NAMD
National Association of Medicaid Directors

NAMD's 1st Annual Medicaid Operations Survey: Summary

Introduction

In the United States, each of the 50 states, five territories, and the District of Columbia operates a Medicaid program to provide health care services to low-income individuals. However, those 56 programs exist amid a diverse range of administrative structures, provider markets, political environments, and programmatic rules and standards that make each Medicaid program unique. The National Association of Medicaid Directors (NAMD) surveyed the nation's Medicaid Directors to gain a clearer picture of how these programs operate in each of the different state contexts.

This summary represents the responses of 45 of NAMD's members, and summarizes the key findings of the survey. In essence, Medicaid Directors across the nation serve many different roles and must have a wide range of skills and strengths. This survey helps articulate the many challenges Medicaid Directors face and the broad spectrum of responsibilities they must meet.

In its First Annual Medicaid Operations Survey, NAMD found that Medicaid programs cover from just over 35,000 to over 8 million lives, with nearly two thirds covering fewer than 1 million individuals (see Figure 1). While some programs may be considered relatively small, they are no less diverse or complex in terms of beneficiary needs, covered populations and services, and federal rules and requirements. Ultimately, the job description for the Medicaid Director does not vary at its core. But the position within the state bureaucracy, the professional responsibilities and training, and the experience of the individuals in these positions do differ widely among states.

Medicaid's Position within State Government

The agency in state government that runs the Medicaid program may be organized quite differently across states. Two thirds of states responded that the Medicaid agency is part of a larger umbrella agency, which often houses other health and human services programs. In a quarter of states, the Medicaid program is its own agency, and in the remaining 10% of states, there is some alternative organizational structure (see Figure 2).

The Medicaid Director's position within state government is also different. In two thirds of states, the Medicaid Director is a political appointee, and in a third of those cases, his/her appointment requires confirmation usually by the state legislature. In just under a quarter of states, the Director is a civil servant, and in the remaining 11% or so, the Director holds some other type of position (see Figures 3-4). In the vast majority of states, the Director reports to an agency head or other Executive office, while 15% of Medicaid Directors report directly to the Governor (see Figure 5).

Medicaid Directors' responsibilities also vary as to their program's relationship with the new Health Insurance Exchanges. Over two thirds of states have taken some type of action to study or plan for a Health Insurance Exchange. Of those, only 4% responded that the Exchange would be housed in the same governmental agency as the Medicaid program. 29% responded that the Exchange will be housed in a separate state agency than the Medicaid program, just over a quarter would be a quasi-governmental agency, 15% will would be run by a non-governmental, non-profit organization, with the remaining 26% still unsure how the Exchange is to be structured (see Figures 6 and 7).

These leadership structures and reporting lines demonstrate the high level of accountability placed on Medicaid Directors. Administrative, political, and fiscal responsibilities necessitate that Directors demonstrate the capacity to manage many aspects of the Medicaid program. Whether working with Medicaid and other state government program staff, stakeholders, media, or before a budget committee in the state legislature, the role of the Medicaid Director is integrally linked with the program's success.

Medicaid Directors' Oversight of Program Functions

As the structure of Medicaid programs varies from state to state, so do the direct responsibilities of the Medicaid Director for different program functions. More than half of Medicaid Directors oversee coverage programs that are funded using only state dollars in addition to the regular Medicaid program (see Figure 8). In 85% of these state-only funded coverage programs, the program covers fewer than 100,000 lives (see Figure 9). The largest state-only program covered 1.4 million lives in 2012.

Directors' primary function is oversight of the federal-state partnership that is the Medicaid program. Federal law requires the appointment of a "single state agency" that is accountable for the program in the state, no matter which other agencies or entities may functionally operate different components of the program.

To better understand how states run the most significant functions of the Medicaid program, NAMD asked which functions the state Medicaid agency operates, and which are run by another state or local agency or by an outside contractor. NAMD surveyed states on seven Medicaid services, including:

- Children's Health Insurance Program (CHIP)
- Developmental disability (DD) waiver services

- Long-term services and supports (LTSS) waivers and state plan amendments (SPAs)
- Mental health services
- Substance abuse services
- HIV/AIDS services
- Foster care services

NAMD also asked about five major Medicaid program functions, including:

- Eligibility determinations and enrollment (E&E) functions
- Medicaid management information systems (MMIS)
- Provider licensing and credentialing
- Third party liability (TPL) claims
- Investigations and provider sanctions

The role of the state Medicaid agency differs across these program functions and services (see Figures 10-11). For example, the vast majority of CHIP programs are administered by the Medicaid agency, while services for DD populations and foster care services are often performed by another agency or entity, and overseen through a contract or memorandum of understanding (MOU). Likewise, the Medicaid agency contracts with another state agency to run the E&E functions in just under half of states. Some states also engage outside contractors for several of these functions, and notably, 43% of responding states contract with an outside vendor to run their MMIS systems.

Of those states that contract with another agency in the state to operate certain Medicaid program functions, some contract with local, county, or regional agencies. NAMD asked states whether they contract with these types of agencies for the following services:

- E&E functions
- DD waiver services
- LTSS
- Mental health
- HIV/AIDS
- Foster care

Of the states that do contract with other sub-state agencies to perform the above Medicaid program functions, the majority do so with county agencies (see Figure 12). The proportion of states that contract with county agencies was highest for eligibility and enrollment functions at 71%, LTSS services was second at 53%, and mental health services was third at 36%. Regional agencies were the second most likely to be contracted to run certain Medicaid functions for the state. Of note, 36% of these states contract with regional agencies for mental health services, and 37% for DD services. Fewer states contract with local or municipal agencies to operate Medicaid functions.

This distribution of functions across multiple agencies adds additional leadership responsibilities for the Medicaid Director. Managing sister agency relationships can be complex and challenging. Directors must demonstrate an understanding of the different

cultures and constituencies of these other agencies, while still holding them accountable for operating under and satisfying Medicaid rules. To successfully oversee this patchwork of programs and functions, Directors must be able to marshal resources, work well with other agencies, and consistently implement a unified vision for the Medicaid program.

State Medicaid Budgetary Issues

The Medicaid program is funded through a state-federal partnership wherein the federal government matches state funds at a rate between 50-75% depending on the state[1]. Medicaid Directors face a range of budgetary challenges at the state level. In 80% of responding states, the state contribution was less than $5 billion in the most recent year of available data, but in three states, the state share of Medicaid funding was over $10 billion (see Figure 13). In the vast majority of states, the state share of dollars going towards the Medicaid program made up between 10-30% of the state's general funds, with 45% of states reporting the state share of Medicaid made up 20-30% of state general funds (see Figure 14).

The magnitude of the state's investment in Medicaid puts pressure on Directors to ensure the fiscal health of the program and the efficiency of its operations. In most cases, Medicaid Directors run the largest health insurance plan in the state with all of the complexities and accountabilities that entails. Directors must be able to identify and focus their efforts on the most critical and pressing fiscal concerns, with an eye toward return on investment and cost containment.

NAMD asked Medicaid Directors to name their top three budget priorities for the next year, and the responses shed light on the major challenges facing states. For all three priorities, the number one most mentioned response was to implement some type of payment and/or delivery system reform, such as transitioning to statewide Medicaid managed care, implementing a demonstration program to integrate care for dual eligibles, or developing accountable care organizations (see Figure 15).

The second most mentioned category of priorities had to do with containing costs and/or seeking new revenue sources to cover existing budget obligations. The third most frequently mentioned category encompassed a range of miscellaneous budget priorities, such as improving provider billing and vendor payment processes, modernizing information technology systems, and annualizing the Medicaid budget. The fourth most mentioned category of priorities that states named was implementing provisions of the Affordable Care Act (ACA). A fifth category that states named had to do with rebalancing their long-term care services toward more home and community based settings.

The majority of the budget priorities that Medicaid directors identified are enduring challenges. Two thirds of states responded that their main priorities have not changed since the previous year (see Figure 16). These concerns are not only relevant to Medicaid,

[1] 2012. (Kaiser Family Foundation: http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4)

but have major implications for other stakeholders in the public and private sectors. In addition to their traditional fiscal responsibilities, it is a growing trend for Directors to also be conversant in health care delivery system and payment reform models and to participate in multi-payer initiatives.

With all of the complexity and accountability incumbent on Medicaid agencies and Directors, expert staff and a sufficient, well-trained workforce are critical to success. However, States' fiscal challenges continue to pose problems with hiring and retaining qualified staff in the Medicaid program. A vast majority of states responded that more than 5% of full-time positions went vacant in the most recent year due to a lack of hiring authority. Two states reported more than 20% vacancy rates (see Figure 17). Only a third of respondents anticipated an increase in the state's hiring authority for the next year (see Figure 18).

There is wide variety in how states staff their Medicaid agencies. In the vast majority of states, most Medicaid staff are full-time state employees. However, in a few states, nearly half or more of Medicaid staff are part-time employees and/or contractors (see Figure 19). When states cannot hire new full-time employees because of budgetary shortfalls, often they resort to hiring temporary or part-time contract employees. States also vary in the volume of staff dedicated to their Medicaid agencies. The vast majority of states fall within the range of 750 or fewer Medicaid employees (see Figure 20).

Medicaid Directors' Experience

Many Medicaid Directors have prior experience within the Medicaid program and state government, while in other states, the Director's position has seen lots of turnover and little stability or continuity in leadership. In the vast majority of states, the Medicaid Director has only been in that position for five or fewer years, with 20% of respondents in their first year as Medicaid Director (see Figure 21). The two US territories that responded had the longest serving Medicaid Directors, one of which has been in the position for 35 years. In comparison, among the states and the District of Columbia, the longest serving Medicaid Director has been in that position for only seven years. The median tenure for current Directors is two years.

The pattern of short tenures also applies to the previous generation of Medicaid Directors. When asked how long their predecessors spent in their positions, states responded that over half spent less than five years as Director (see Figure 22). However, the previous generation had a higher proportion of Directors with longer terms, including six Directors (or 14%) with more than eight years of experience. The median tenure for these former Directors is three years.

Many current Medicaid Directors, however, have experience in other positions in the Medicaid agency and in state government prior to their tenure as Director. The vast majority of Directors spent at least one year in another position in the agency before becoming Director, and more than a third had been with the agency at least five years (see

Figure 23). Only 12% of Directors had never held a position in their state's Medicaid agency before assuming their position. For current Directors, the median tenure spent previously in other positions in the Medicaid agency is 4.5 years.

These findings indicate the steep learning curve Medicaid Directors face and the need for technical assistance in the many aspects of their jobs. They must secure sufficient levels of competent staff to support their transition and seek outside information sources and the support of their colleagues in other states to successfully serve in their new role.

Conclusion

Medicaid Directors are a diverse group of individuals, functioning in a wide variety of environments. They come to their jobs with a range of experiences, face a range of responsibilities, and have a range of administrative tools at their disposal. At a basic level, however, the jobs of each of the 56 Medicaid Directors are relatively similar. NAMD intends for its annual Medicaid Operations Survey to shed light on the contexts in which these state government officials run their agencies in order to better understand the strengths and challenges of the Medicaid program and its leadership.