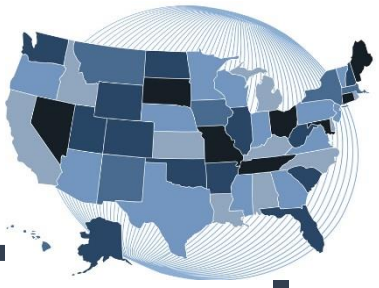
NAMD
National Association of Medicaid Directors



State Medicaid Operations Survey:

Second Annual Survey of Medicaid Directors

National Association of Medicaid Directors

February 2014

Acknowledgements

The National Association of Medicaid Directors thanks its members for their time and perspectives in responding to this survey. We also appreciate the contributions of their staff to each state's submission. We know that there are many demands on their time and calls for reports on these programs. We appreciate their commitment to this survey during perhaps the busiest time for Medicaid Directors and their staffs since the inception of the program. We further appreciate the contributions of the many Directors who provided guidance and direction on the report.

About the National Association of Medicaid Directors

The National Association of Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD is committed to providing a focused, coordinated voice for the Medicaid program in national policy discussion and to facilitate dialogue amongst the members in the 50 states, 5 territories and the District of Columbia, and help provide best practices and technical assistance tailored to individual members as they seek to sustain the program and ensure it continues to serve the needs of current and future enrollees.

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EXECUTIVE SUMMARY

Through 2013 and into 2014, the nation's Medicaid Directors have remained focused on steering their programs through a time of great transition. This change is twofold: on one hand, Directors are working towards implementing the Affordable Care Act (ACA) and, on the other, ensuring the long term sustainability of their programs by addressing the significant challenges involved in health system transformation. For the most part, Directors are making this happen with substantial resource constraints that make the realization of implementation and transformation major undertakings.

Despite the new challenges, the core duties of Medicaid Directors remain the same: they work within tight budgets and seek to maximize the value of their dollar; they manage a multitude of relationships with different partners and stakeholders in order to leverage a complex system environment to bring services to beneficiaries; they are accountable to both state leaders and federal regulators for the activities and outcomes of their programs; and they continue to find ways to achieve quality outcomes with limited internal resources.

This year's survey also demonstrates how Medicaid Directors are moving forward with an array of programmatic reforms that will reshape their programs for years to come. Payment and delivery system innovations like medical homes and episodic payment, expansions and value based purchasing efforts within managed care, and integrated care for individuals dually eligible for Medicaid and Medicare were all identified by Directors as major priorities for their state fiscal year.

Directors Must Lead Large and Complex Systems

As was the case last year, NAMD found that the roles and responsibilities of the Medicaid Director cover a wide range and vary from state to state. Directors continue to have to focus their energies on managing budgets for complex and expensive populations.

- Across states, FY 2013 budgets ranged from $604 million to over $55 billion dollars, and the program provided services to 88,000 to over 9.1 million beneficiaries. However, each state grapples with substantial variation in populations covered and services offered, making the program exceedingly complex.
- The median Medicaid program budget ($5.5 billion) would place it in the rankings of the Fortune 500.

To manage a wide set of services for a broad swath of beneficiaries, Directors continue to leverage relationships with other agencies, contractors and entities in order to ensure needs are met in all areas. Delegation and oversight of program operations by other state agencies and contractors can present challenges. However, the Director is still responsible for activities and outcomes of the program, no matter who may be running a portion of it.

> *"The face of Medicaid has always been low-income working families and children, because that is who represents the bulk of the program's 72 million beneficiaries. However, Medicaid is the largest payer for practically every complex health care condition, from mental health to HIV/AIDS, and from premature births to long-term care. "*

Resource Challenges Remain

It is critical to point out that while the roles and business processes of the Medicaid agency may grow, current functions and duties shouldered by the programs still exist. Programs must continue to meet the obligations and provide the services that they have provided in the past. Expectations and responsibilities are layered on top of each other – unlike the private sector, lines of business are never closed. In light of this, internal resource constraints continue to present obstacles to Directors as they move to manage their budgets, implement the ACA, and transform their programs.

- While shifting downwards from last year, the median vacancy rate range for agency employment is still 6-10 percent, with some states reporting double-digit vacancy rates for authorized positions.
- Only 37 percent of Medicaid programs expect to be able to hire new personnel in FY 2014, despite programs having to take on major new responsibilities.
- Nearly 73 percent of Directors are paid in a range that is below the median salary for a CEO in their state. Compared with the average Fortune 500 CEO, the average salary is 3.5% of what many of their peers are paid, despite the fact that their budgets rival the revenues of these companies.

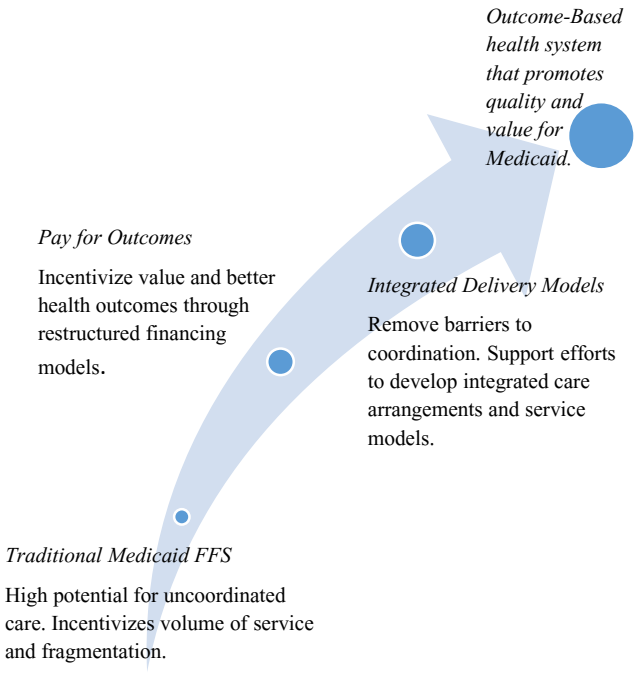
These workforce issues loom large for Director's abilities to effectuate major reforms to programs. Medicaid programs are looking towards hiring staff that have different backgrounds than historical hires, in order to put payment and delivery system reform ideas into practice. In many reform initiatives, Directors need staff with diverse skill sets, education, and experience. Without resource support, Directors will continue to encounter difficulties on the road to reform.

The Affordable Care Act & Programmatic Innovation

This fiscal year, the implementation of the Affordable Care Act (ACA) has emerged as the top cited priority for Medicaid Directors due to the significant administrative and technological overhaul they must implement in a relatively short amount of time. Approximately 46 percent of Directors named the ACA their top priority.

Alongside the changes brought on by the ACA are the equally impressive efforts to change Medicaid from its historic fee-for-service (FFS) orientation to one that is increasingly focused on care coordination, value, and quality. Approximately 73 percent of Directors named reforms to long-term care systems, payment and delivery system reforms, behavioral health, and managed care as a priority for their programs.

PAYMENT AND DELIVERY SYSTEM REFORM IN MEDICAID



State Medicaid programs are also undergoing a major technological modernization – in eligibility determination systems, information management and reporting systems, and data analytics capabilities, as Directors focus their attention on new procurements and enhancements. Program integrity initiatives also loom large, as 73 percent of Directors reported an expanded emphasis on that issue as well.

Looking Forward

As Medicaid agencies face new responsibilities, Directors find opportunities to adapt to new challenges. FY 2014 has brought significant changes to how payers, providers and clients interact across the health care industry. Directors are leading the way in navigating the new systems to bring the best outcomes to their beneficiaries and partners.

Purpose of this Survey

Questions abound regarding how Medicaid operates and how Directors can and will address the many challenges they face. NAMD undertook this survey to help answer some of those questions. We will use the results to inform our efforts to support and advise Medicaid Directors, and to strengthen the general understanding of the current and future Medicaid program. Our members will use the information contained herein to assess the conditions and approaches of their own states, and to network with their colleagues about common challenges and potential solutions.

For the broader Medicaid community, we hope this report helps educate ongoing efforts to support Directors on our mutual goals of Medicaid-driven innovation, quality improvement, and program reform.

INTRODUCTION

The past year has been a watershed moment for Medicaid agencies and their leadership. The federal-state partnership continues to be operated by individual states in unique ways that reflect their histories, governmental structures, political, and health system realities. This year, state Medicaid programs are continuing a profound evolution as they work to implement the new rules and responsibilities of the Affordable Care Act (ACA) while simultaneously working on a host of programmatic innovations that impact program operations, provision of services, and payment to providers. Coming at the heels of an economic downturn that pushed enrollment and Medicaid spending to new heights, these parallel efforts are going forward even as Medicaid programs remain committed to providing their bedrock services, all within a challenging, resources-limited environment.

To capture their experiences in this pivotal year, the National Association of Medicaid Directors (NAMD) surveyed the Directors to gain a clearer picture of how Medicaid programs work and what they are doing to effect transformation. This survey reflects the responses of 45 states (though not every state representative answered every question in the survey) and represents program status as of the end of the 2013 calendar year.

The survey describes the position of the Medicaid Director and agency, key aspects of their roles and responsibilities, and their priorities moving forward. It describes how they are adapting to challenges and demonstrates that Directors are continuing to manage highly complex and diverse programs that are in a state of flux, often with significant resource constraints.

It also shows how Directors are leading the way in transforming their programs from fee-for-service (FFS) models towards payment systems that incentivize better health outcomes. Across the health care landscape, public and private payers have embarked on an ambitious set of reforms to change how care is paid for and delivered. As the program that covers the nation's most vulnerable beneficiaries, Medicaid Directors are on the forefront of this change.

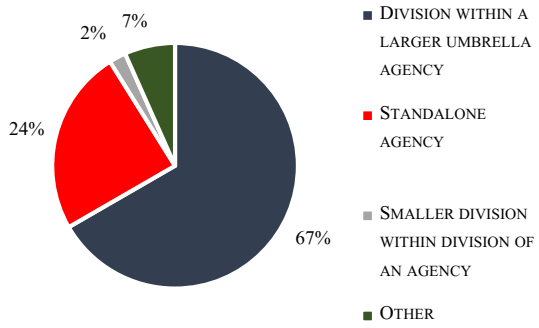
POSITION OF THE DIRECTOR

Each of the 50 states, five territories, and the District of Columbia operates a Medicaid program. However, those 56 programs exist amid a diverse range of administrative structures, health care markets and programmatic rules and standards that make each Medicaid program unique. The position of Medicaid Director is something that all states have, even if the particular job duties vary across the states. Federal regulations mandate that the services rendered under a Medicaid program be located operationally within one single state agency and that accountability flows through that single entity regardless of the operational approach.

Agency Structure & Appointment Process

In our first Operational Survey, NAMD found that the majority of state programs were under the umbrella of a larger state agency. This survey reinforced those findings. The most common umbrella agencies were health, human services, and health *and* human services agencies, illustrating Medicaid's historical and operational ties to both state health departments and the larger state safety net apparatus. In total, 76 percent of programs are housed under another agency or department, while 24 percent are standalone agencies. Predictably, the organizational structure is tied to governance, as 82 percent of the standalone agencies report directly to their Governor, while all but one of the programs housed in an agency directly report to their agency or department head. (See Figure 1).

FIGURE 1: POSITION OF MEDICAID AGENCY IN STATE BUREAUCRACY



In many states, the Director position is appointed (61 percent) while 30 percent are civil servants and nine percent are awarded the position in some hybrid way. (See Table 1). Of those appointed, the majority are appointed by their agency head, while some are directly appointed by their governor. Appointment structure does not appear to be tied to program size or budget, as both the political appointee and civil service categories were represented across the continuum of budgets and enrollment size. As one might expect, when a Medicaid agency is a standalone agency, the majority of the Directors are appointed (82 percent).

TABLE 1: PERCENT OF MEDICAID DIRECTORS BY APPOINTMENT STATUS

CIVIL SERVANT	61%
POLITICAL APPOINTEE	30%
OTHER	9%

Budgets and Enrollment

The size and scope of Medicaid programs is remarkable. In 2012, total Medicaid spending reached $421.2 billion, equaling 15 cents of every health care dollar spent.[1] Across states, FY 2013 budgets ranged from approximately $600 million to over $55 billion dollars. Along this continuum, the median Medicaid expenditure for FY 2013 was approximately $5.5 billion in total state and federal dollars. At this spending level, the median Medicaid program would rank as a Fortune 500 company in comparison to revenues of the companies that populated the list in 2013.[2] (See Table 2).

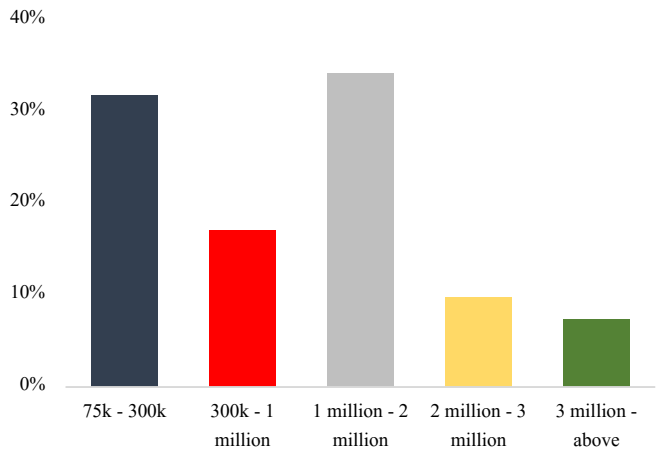
TABLE 2: MEDICAID BUDGETS BY RANGE, FY 2013

$10 BILLION AND ABOVE	22%
$6 BILLION TO $10 BILLION	22%
$4 BILLION TO $6 BILLION	18%
$2 BILLION TO $4 BILLION	11%
$1 BILLION TO $2 BILLION	20%
$500 MILLION TO $1 BILLION	7%

From state to state, the Medicaid program's total enrollment also varied, stretching from 88,000 to over 9.1 million beneficiaries. (See Figure 2). However, a relatively smaller number of individuals does not imply an easier program to manage. Within each covered population, there are distinct subsets of individuals with their own specific needs, ensuring operational complexity for every Director. Programs must cover low-income children, pregnant women, people with disabilities, older individuals, and some parents. These coverage groups utilize different benefits and require a broad understanding of health care and support services. In order to run their programs, Medicaid Directors must know how the constituent groups that make up the country's most vulnerable populations access and use services, and must build programs that meet their divergent needs.

States may also cover optional coverage groups, though the impact of the ACA's optional Medicaid expansion may shift the basis of eligibility for some of these populations. NAMD found that 82 percent of states that responded cover optional pregnant women, 89 percent have a Breast and Cervical Cancer program, and 73 percent have a buy-in program for disabled working individuals. This is not an exclusive list of optional coverage groups, as many states have opted to cover groups of their own definition through state plan amendments and 1115 waivers, including working parents and childless adults.

FIGURE 2: MEDICAID ENROLLMENT BY RANGE, FY 2013



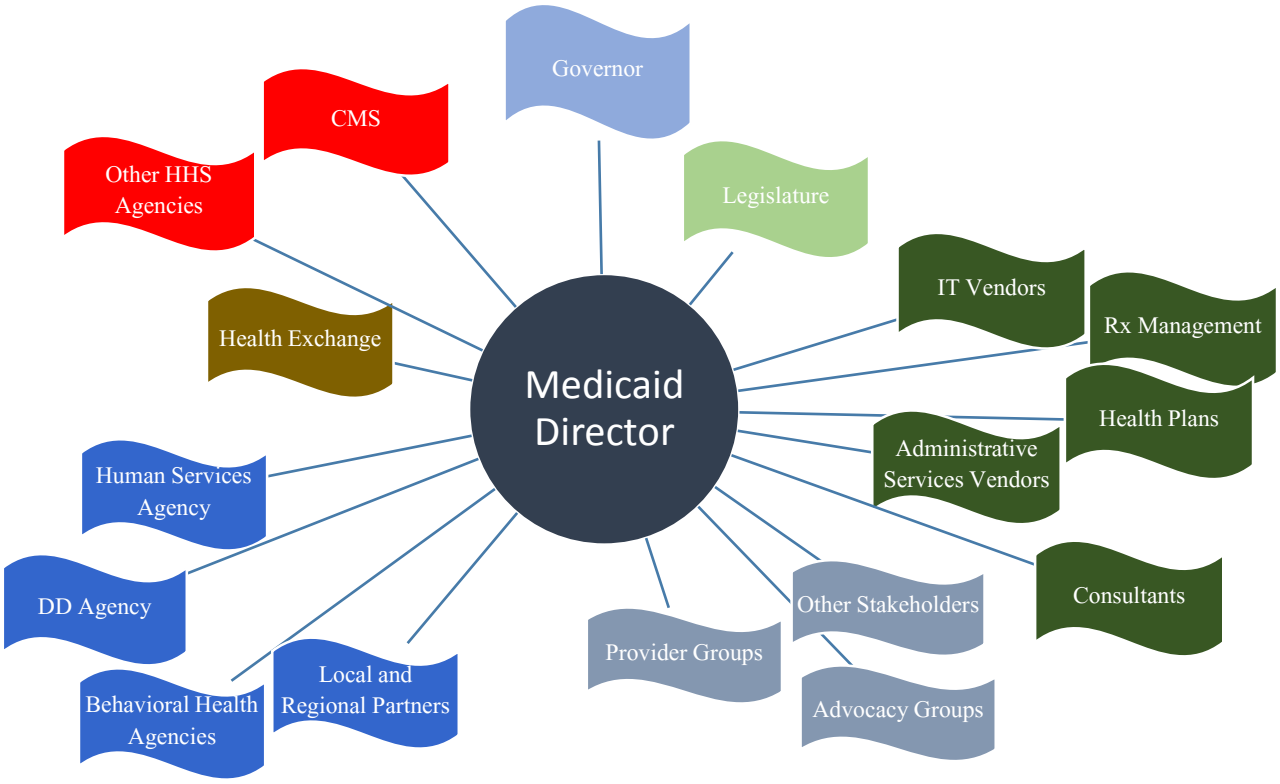
Additionally, Medicaid Directors may oversee health care coverage programs that are not funded or regulated by the federal government. Twenty-eight Directors reported overseeing state-only programs. These programs run the gamut from small business insurance programs to pharmacy assistance to state-only funded support services for women's programs. Program enrollment varies widely as well. One state only covered 10 individuals in a state-only program that it ran; on the high end, one state covered approximately 150,000 beneficiaries in several state programs. The size may not be as important as the function, as these programs will often have different program requirements and service models, and all add another layer of complexity to the policy agenda of Medicaid Directors.

The breadth of expenditures and enrollment across states, as well as the hidden internal complexity of these numbers, demonstrates that each Medicaid program is highly specific to the state, with substantial variation in populations covered and services offered. In some ways, Medicaid Directors could be considered to be running several different health care programs under one umbrella. Furthermore, individuals covered by Medicaid very often have high-levels of most health care needs. In every state, the Medicaid

[1] CMS. National Health Expenditures 2012 Highlights. 2012.

[2] Fortune Magazine. List of Fortune 500 Companies. 2013.

FIGURE 3: KEY EXTERNAL OPERATIONAL RELATIONSHIPS OF THE MEDICAID DIRECTOR



[For illustrative purposes - not representative of any particular Medicaid Director or program]

program, by virtue of the dollars it spends and the populations it covers, has a significant impact on the larger health care market.

ROLES, RESPONSIBILITIES, & KEY ASPECTS OF MEDICAID AGENCIES

Over time, Medicaid enrollment has grown steadily and this diverse group of populations with major health care needs has expanded. Concurrently, health care costs for all payers have grown exponentially, increasing budgetary pressures on states and the federal government.

The main goal of Medicaid Directors in facing these pressures is to maintain a sustainable program that ensures that beneficiaries receive high quality of care. To carry out this key objective, Directors must rely on their abilities to manage an array of external relationships while developing an internal capacity to handle sophisticated and – in many cases – entirely unique tasks. While each program is configured differently, there are similar frameworks that Directors must work within, especially in regard to external relationships and internal capacity. (See Figure 3 for a representation).

External Relations & Delivery

The modern Medicaid Director's job requires the dexterity and the ability to manage a constellation of relationships. Directors must maintain relationships with state leaders like their Governor, agency heads, state legislators and others. As states are increasingly exploring statewide health system transformation through the Center for Medicare & Medicaid Innovation (CMMI) State Innovation Model (SIM) grants and other vehicles, their role representing their agency in multi-payer efforts is growing. Directors must maintain relationships on a federal level as well; Directors have contact with personnel throughout the Center for Medicare & Medicaid Services (CMS) reflecting the agency's traditional regulator relationship, and now with staff in other departments working on health system transformation and individuals overseeing the Federally Facilitated Marketplace (FFM) and the state-based marketplaces (SBM). Directors must also work with Members of Congress, the Office of Inspector General in the Department of Health & Human Services (HHS OIG), the Government Accountability Office (GAO) and others on Medicaid policy issues. Finally, Directors also must work with a host of provider groups, stakeholders and advocacy organizations that are impacted by the decisions the Director makes.

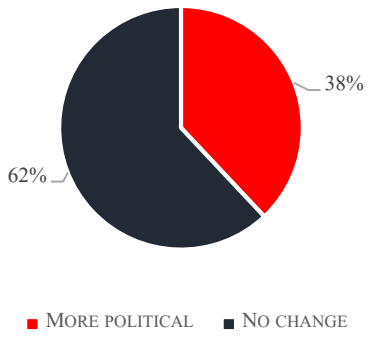
Effectively leveraging these relationships is key to the Director's success, as the program's size, duties and budget are enormous. The average Medicaid program represents nearly 25 percent of a state's budget each year, and in some states, it equates to approximately a third.[3] A program of this size will attract attention from senior levels of state leadership. Second, as a payer, it is a major source of revenue for many providers, from large hospital systems to individual practitioners. For some provider groups, it is their principal source of income, having an enormous impact on their businesses. Medicaid's outside impact requires Directors to be highly attuned and ready to address external concerns.

Relationship management is also important as Medicaid Directors continue to move away from the FFS landscape and towards newer payment and delivery structures that incentivize value over volume. Directors must still address and work within existing relationships in order to be successful in implementing reform.

Reflecting this substantial external component of their work, 38 percent of Directors noted that their job had become more political over the past year. There does not seem to be any correlation between this trend and agency structure, appointment process, program size, or status in a major payment or delivery system reform effort. The Medicaid expansion status was also not correlated to this answer. More likely, the cumulative effect of these features, as well as state specific political realities, have combined to heighten political tensions for these Directors. (See Figure 4).[4]

"The job requires so much to be done with so little. It's complex but rewarding to know we touch so many lives."

FIGURE 4: PERCENT OF MEDICAID DIRECTORS WHOSE JOB HAS BECOME MORE POLITICAL



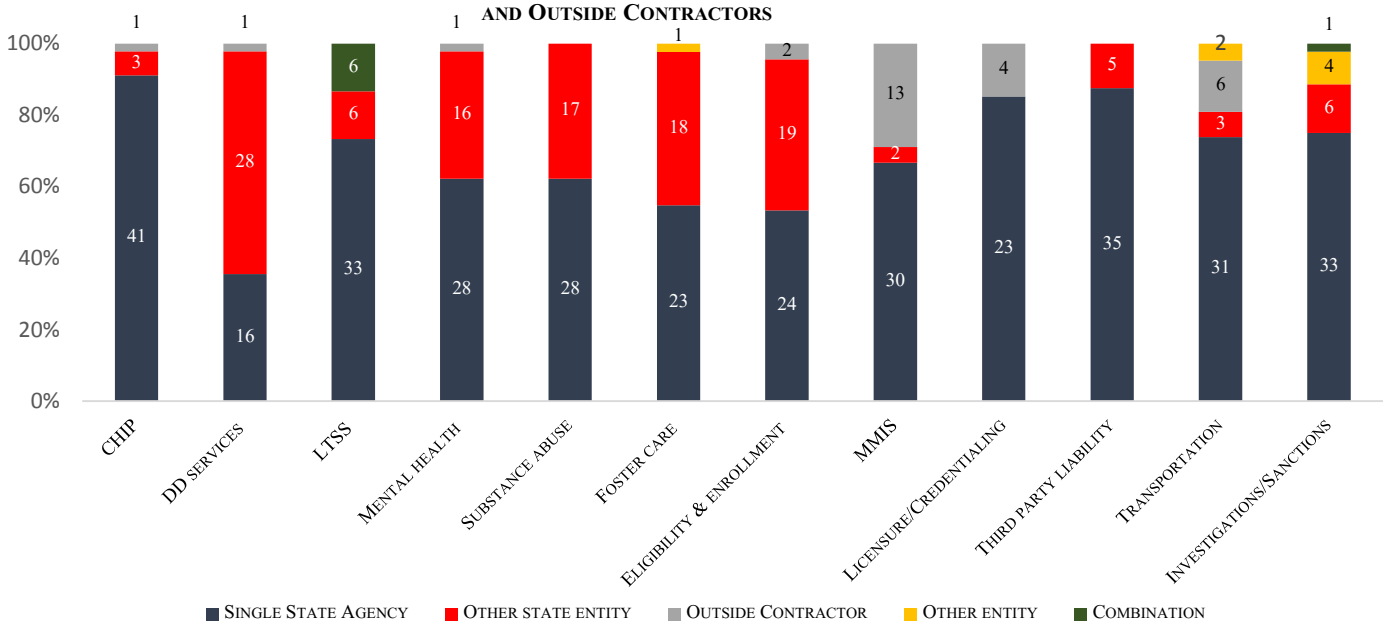
Beyond the political challenges, the ever-growing operational complexity of the program also requires the input and collaboration of an array of other entities. While the single state agency concept vests Directors with authority and responsibility for the program, there is enough flexibility to allow for different operational structures and approaches. Today, many program services and functions are conducted by sister agencies, local and regional partners, and outside contractors and vendors. For the Director, delegating day-to-day operational management does not mean ceding responsibility. Medicaid Directors and their staffs are required to oversee the other entities' operations and ensure that dollars are managed well, that data is reported back to the agency, and that the needs of beneficiaries are addressed across the different structures. The model is not one of devolution, but instead of accountability and coordination.

Many agencies, over the nearly 50 years of the program, have signed memoranda of understanding (MOUs) with other state agencies to handle certain functions or services where their sister agency programs offered greater expertise, capacity, or funding streams. Sixty-two percent of programs have sister agencies run the operations for developmentally disabled (DD) services, while 38 percent have signed MOUs with other agencies for behavioral health services. Thirteen percent have some agreement in place to assign operational duties for long-term services and supports (LTSS) and 40 percent have agreements for other agencies to run operations for foster care services (See Figure 5).

[3] The National Association of State Budget Officers. State Expenditure Report. 2013.

[4] It should also be noted that the Directors that answered that their job had not become more political did not mean that their job was not political, only that it had not become more political over the past year.

FIGURE 5: MEDICAID SERVICES & FUNCTIONS BY STATE ENTITY, OTHER ENTITIES AND OUTSIDE CONTRACTORS



In addition to categories of services, functions such as eligibility and enrollment or investigations and sanctions are handled by other state entities as well. Forty-two percent of agencies have their eligibility functions managed by a separate agency, while seven percent have their transportation operations managed by another agency. Eleven percent have agreements in place for third party liability.

The relationships that Directors have with contractors and vendors often concern the most important operational issues confronting the program. In states with managed care, Directors work within a delivery system where they manage contracts with health plans that arrange the care for beneficiaries. Some key technological aspects of programs may also be developed and hosted by a vendor. For example, 29 percent of programs have outsourced their Medicaid Management Information Systems (MMIS) operations to an outside contractor, and nine percent have outsourced their licensure and credentialing functions. These business relationships are crucial to many Directors and the operation of programs and touch on a wide scope of services.

Some Directors must also manage relationships with regional and local entities – notably in the areas of eligibility and enrollment, services for DD, LTSS, non-emergency transportation, foster care, and mental health services. In total, 18 states, or 40 percent of states that answered the survey, had some agreements with entities like local agencies on aging or community services boards. (See Table 3).

Across the span of state, regional, county and local agency relationships, Medicaid Directors nearly always retain direct responsibility for medical services for recipients who use services overseen by a sister agency. This distribution of responsibility mirrors similar divisions at the Federal level, and helps illuminate the challenge Directors face in addressing the needs of Medicaid's most expensive populations. Beyond this common element, the exact scope and characteristics of these relationships are highly varied.

TABLE 3: PERCENT OF STATES THAT HAVE SERVICES AND FUNCTIONS RUN BY LOCAL, COUNTY AND REGIONAL AGENCIES

	LOCAL	COUNTY	REGIONAL
ELIGIBILITY & ENROLLMENT SERVICES	16%	7%	2%
DEVELOPMENTAL DISABILITIES SERVICES	4%	11%	16%
LTSS	7%	13%	13%
MENTAL HEALTH SERVICES	7%	18%	11%
NON-EMERGENCY TRANSPORTATION	2%	9%	4%
FOSTER CARE SERVICES	7%	9%	4%

The Medicaid Workforce

The complexity of services, functions and relationships that Directors handle externally is mirrored by the work they must do in their own shop.

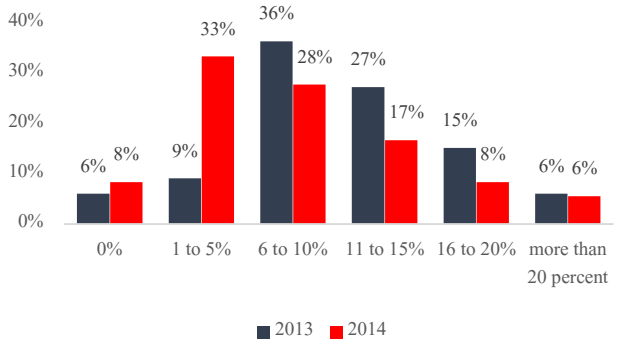
As was the case in the previous year's survey, the majority of Medicaid agencies employ 750 full time employees or fewer, while the median number of full time employees is 421. Several states again reported using part time and contractual employees as a major part of their workforce. Nineteen percent of states reported a workforce that was made up of 20 percent or more of part time or contractual employees. Twenty-seven percent reported that at least 15 percent of their workforce was made up of part time or contractual employees.[5] (See Table 4).

TABLE 4: DISTRIBUTION OF FULL TIME AND PART TIME EMPLOYEES AS A PERCENT OF MEDICAID WORKFORCE, FY 2014

100 PERCENT FTE	11%
95 – 99 PERCENT FTE / 1 – 5 PERCENT PTE	39%
90 – 94 PERCENT FTE / 6 – 10 PERCENT PTE	8%
85 – 89 PERCENT FTE / 11 – 15 PERCENT PTE	14%
80 – 84 PERCENT FTE / 16 – 20 PERCENT PTE	8%
0 – 79 PERCENT FTE / 21 – 100 PERCENT PTE	19%

Directors also face vacancy rates in funded positions, which can vary substantially from state to state, from a vacancy rate of zero to 35 percent. In comparison with last year, the FY 2014 median vacancy rate shifted downwards, indicating that the pressure in vacancies for some programs may be easing. (See Figure 6).

FIGURE 6: PERCENT OF FUNDED POSITIONS IN AGENCY THAT REMAINED VACANT, 2013 & 2014

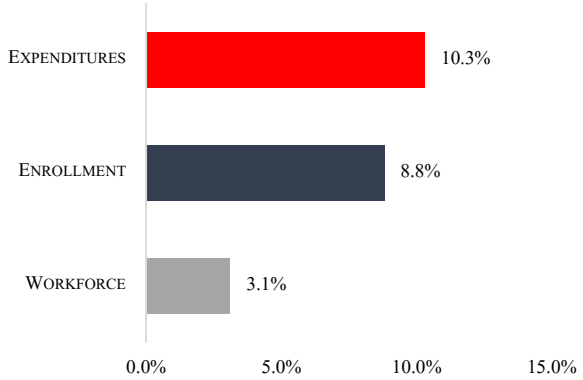


Medicaid Directors have also looked towards outside consultants to advise, inform, and in some cases, manage the operational elements of their agencies. These outside entities can include universities contracted for data informatics support, actuaries to determine managed care capitation payments, and business consultants to study and inform decisions on programmatic and policy issues.

For FY 2014, across all states, the full time Medicaid workforce grew by an average of only 3.1 percent. For purposes of comparison, in this same time frame, Medicaid enrollment is expected to grow 8.8 percent and expenditures are supposed to increase 10.3 percent.[6] (See Figure 7).

This is just a part of the picture. When contemplated in regard to the list of new responsibilities that are expected of Directors, the small increase is even more concerning. In order to be effective stewards of public money and to provide the best care to its populations, Directors have to be able to increase or retrain their workforce in key areas like contracting, data analytics, policy analysis, program integrity and other skill sets. This new pressure is due, in part, to the new focus of Directors on payment and delivery system reform and other programmatic innovations. Where the Medicaid workforce was once rooted in the needs of claims processing, provider relations, and other functions associated with a FFS system, the new Medicaid environment requires new skill sets oriented towards managed care oversight, financial modeling, and similar capabilities.

FIGURE 7: EXPENDITURE GROWTH, ENROLLMENT GROWTH, AND FTE GROWTH, FY 2014*



*Expenditure and enrollment growth taken from the Kaiser Commission on Medicaid and the Uninsured

[5] This number does not include personnel working in managed care entities in states with managed care or similar arrangements.

[6] Kaiser Commission on Medicaid and the Uninsured. Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. October 2013.

Hiring authority and resources have not risen with internal demand. In the Directors' state fiscal year 2014, only a minority (37 percent) of Medicaid programs expect to be able to hire additional personnel, and several of these increases are based on major functional changes, such as transferring eligibility functions back "in-house" from another agency. Staff resource constraints are still a major obstacle on Medicaid operations across states, and have an impact on how effectively reform plans can be implemented.

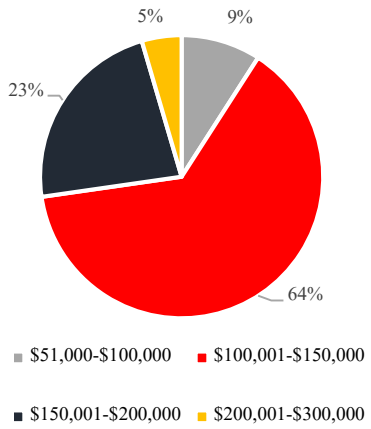
Director Salaries & Tenure

Like other public service professionals, the salaries of Medicaid Directors and their staffs tend to stay relatively static and lag behind comparable private sector jobs. In comparison with last year, the pay ranges of Directors largely stayed the same. Only three Directors' pay increased to move them up a range, while one new Director saw their pay range decreased from their predecessor's salary. (See Figure 8).

Medicaid Directors are paid less compared with their private sector counterparts. The best comparison for a Medicaid Director in regard to duties, skills and responsibilities would be a Chief Executive Officer (CEO), whose average salary nationwide in May 2012 was approximately $177,000 according to the Bureau of Labor Statistics.[7] This lies outside of the average Medicaid Director pay range of $100 – $150k and below, where close to 73 percent of Medicaid Directors are paid. Looking at a state-by-state comparison, only four Directors had salaries in pay ranges higher than the average CEO pay. Thirteen Directors were paid in the same range as the average CEO pay, while 27 were paid below it.

This number does not adequately capture the magnitude of the difference between Medicaid Directors and their peers, which in many cases would be Fortune 500 CEOs. The average salary and bonus for a Fortune 500 CEO was $3.5 million in 2012, not including other compensation, such as stock offerings.[8] This salary dwarfs even the most highly paid Medicaid Directors.

FIGURE 8: DIRECTOR SALARIES



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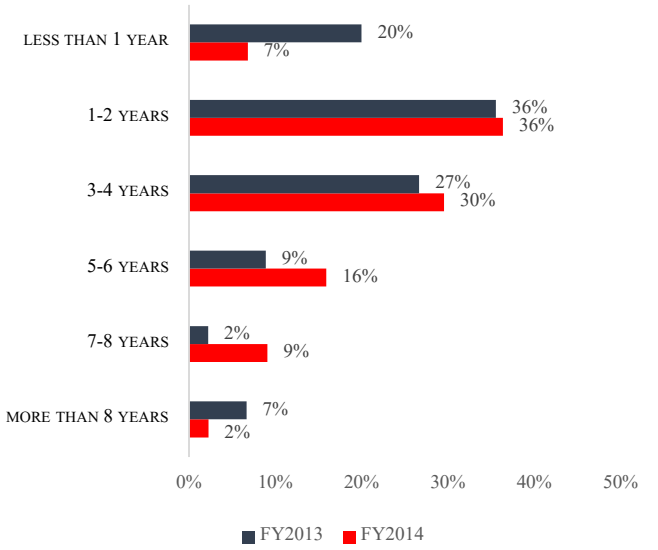
Leadership of state Medicaid programs often arises within the agency from a deep bench of staff that have the institutional knowledge and practical experience of their programs. Sixty-seven percent (30 Directors) served in their agencies prior to their appointment as Director. Fifteen Directors, or 50 percent of those with "in-state" experience had most recently served as the deputy Directors of their agencies. Ten Directors (33 percent) had recently served in a management position in a division within their agency tasked with policy or planning, and six indicated they had a background in budgeting and finance.

Prior experience in the Medicaid agency is not the only path to becoming a Director. Five Directors had served as a Medicaid Director or higher in other states, indicating that there is inter-state appeal for Medicaid experience. Directors not previously working in their agency had experience in health plans, academia, human services, law, and long term care, among other fields.

[7] Bureau of Labor Statistics. Occupational Employment and Wages, May 2012.

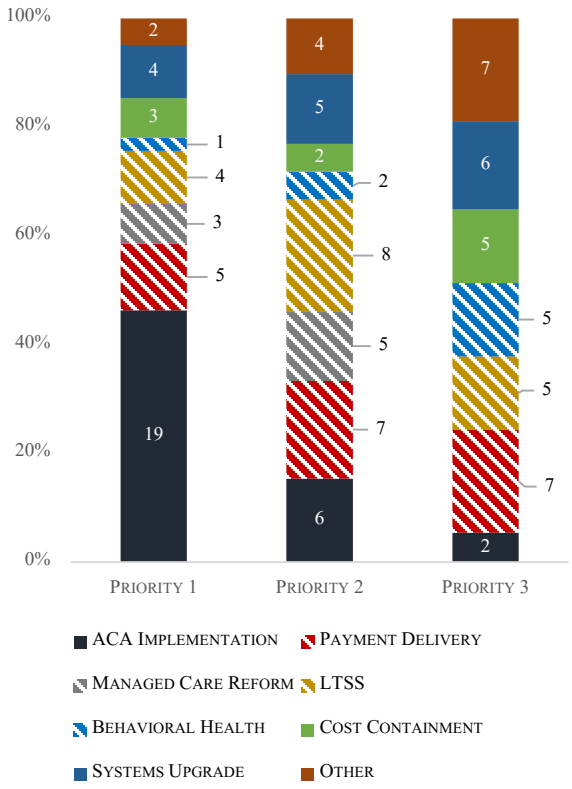
[8] Forbes. Two Decades of CEO Pay. 2012. (accessed at http://www.forbes.com/lists/2012/12/ceo-compensation-12-historical-pay-chart.html).

FIGURE 9: DIRECTOR TENURE, FYS 2013 AND 2014



The median Director tenure jumped from two years to three years from last year's survey, due to a lack of turnover for this year. This development has provided agencies with more continuity at the highest level. (See Figure 9).

FIGURE 10: MEDICAID DIRECTORS PRIORITIES FOR FY2014



THE ROAD AHEAD: PRIORITIES AND CHALLENGES

Thus far in state FY 2014, Directors largely have been focused on two overarching goals – preparing and then leading their agencies through the implementation of major aspects of the Affordable Care Act, and designing and deploying innovative programmatic reforms. These are not the only major issues that Directors face; Medicaid programs are also engaged in a major effort to upgrade their systems and develop their data analytics capacity as well as enhancing their efforts on program integrity. (See Figure 10).

Implementation of the Affordable Care Act

One of the major priorities of Medicaid Directors in FY 2014 has been the implementation of the Affordable Care Act. This should not be surprising, as the law and the federal government's regulatory approach has led to considerable administrative work on the part of all Medicaid programs. The high interest in this priority reflects that FY 2014 is the critical year in implementation.

When asked to list their first, second, and third priorities for 2013 and 2014, 42 percent of Directors answered Affordable Care Act implementation was their top priority, 13 percent listed it as their second priority, and 4 percent named it their third. Of these Directors, 41 percent were from states that are not currently expanding Medicaid. Of interest, prioritization was higher in states using the Federally Facilitated Marketplace (FFM), as 70 percent of Directors that listed ACA implementation as a priority were FFM states.

Although ACA implementation was a high priority, the exact workload and focus on implementation may vary depending on a number of factors, including whether the state is expanding Medicaid eligibility; the sophistication and adaptability of their existing IT infrastructure; the presence of a State-Based Marketplace or the FFM; and an array of other factors. Thus, while Directors may identify compliance with ACA as a priority, their actual experiences may differ depending on how their state was positioned to take on the ACA's changes.

It is important to note that this is likely the high water mark of ACA implementation as a priority from an operational perspective. Many of the concerns voiced by Directors on issues such as

communications and connections between Medicaid and the Marketplaces, technological upgrades, converting to the new eligibility paradigm, and submitting required state plan amendments, are not likely to remain as major priorities once they are established and stabilized. However, the impact of the Affordable Care Act is likely to be felt by Medicaid programs for some time into the future, including its effects on issues such as access to services, churning between public payers, benefit design, and costs, among others.

Programmatic Innovations

The role of the Medicaid Director is increasingly changing from a payer of claims on a fee-for-service basis towards a very different model, incorporating elements of a health plan, quality improvement organization, value-based purchaser, regulator, and other functions. As programs have grown and health care markets have evolved, Medicaid agencies are transforming in tandem to keep the program on a sustainable path. In many states, the Medicaid program acts as the linchpin in broader reform efforts and is driving system change.

> *"Payment reform is one of three pillars on which our strategic plan is built. Pursuing innovative ways to move away from the traditional fee-for-service payment methodology toward methods that reward quality and cost savings over volume are a critical part of building a sustainable Medicaid program for our state."*

Medicaid Directors are taking on programmatic innovation as a budgetary necessity to ensure the long-term financial viability of the program itself. Escalating costs are increasingly driving Directors to think about their programs as not just providing insurance coverage and ensuring access to services, but ensuring the health of beneficiaries while under substantial budgetary limitations.

In total, 73 percent (33 Directors) of all survey respondents named a broadly defined Medicaid reform that touches on how services should be delivered as one of their top priorities for the state fiscal year. (See Table 5).

- Thirty-eight percent (17 Directors) identified some aspect of long term care delivery as a priority. Five Directors listed planning or implementing managed long term services and supports as a priority, and six specifically mentioned integrating care of dual eligibles – and of these, four specifically mentioning the duals demonstration projects or related efforts.
- Thirty-six percent (16 Directors) named broad payment and delivery system efforts as priorities for FY 2014. These efforts include a range of reform approaches, including episodic/bundled payment, global payment, accountable care organizations, value based purchasing, and health homes. They also spoke to a range of payment and incentive structures, including shared savings and at-risk approaches.
- Eighteen percent (8 Directors) listed behavioral health initiatives as a priority. Two Directors named the rollout of managed behavioral health care as their first and second priority, while three Directors specifically mentioned behavioral health integration with physical health as a priority.
- Thirteen percent (6 Directors) listed a managed care initiative as one of their top priorities, spanning from specific and discrete populations or services being carved into managed care to statewide expansions or reforms of managed care.

TABLE 5: BROAD MEDICAID REFORM PRIORITIES, FY 2014

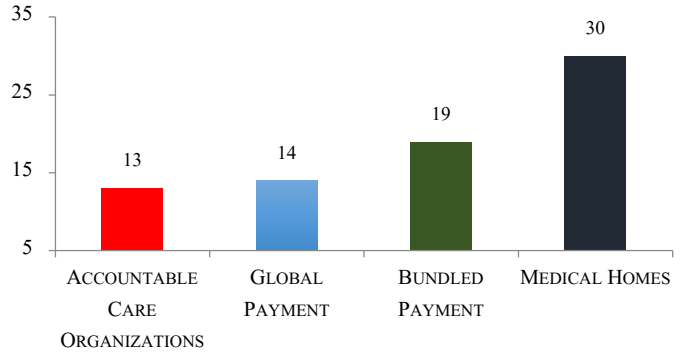
LONG TERM SERVICES AND SUPPORTS	38%
PAYMENT AND DELIVERY SYSTEM REFORM	36%
BEHAVIORAL HEALTH ISSUES	18%
MANAGED CARE INITIATIVES	13%

This year, fewer Directors mentioned cost containment as a priority. This drop may be attributed to stabilizing budgets and rising economic conditions, as well as a different way of describing their approach. Directors are addressing the budgetary challenges they see with a greater focus on benefit and service design and management rather than using older tools like benefit or eligibility restrictions. Concerns over cost containment are evolving into interest in reform.

Medicaid has historically been an area for reform through managed care and similar innovations. In keeping with that tradition, Medicaid programs are looking towards some newer reform concepts and initiatives, including: medical homes (encompassing the Patient-Centered Medical Home, the ACA's Section 2703 health homes, and other related arrangements); bundled or episodic payment; innovations in global payment; and accountable care organizations. Ninety-three percent of states indicated they were

either contemplating or moving towards implementing one of these concepts in FY 2014. (See Figure 11).

FIGURE 11: NUMBER OF MEDICAID PROGRAMS CONTEMPLATING OR WORKING TOWARDS SPECIFIC REFORMS IN FY 2014

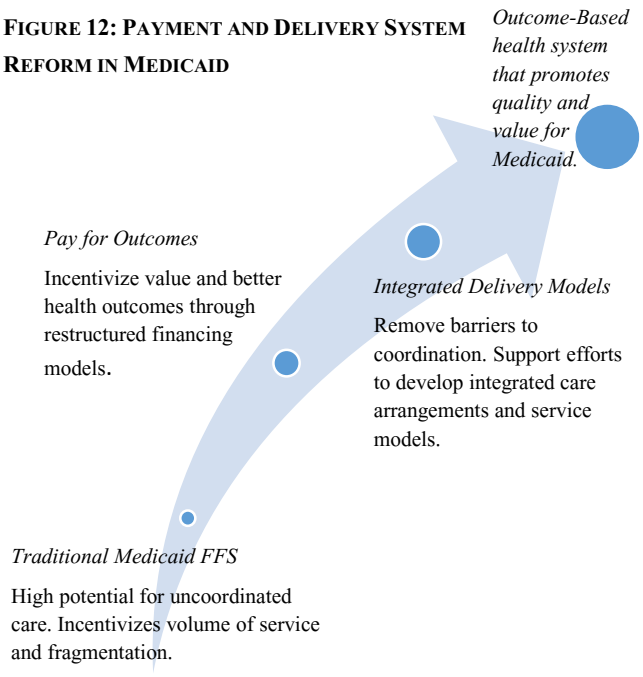


In this new era of reform, implementation has many faces. The scope of reform and number of beneficiaries involved varies from state to state. In many states, the effort is tied to larger, multi-payer reforms, including State Innovation Model (SIM) grants, where Medicaid may be the leading agency, while in others it is more of a pilot-program approach. Regardless, states are not just exploring or implementing one concept – rather they are moving forward with studies and design of several reforms simultaneously; over half of the states reported considering or pursuing more than one of above mentioned reforms in 2014.

Previous reforms had an impact on how Medicaid agencies were staffed and configured, and newer reforms will have the same effect. Programmatic innovation will have ramifications for workforce training and hiring, on Medicaid Director relationships with other public and private payers, and on IT infrastructure needs. Administrative structures must adapt to meet the needs of new programmatic realities.

The reforms will also affect the larger health care market at large. Medicaid has historically been the largest payer for a host of complex chronic conditions, long term care, and births. It is an indispensable part of the health care market in each state, not just because of the money spent, but because of the critical populations it serves. The reforms undertaken by Medicaid Directors today will have a major impact on how health care is delivered across the market in the next few years and beyond.

FIGURE 12: PAYMENT AND DELIVERY SYSTEM REFORM IN MEDICAID



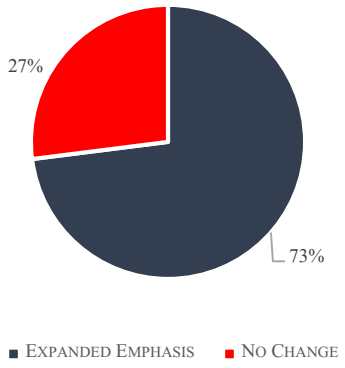
Program Integrity

Another longstanding and cross-cutting issue coming to the fore is program integrity. One of the most significant responsibilities of a Medicaid Director is program integrity. Program integrity activities have both federal and state dimensions and often involve multiple agencies in both levels of government.

> *"Our emphasis on program integrity has greatly increased. Our staffing has more than doubled and our monitoring has grown exponentially."*

Approximately 73 percent (33 Directors) reported that either program integrity issues had become a larger part of their job or that they had taken on additional program integrity initiatives, projects, or activities. Directors are leveraging data analytics as well as working to generate access to additional data and information that may be used to ensure appropriate oversight of their programs. (See Figure 13).

FIGURE 13: MEDICAID DIRECTORS' EXPANDED EMPHASIS ON PROGRAM INTEGRITY



Systems Upgrades and Data Analytics

Directors also specifically mentioned systems improvements as major priorities in the next year. Seventeen percent (seven Directors) identified new procurement or upgrade work to their Medicaid Management Information Systems (MMIS) as a priority, while 15 percent (six Directors) mentioned implementing a new eligibility and enrollment system. Medicaid's information system procurements typically involve projects costing tens or hundreds of millions of dollars, and are frequently among the largest, most innovative and politically difficult procurements in state government.

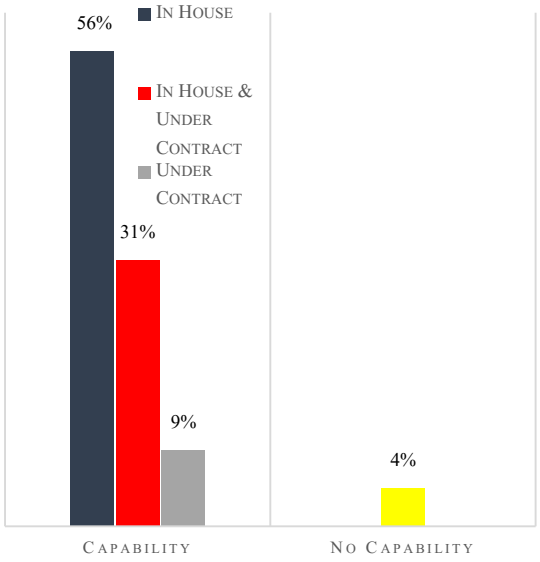
The number of states implementing or "standing up" entirely new eligibility and enrollment systems is tied to the Affordable Care Act, as many states found that they needed to either create a new eligibility system in Medicaid to adapt to the eligibility changes in the law, or to create a new system in concert with a Marketplace. The federal government's release of enhanced matching funds for technological improvements may also have led states to upgrade their technology during this time period. This may also be another indication of the lasting impact of the ACA has had on programs.

Alongside this focus on internal information management systems is a growing sense among Directors about the importance of data analytics or informatics. Medicaid programs continue to develop and enhance their internal data analytical capacity, and in some states this is being tied with their technological improvements. Thirty-nine Medicaid programs maintain some data analytics or informatics capacity in-house, with 14 of those also maintaining a contracted outside vendor to supplement their internal operations or handle other functions. Four agencies relied on outside vendors without maintaining the capability in house, with only two reporting having no capability. (See Figure 14).

Four states reported that they had some data analytics capacity, but were planning on building up that capability in this fiscal year. The use of outside vendors was split between the use of consulting or actuarial firms and the use of academic institutions, such as universities.

Analytics or informatics capacity allows Medicaid Directors to keep certain functions crucial to the operation of the program inside the agency. Staff and resources may be used for payment reform, regular business decision making tools, and program integrity, among other uses. However, Directors have reported that recruiting and maintaining personnel for these operations is a challenge.

FIGURE 14: DATA ANALYTICS CAPABILITY



CONCLUSION

In FY 2014, Medicaid Directors continue to meet their core responsibilities while taking on significant new or stepped up activities like the Affordable Care Act, programmatic innovations, program integrity, and systems enhancement. The Medicaid program has grown dramatically in most states, both in enrollment and in expenditures, and is poised to do so in the future. Directors will remain committed to focusing their efforts to meet the health care needs of a diverse population with high rates of utilization within the rubric of a sustainable program.

Directors will do so in their own, state-specific contexts. The survey demonstrates, as it did last year, that while each state has a Medicaid Director, every program is different and a product of its own environment and institutional history. Despite the differences, Directors will again face many of the same challenges in managing relationships and contracts for services while in a leadership role and dealing with significant internal resource constraints.

As Medicaid programs meet new responsibilities and begin new initiatives, Directors will continue to find that new business processes require different capabilities, expertise, and configurations of staff. Agencies will continue to evolve by meeting the emerging challenges brought on by budgetary constraints and health system transformation, and Directors will be at the forefront of change.