things that we're studying in a safe sandbox, focused on the end users. It's not about the technology and just checking the box to get the technology rolling, but what technology is going to move the needle for Utahns to improve their health outcomes. So, it's very exciting. I think you've got to do it because the federal government is just a little bit wrapped around the axle on how they're going to address it. The FDA has released some important documents and analyses on it. But at the end of the day, the states are the true regulators on the ground, and how are we going to regulate these products while protecting the citizens of the state of Utah?

Kody Kinsley

I'm going to pull a few threads together, and then I'm going to kick it to Meena. We are still in a place where I think all states are still managing through substance use disorder issues and behavioral health issues broadly, on the other side of an innovation in pain medicine. We just saw a big Meta settlement on the other side of an innovation in social connection and what that looks like and how we navigate there. And as you said, the AI horses are pulling forward. You all have your hands on a space of charting a course and trying to make it safe. So, Meena, as a physician, health economist, and all the things you are, how do we navigate through the middle of that risk?

Meena Seshamani

Well, I think if I can take one step back. I think what all of us at the state level are looking at, there are three ways in which we engage with AI. The first is how we engage with AI for state services, right? The stuff that we do. How are we leveraging AI for our own workflows? Some of us, I'll say for Maryland, we have 11 state-run hospitals, so we are health-care providers as well. And how are we leveraging AI? The second bucket is that regulatory oversight. So, this starts to get to some of what you're talking about, of what are the mechanisms by which we have oversight of how AI is being used in the ecosystems in our state. And the third bucket is, where are we putting our shoulder to the wheel where AI holds promise for solving all of the issues in health care? Around access, workforce shortages, bending the cost curve, right, where you can then reach people sooner, keep them healthy. And I think it's important for us at the state level that we are looking at all three of those. And so, in terms of balancing that risk, I think that's exactly where states can play a role. It actually comes back to what we were talking about before. We are much closer to the ground than the federal government is. I say that having come from the federal government. There's pluses and minuses and great things about each. One of the benefits of the state—

Kody Kinsley

We've converted her.

Meena Seshamani

One of the benefits at the state level is that you are that much closer to the ground, where you can engage in that way and be able to, to piggyback off of what Tracy said, in a safe environment. And I would say also, where we can guide, shape where AI is being deployed to address issues of workforce shortages, access issues, where you need to move care upstream, the basics of care navigation. There's still a long way to go there that AI can really be a tool that can help us for cost containment, for population health, right? And so how do we as states both regulate and also encourage and push? And I think they go together.

Kody Kinsley

Other thoughts on where we're a little worried about AI? Anybody?

Gloria Sachdev

Well, I think for us, we're looking at AI—we are really leaning into AI. I was told this week to make an agent, and I'm like, "an agent?" *[Laughter]* And so, I've been using AI, like you said, at work for our purposes, but now we are really going to have individual agents that can help us, supposedly. I would say an opportunity or a challenge for us is we have to do quarterly eligibility checks for Medicaid—

Kody Kinsley

Wow.

Gloria Sachdev

Starting 1/1 per state statute, where the federal government's requiring it to be done every two years. I mean, twice a year. Also, we do a three-month look back. So that means we're just doing it year-round, and we need to lean into AI to help us with that. Right now, we hired 400 additional people, which being a Republican governor's office, we'd want small government, right? Not 400 more people. But that's really where we're at. So, we want to have a—

Kody Kinsley

But it's a different frame on work requirement.

Gloria Sachdev

Yeah. Different framework. I think it's really leaning into fraud, waste, and abuse is what our legislators had in mind. And I hear we also need to look at payment integrity upfront. So, we spent $2 billion—our Medicaid budget is $20 billion, and that's just one part of what I do. We pay across the agencies, all these providers. We're paying them like we're a bank. Okay? They bill us, we pay them. And I'm very data-oriented, so looking at how much are we paying the FQHCs? Well, why are we paying them between $160 and over $500 per visit? Okay. Are they providing commensurate value? Or, and when I say value now, I really mean improving patient outcomes. I don't want any more process measures. I don't think CMS wants any more process measures. They've made that very clear to us across the board. And you've heard here, really improving patient outcomes. So, access to care, we think will improve patient outcomes, but could it be technology's a part of that as well, right? And wearables, and all the other things that can improve patient outcomes. So, I would say on the front end, we hope to—we are starting to, we have a pilot partnership with a big tech company, and that's looking at payment integrity on the front end. Does this even make sense? They just sent us a bill that's 10 times the bill they sent last month, right? That should get flagged. We shouldn't just pay it. And then we also need to do a much better job on the auditing piece, where I do think AI again—we have all the claims data. We have so much data, it's just making sense of the data, right? And using it.

Kody Kinsley

Totally. And I appreciate, Gloria, that you're bringing in this tension, right? We've got this tension that the state leaders are sitting with, which is more pressure on reducing waste and inappropriate payment, and yet that slows things down and nothing will make the providers run at you faster than slowing down payment, right? At the same time, you're hearing we need to create more oversight of public benefits, and then we're making our public benefits harder to access, which creates the economic flywheel not to work, right? And so, figuring out how to thread that. If you haven't yet, there's a QR code, and you can put your questions in, or compliments, whatever. And I'm going to lift up this little iPad and, oh, look, there's already some, and we'll go to them in just a second.

Meena Seshamani

Maybe they're dessert suggestions for our dinner party.

Kody Kinsley

That's right. Exactly.

Tracy Gruber

Can I just maybe say one thing, which I think is, how many of you are government people? There's like three hands. Not very many. I think what's important to know from what's going on at the states, from more eligibility determinations to people losing SNAP benefits to H.R. 1 implementation in January. These folks are going to need care, and they're coming to the health systems. And, to my earlier point about where are you sitting in terms of the roles that you can play on the frontline of providing health care, if you don't know what's going on in the states at this level, you can't anticipate what's coming your way. So, I think one of the things that's really important is there's a lot of tumult. There's a lot of change happening at the states. There's a lot of change that are impacting the people in this nation and where are we all going to be in helping our brothers and sisters take care of their lives and ensuring that they have opportunities for success given the changes that are occurring in our states.

Kody Kinsley

That's great. I'm going to jump to a question that popped out at me, which is we've had a lot of innovation in behavioral health. So, Tracy, I'm going to stay with you for a second on this, but everybody, but a lot of innovation in behavioral health in each state over the last several years. Which innovations do you want to see scaled nationally? Where should we be doubling down faster?

Tracy Gruber

Yeah. I don't know if this is a grand innovation, I would say, but we've got to do better on integrating behavioral and physical health. And that integration is very hard to come by right now in a really disconnected kind of data environment between physical and behavioral health. In Utah we're focused very—I think we have a really great crisis system. We are diverting people from emergency rooms by having law enforcement be able to take people who are having a mental health crisis to a receiving center, having them get connected to resources, sending them on their way. We have tremendous data outcomes on that. But we need to focus in the innovation space, on prevention and how we're kind of addressing what we're seeing with the behavioral health-care needs of our youth. And the kind of social disconnection. We need to focus on social connectedness. I think the Meta settlement kind of demonstrates what we know. They tried very hard to say it wasn't impacting the well-being of our youth. It's impacting adults as well, but, and it was proven otherwise. And we've got to be focusing on, given the generational difference, when I think about social connection, I think about having dinner with my friends. The youth are not thinking of it in that way. So how are we going to innovate to get them more socially connected in this new era? They don't believe in my strategies. So, we've got to figure out those things. Utah has a behavioral health commission, public-private partnership, payers, providers, government, all sitting together to try to figure out where investments should be made, what outcome metrics we should be looking at, how to connect the data environment, and really integrating behavioral and physical health.

Kody Kinsley

Dan, from a public health perspective, how are you thinking about behavioral health? And also, how are you partnering with academic institutions and public health schools in training the future cohort of public health practitioners?

Daniel Edney

Great question. It's the same solution that's true for all things in public health. Absolutely, I keep preaching that we've got to look at global health, somatic and mental health, and not just have this hard demarcation because they blend over, and they're critically important. But it's making the investments as far upstream as we can, and right now we're dumping billions of dollars way downstream to keep all of this from going over the waterfall when in Mississippi, we're implementing Canopy [Any]where, which is working with K-12 students, just a small segment of every school day, educating them on behavioral health issues, mental health, wellness issues, and making those investments way upstream. And unfortunately for us, it's not that far upstream because our high schoolers are really struggling with mental health issues. So, the state is making a substantial investment, and it's not like us to do that, to make that investment far upstream. I'm used to just pulling the bodies out before they go over the waterfall. But the importance of our academic partners cannot be overstated. We have four main academic partners in the state, all doing work in different spaces. We work with all of them. We provide internships and fellowships and opportunities to cross-pollinate public health, into our schools of health-related professions, in all of our institutions, trying to get workforce coming our way. But also, for me, it's really important just for doctors and nurses in Mississippi to understand what public health is, the relevance of it, and how every provider in the State of Mississippi is a public health provider. And that just have that touch point. We do that through our academic partners. I do have to say, after the public health emergency 2025, we reduced infant mortality by 30 percent. *[Applause]* That's 45 babies in 2025 celebrated their first birthday that in 2024 would not have. I can't tell you why. Because we slammed every lever we had. And so now we're using AI to go back

and say what happened '23, '24, '25, each county, granular level of our populations, which levers worked, which didn't, and where do we need to put our investments to keep saving babies.

Kody Kinsley

It ties right into what Meena was saying earlier, is really being able to measure, figure out what works. The AI is a tool there in this laboratories of innovation kind of space. So, I think I want to press everybody on this question, which is, what are the innovation that you see happening in your state that you would like to push out to the rest? Again, as I opened up, we've got 36 gubernatorial elections. All governors are constantly being responsive to this. What's the innovation you're going to take on the road for everybody to do that's happening in your state, Marvin?

Marvin Figueroa

I think for me, there's so much happening.

Kody Kinsley

Pick one.

Marvin Figueroa

It's like what is happening that I want to talk of, right? For us, the challenge is everything's happening all at the same time. I'm focused a lot right now on child welfare. Because of some issues that we have with congregate care in Virginia. And looking upstream and saying, like how do we prevent a person from having to get to a situation when they have to put their child in congregate care? And so, it is looking upward, looking upstream, and thinking about where does social services come into play? Where does Medicaid come into play? What does the Department of Behavioral Health have a role, and their regulations on who they license? And then the Office of Children and Family. And then Department of Juvenile Justice, then you have education. And so, I'd say the innovation that I'm looking at is like, how do we reduce the need for heroics because the system is working better? And that is everything from what does sanction authority look like? What does it mean for someone to have what they need earlier? What are the settings where they can get it? And then who pays for it and at what rate? So, my advice to the 36 is, a lot of these things, because they touch so many different agencies, everyone says, "It's not my responsibility." Or there's one that tries to take it on, and they don't have enough of the support to be able to do it. And so, pick whatever issue there is and see who has a different interest in that issue, and then figure out how do those different agencies work together. And have someone be accountable for being at least the quarterback that throws the ball, depending on where the ball needs to go.

Kody Kinsley

Tracy.

Tracy Gruber

I'm like Marvin. I think it's really hard to say what one innovation—I think we're really focused on innovating at the really bureaucratic level, which isn't all that exciting for almost everyone in this room. But I think the rural—

Kody Kinsley

Bureaucracy.

Tracy Gruber

And that's significant. I don't want to understate. If we're dealing with data interoperability and portability for our patient population, that's a big deal. Yeah. But talking about that is not something like a statistic like Dan shared about the real impact that their initiative focused on. I think we're going to see a lot of innovation coming out of the Rural Health Transformation grants. Our state, in particular, has really said to our communities that are applying for money, and a lot of our funding is in almost like this consortium. It's not like just the hospital apply. If a rural community needs rural health money, we want the FQHC, the hospital, the independent providers, the schools, the meat processors. We want everybody at the table. And I think we're going to see some real advancements in innovation for them to then to solve really tricky problems. So, we think about states as laboratories of innovation. The closer you get to the people, the more innovative things become, and I think we're going to see some incredible things. And I'm super excited about the opportunity that that funding is bringing to the rural health environment.

Gloria Sachdev

So, agree with the statements made here, but since we have to pick one, it really is affordability for us. Health care is not affordable. You hear that at the federal level. It's the number one issue across the country. It's the number one issue in Indiana as well. And what is something that I'd like to share, I guess, that we're doing? Something new is our managed care contracts, where most of—we have 1.4 million Hoosiers that are on Medicaid. Most of them are in our managed care space. And that does, as mentioned, cost quite a bit of money. We have an RFP out right now, and we're putting patient outcomes as a shall in it. They need to submit plans to us of how they're going to improve patient outcomes, which patient outcomes, and then we're going to put them at risk. So, we've never done that before. I don't know if other states have, but in the commercial space that happens, where we talk about two-sided risk. In the managed care entity, at least in Indiana, that hasn't happened before. And we, I think there's a huge opportunity, again, to partner in the innovation space with tech and providers. The other thing is, I'm kind of sick of all the middlemen that are in between physicians and providers and employers, patients, state. They have all these middlemen, insurance companies, PBMs, benefit consultants, and all. And they're not adding commensurate value. Our population is not better. We don't have better outcomes necessarily for the billions of dollars they're extracting out of our health-care system. So, we heard at the prior meeting, or the presentation this morning from big pharma, that 50 percent of the cost of their drugs is siphoned by the middlemen. So, I think there's an innovation opportunity in just making that direct contract, direct-to-employer contracting.

Meena Seshamani

I guess it's my turn. I would say the innovation to scale is more of a theme of looking for those opportunities where improving health also improves the economy in our community. So, I gave the example of what we're doing in Maryland around food, where our medically tailored meals will be coming from local agriculture, and we're supporting local agriculture to build those businesses. I think a similar theme with health-care workforce, where you can, and we are doing, investing in apprenticeships and training in local communities, particularly those that have higher unemployment rates, so that you can have community health workers and peer recovery coaches and care navigators and others who you're then able to employ, which lifts the economy of those communities. And quite frankly, they will do a much better job than other people will in those roles. And it presents that opportunity then for career advancement. So just two examples of what I think is a theme of let's break out of the health-care bubble because health care is an essential part of the overall economy. And how do we capitalize on that? By both improving health and improving the economy.

Kody Kinsley

Dan, anything else you'd add?

Daniel Edney

For us, it's innovation and policy, being willing to take risk for the sake of our people, being willing to not just think outside the box, but get outside the box and do things in ways we've never done them before. We don't have bad doctors and nurses and hospitals in the state. We have a bad system, and our system's perfectly designed to deliver Mississippi what we're getting. And so, we're working through our HTP and every opportunity we have to redesign the system for the benefit of our people. We threw the country a curveball last Tuesday from Mississippi. But if you're going to play in the big leagues, you've got to hit the curveball.

[Laughter]

Kody Kinsley

So, we've only got about 160 seconds left—minus three—I want to invite anybody on the panel—we have a room of non-government folks, people who are across philanthropy, innovation, the private sector. And I remember when I was secretary, everybody would come into my office and try to sell me something. It was what I'd call the solution in search of a problem. And I'd spent a lot of time trying to help them figure out how to get their solution to fit my problem. But the one out of 10 times when it was actually a solution to my problem, I'd buy it. Because if I could buy myself out of problems, and you hear all the problems these folks got, they would do it. So, what's the solution that you're hoping from the private sector, from this innovation sector, that would walk into your office tomorrow and invite an opportunity to partner? Anybody?

Gloria Sachdev

You heard all my problems. So, I would really like to invite the audience to—they are the solution. You're saying they're the solution. So, we have only problems. We have only problems. So, I don't know. I'll mention my one problem that I would really like a solution for is just really thoughtfully measuring actual patient outcomes because we want to align payment with outcomes for every agency. And we have billions of dollars in contracts, and I just think we can do a better job. So, find me afterwards if you are in that space because I'd be really interested in talking to you. I don't know if I'm answering your question.

Kody Kinsley

I like it. No, that's exactly it. Who else? Meena.

Meena Seshamani

I would say the solution is to have everybody come to the table and stop the zero-sum game. I feel like there's so much of everybody digging in their heels and retreating to their specific corner and then just fighting with all might, and to protect their particular interests, perhaps losing sight of the fact that there are lots of win-wins out there for us to capitalize on. And so, if we can exit some of the zero-sum game, *Hunger Games* mentality, and actually come together for where there are those opportunities, that it can be a win for everyone. And when it's a win for everyone, oftentimes it means nobody gets 100 percent of what they asked for, but it ultimately leads to the health care working the way that we want, which is why we all went into health care. So that's what I would say.

Kody Kinsley

So don't bother me unless you have a win-win. Anything else? Last thoughts?

Marvin Figueroa

Usually, people come to my office and say how can they help? And I want to return the question, how can you help? In a way that doesn't mean that you're going to sell me something. Because there's always a product that people sell, and I want to start from the issue we're going to solve together rather than the new product that you say is going to solve all my issues.

Kody Kinsley

Okay. Well, friends, we got 99 problems, but these health folks are not one. They are amazing. We are so lucky to have their leadership. Please join me in thanking them for everything they do.

[Applause]

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