

NOVEMBER 2014



State Medicaid Operations Survey:

Third Annual Survey of Medicaid Directors

ACKNOWLEDGMENTS

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.

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

State fiscal year 2014 was a year of significant change for Medicaid Directors and the programs they oversee. Medicaid agencies continued their diligent efforts to implement the Affordable Care Act (ACA), while at the same time moving forward a multitude of payment and delivery system reforms and innovations. Together these changes are transforming how Medicaid is provided and transforming the agencies as well. Some of the key findings this year include:

- Directors' ability to manage relationships with a host of critical partners is key.
- Directors and their agencies are taking on multiple and varied payment and delivery system reforms simultaneously.
- Even with modest growth, Directors face major capacity constraints.
- Despite variation, the priorities for Medicaid are increasingly coherent across programs.

Managing Critical Relationships

As found in previous State Medicaid Operations Surveys, Medicaid Directors often rely on their ability to manage relationships with other governmental partners to provide services to beneficiaries. A number of Medicaid services and functions — from behavioral health and services for children and adults with developmental disabilities to eligibility determinations and non-emergency transportation — are provided by other state agencies, entities, or contractors. This division of labor increases the emphasis Directors place on coordinating multiple activities in a state environment with many actors.

Sister agencies and other governmental divisions are just one of the essential partners for a well-functioning Medicaid program. This survey highlights both the complexity and breadth of these relationships as well as the shifting dynamics of partnerships in the midst of Medicaid reform.

Multiple Payment and Delivery System Reform Pathways

Much has been written in the last few years about the promise of payment and delivery system reform to change the landscape of American health care — particularly in lowering expenditures by providing services more effectively. Innovation in Medicaid spans a range of efforts, and can include episodic payment, accountable care organizations, Financial Alignment Demonstrations for Dual Eligible Beneficiaries (Duals Demos), and initiatives in managed care. Medicaid programs are seeking to leverage their position as leaders of reform to increase quality and limit expenditures.

In 2014 and into 2015, Medicaid programs have taken on a number of efforts simultaneously and are moving full steam ahead with programmatic change on different fronts. This survey demonstrates that Medicaid Directors are leading an increasingly complex and policy-focused organization that impacts the nation's health care systems more each day.

Capacity Challenges Continue

This year, Directors again noted that their administrative capacity to take on the growing list of Medicaid responsibilities was impacted by two major factors. First, the average vacancy rate remained relatively high at 9 percent — meaning virtually 1 in 10 jobs in a Medicaid agency was unfilled. Vacancy rates have been an ongoing issue for Medicaid programs, with some programs facing vacancy rates as high as 30 percent.

Second, Directors regularly cited resource constraints in their ability to recruit, hire, and retain particular skilled and professional positions for their jobs. These positions, focused on areas like data analytics, clinical review and policy, and other areas, are critical players in supporting successful reforms and to ensuring the efficient operation of a program that is growing in size and intricacy.

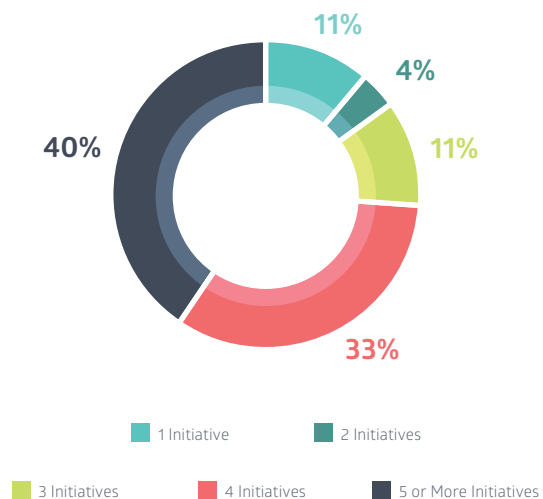


FIGURE 1. Number of Payment & Delivery System Reforms undertaken by State [2015]

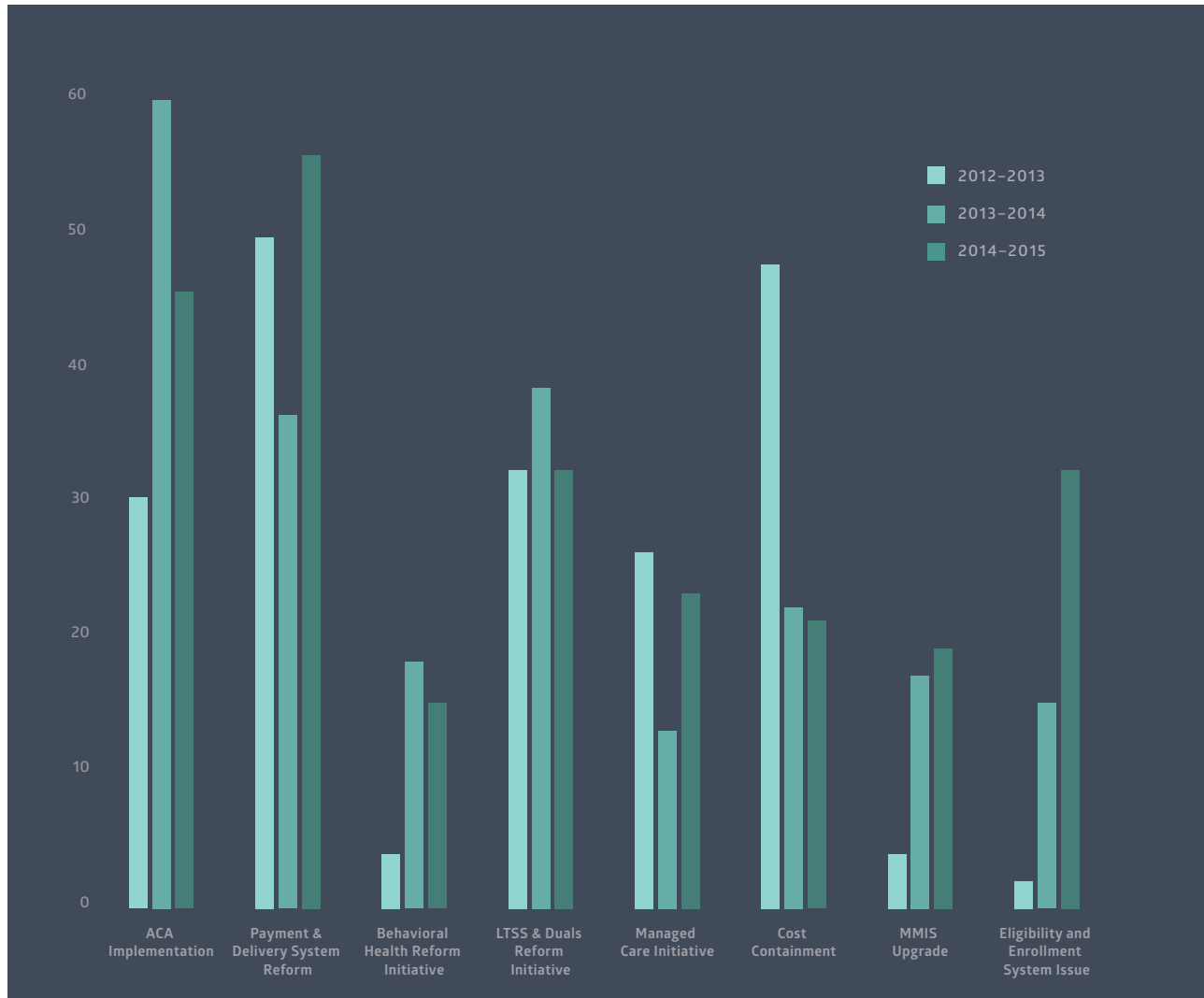


FIGURE 2. Percent of Director Top Three Priorities over Time [FY2013 - FY2015]

Director Priorities Coalesce

When asked for their top three priorities for 2015, Directors across the country answered similarly. Implementation of the ACA, planning or standing up new payment and delivery system reforms, and upgrading systems — both eligibility and enrollment and Medicaid Management Information Systems (MMIS) — were foremost on the minds of Medicaid Directors going into this 2015 fiscal year.

In previous years, other priorities had often been ranked alongside these three major items. But this year’s consistency among Directors on the major priorities shows how common trends across Medicaid are coming together in response to factors like the Affordable Care Act and growing recognition of the importance of payment and delivery system reform.

Purpose of this Survey

NAMD undertook this survey to help answer some of the leading questions regarding how Medicaid operates and how Directors can and will address the many challenges they face. We 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 use the information to assess their own programs, and to network with their colleagues about common challenges and potential solutions.

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

INTRODUCTION

The 2014 fiscal year was a critical period for Medicaid programs and their senior leadership. Throughout the year, Medicaid Directors were focused on putting everything into place for the changes brought on by the Affordable Care Act (ACA), which has proven to be one of the most significant operational undertakings in the program's history, touching on policy changes, system upgrades, and capacity development—regardless of whether the state expanded eligibility. Surges in enrollment, as well as growing expenditures, have ramped up pressure around program efficiency and performance, adding to the workload of Medicaid programs.

This year also saw Medicaid continue its evolution as a transformational force in the health care system, demonstrated by the increasing focus on paying for value over volume through a host of different programmatic innovations. Major reforms — including new payment arrangements like bundled payments, new delivery system innovations like accountable care organizations, and new initiatives to better provide care to core populations like dual eligibles and super-utilizers — are changing not just how services are delivered to the beneficiary by the provider, but how Medicaid programs conduct the business of arranging for that care, and how they relate to a host of other entities and stakeholders.

Meeting these challenges have made Medicaid programs more dynamic organizations, but Directors continue to struggle with internal capacity. The rapid shifts in different programmatic functions due to the ACA and system reforms, coupled with human capital challenges has necessitated that Directors learn to do more with less. This is astonishing given the enormous challenges and demands placed on Medicaid programs over the last few years.

This survey reflects the responses of 47 Medicaid programs (though not every program representative answered every question in the survey) and represents program status in each state's 2014 fiscal year and their outlook for 2015. The survey describes the position of the Medicaid Director and agency, key aspects of their roles and responsibilities, agency capacity, and Medicaid priorities moving forward. It shows 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.

MEDICAID AGENCIES AND THEIR DIRECTORS

Each Medicaid program has its own particular administrative structure, specific programmatic rules, standards, and procedures. Though these diverse factors make for truly unique programs across the 56 jurisdictions, each program does share the position of Medicaid Director and a number of other fundamental similarities in functions and design.

Though a Medicaid Director's specific job duties may vary from state to state, each is responsible for ensuring accountability and providing leadership for an agency that in many cases represents between a quarter and a third of a state's spending each fiscal year.

Agency Structure

Medicaid programs are most commonly located within a larger state agency. These larger agencies are usually health services agencies, human services agencies, or both health and human services agencies. These organizational structures reflect Medicaid's conceptual and historical roots as a social welfare and safety net program.

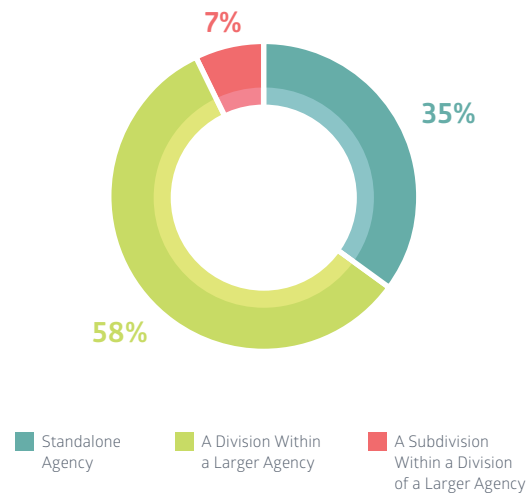


FIGURE 3. Position of Medicaid in State Government [2014]

This year, 65 percent of programs indicated their Medicaid agencies operated within a larger state agency and 35 percent indicated their agencies were standalone entities. (See Figure 3.)

The organizational structure of the Medicaid agency also impacts to whom the Medicaid Director reports. Directors of standalone agencies most often report directly to their Governor and — to a lesser extent — a Cabinet-level executive, while Medicaid agencies operating under another state agency most often have their Directors report only to Cabinet-level executive, their deputy, or a specific agency head.

Budgets and Enrollment

Using the singular term of Medicaid can mask the underlying complexities of the program. Given the range of beneficiaries, Medicaid Directors and their agencies could be viewed as running a number of different health programs under a single umbrella, with diverse services covered and varying approaches for each group.

The number of lives covered by Medicaid, and the commensurate funding in order to provide that coverage, is striking. In 2014, program resources ranged state-to-state from \$632 million to over \$90 billion, with a median budget of \$6.1 billion in combined state and federal dollars. This figure reflects a growth of 10 percent over last year's \$5.6 billion median.

Just as the size of budgets vary, so too does the size of the enrolled population, from 69,000 to over 10.3 million beneficiaries. But state and federal rules — as well as the diversity of beneficiary needs — are a factor regardless of program size. Even relatively small Medicaid programs must perform many of the same functions as large programs and each Director must be prepared to provide for the complicated health care needs of their beneficiaries.

Further, many Medicaid Directors operate programs in their agencies funded solely by state dollars and managed by the state. These programs are often focused on specific populations, covering anywhere from 50 to over 230,000 people. This year, 27 Directors reported running at least one program with state-only dollars.

Medicaid Director Experience

Medicaid Directors bring a depth of knowledge and experience to their roles, and this experience is often gained by rising through the ranks of the Medicaid agency. Sixty-eight percent of Directors have served previously in other positions within the agency before becoming Director, with over half of those recruited from within the agency serving as a deputy director before their promotion.

Given the complex nature of a program and the unique skill set required to run it, it is not surprising that these internally-hired Directors have often held more than one prior position within the agency. Forty-one percent of Directors reported holding two or more prior Medicaid agency positions. Other Medicaid agency roles Directors held before moving into this leadership position were in finance, policy, operations, and legal counsel.

The expertise necessary to serve as Director can also be gained outside the agency. Some Directors are recruited from other government agencies or the private sector and bring their own unique experience and skillsets to this role. Some of these backgrounds include experience in federal and state policy, managed care, consulting, working in other state agencies, or serving in the world of academia.

Appointment Status

Similar to previous years, this year's survey results show that a majority of Medicaid Directors are appointed to their positions. Forty-seven percent of respondents indicated they were politically appointed and did not require confirmation from the state legislature, or some other board or panel. Sixteen percent of respondents indicated their appointment required confirmation. Twenty-nine percent of Directors are civil servants, while 9 percent come into their positions through a direct hire — meaning they are hired without receiving a political appointment or going through the civil service process. The method used to name a Medicaid Director is not related to the size of a state's Medicaid program or budget. Both civil servants and political appointees are represented along the entire continuum of program sizes and budgets. (See Figure 4.)

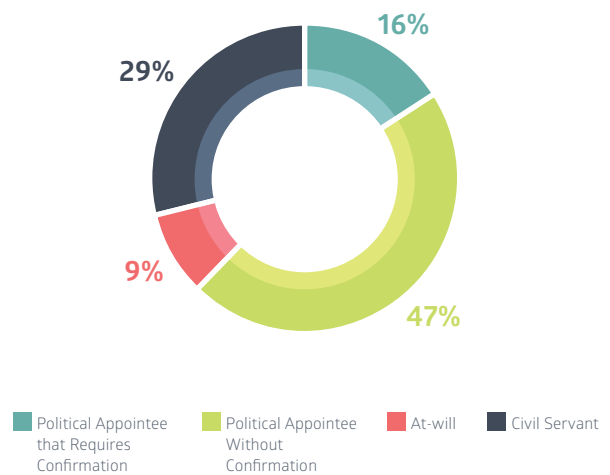


FIGURE 4. Appointment Status [2014]

Tenure

This year, the median tenure for a Medicaid Director dropped to 2 years and 3 months, from 3 years in the previous year, and closer to the 2 year median that was present in 2012. The change reflects a greater number of Medicaid Directors leaving state service for a number of reasons. In the last year, most Directors left not for retirement or for internal promotion within the government, but for other opportunities. (See Figure 5.)

Between 2012 and 2014, 38 percent of Medicaid agencies saw one or more Directors leave their position for various reasons. Of those Directors, 44 percent took a position in the private sector, while others took new positions in government, retired from the workforce entirely, or left for some other reason.

This high level of turnover across three years shows how the institutional knowledge and the specialized executive skill set necessary to operate a Medicaid agency is for many states in constant demand.

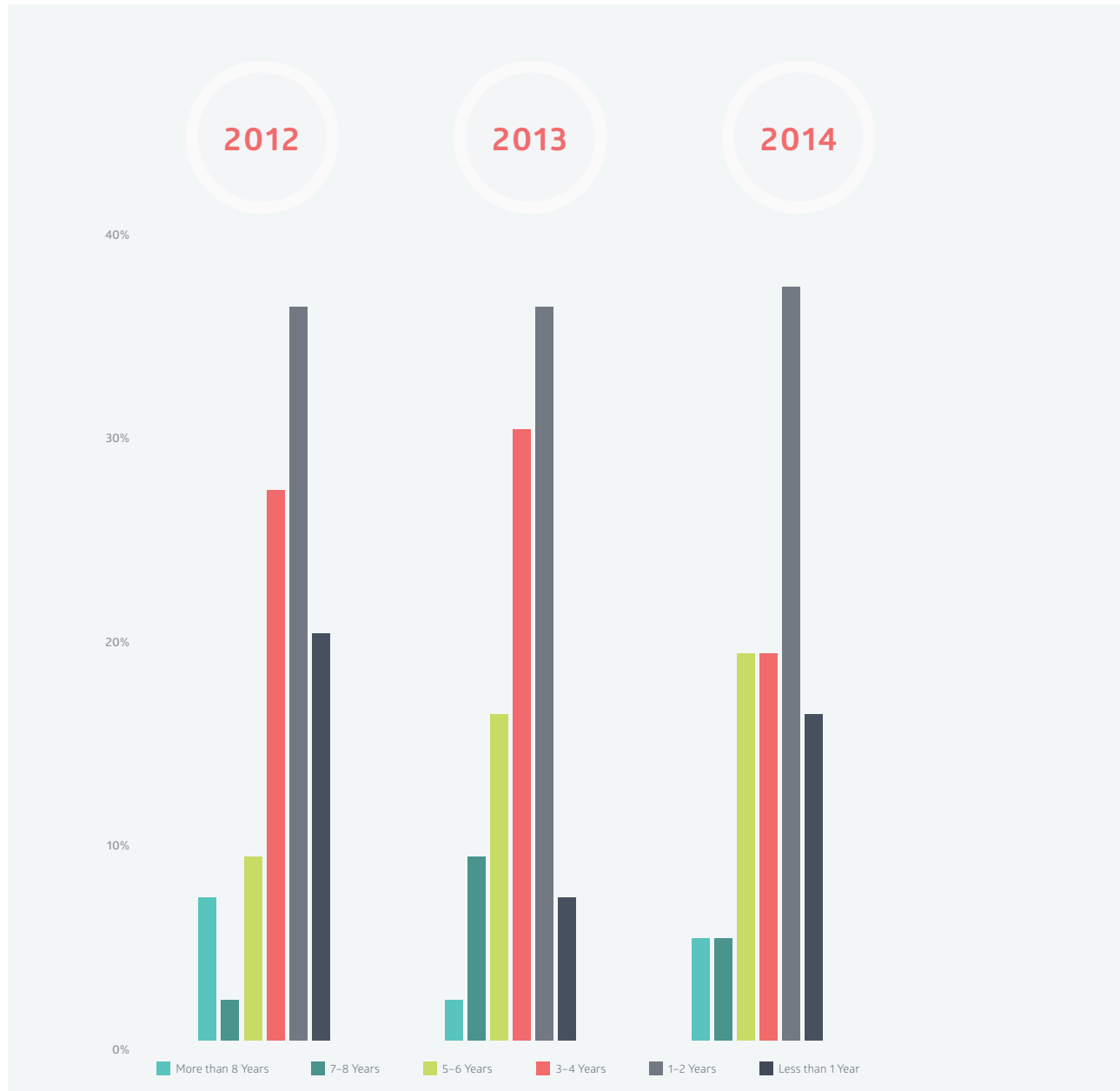


FIGURE 5. Director Tenure over Time [2012 - 2014]

JOB RESPONSIBILITIES AND ROLES

Medicaid touches many different aspects of a state's health market and its many actors. Managing the agency's relationships with these actors, which include federal government partners, other state agencies, private insurers and contractors, patient groups, providers, and other stakeholders, is critical to the success of a Medicaid program.

Directors also pay close attention to the internal workings of their agencies and drive improvement in program functionality, staff capacity, and business processes for this large-scale program. The responsibilities described in this section demonstrate the need for Medicaid directors to have a range of skills: communications and stakeholder relations, fiscal and management capacity, and strong organizational skills.

Managing External Relations

Medicaid Directors today manage a myriad of external relationships with an array of partners and stakeholders. The specific nature of these relationships depends on the particular programs, reforms, and innovations a Director opts to pursue.

As a matter of course, Directors must maintain relationships with their Governors, agency heads, state legislators, and other actors at the state level. In virtually every state, Medicaid is one of the largest budgeted programs in a given fiscal year, and thus naturally attracts attention due to its impact.

As Medicaid is jointly financed by the states and the federal government, part of the Director's role is to maintain working relationships with the federal agencies which routinely interact with the Medicaid program. The most common federal partner is the Centers for Medicare and Medicaid Services — in particular, the Center for Medicaid and CHIP Services (CMCS), the agency responsible for federal regulation and oversight of Medicaid and approval of state Medicaid initiatives. Other federal agencies which interact often with or are impacted by Medicaid include the Health and Human Services Office of the Inspector General (HHS OIG), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Furthermore, Members of Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC), and the Government Accountability Office (GAO) may also request information or testimony from Medicaid Directors.

Directors also regularly work with the beneficiaries, advocates, and providers who are affected by Medicaid policy decisions, as the impact of these decisions can be significant. Medicaid policy affects which providers can deliver services and the reimbursement for those services, the types and frequency of services available to beneficiaries, and what supports are available to Medicaid consumers.



FIGURE 6. Directors Navigate Complex External Relationships

For illustrative purposes — not representative of any particular Medicaid Director or program

Other key relationships include outside vendors and contractors, as Medicaid programs often rely on outside entities to deliver services to beneficiaries (such as managed care plans) and to provide major system functionalities (such as IT vendors and analytical service vendors). Additional partners for Medicaid agencies include universities and academics, who may provide data analytics support and research to inform policy decisions, as well as quality improvement organizations who assist in achieving key strategic programmatic objectives.

Inter-Agency Relationships

Under federal law, states must operate a Medicaid program through a single state agency, however there is significant room for states to tailor their operations to best fit their circumstances, often spreading programmatic functions across divisions inside the single state agency or with sister state agencies, local and regional bodies, other entities, and contractors.

This delegation of operations increases the emphasis Directors place on coordination and oversight. Directors must ensure that all partners involved in Medicaid operations are effectively managing Medicaid resources, reporting accurate and timely data on their activities, and meeting the needs of beneficiaries. It also speaks to the challenges that Directors have in being able to make changes to their programs, as many operational details are not in their immediate set of responsibilities.

The scope of work and the entity responsible for any given service or function varies by state. For example, in regard to mental health, the Medicaid agency may be directly responsi-

ble for paying for a few mental health services in a handful of settings, while a separate division handles the bulk of mental health service delivery and payment for Medicaid beneficiaries.

Aspects of service delivery for several populations, including children and adults with developmental disabilities (83 percent), foster youth (81 percent), persons with mental health needs, (61 percent), and persons with substance use service needs (68 percent) are commonly run by other divisions within the single state agency, sister agencies, and entities other than the Medicaid program itself.

Some services are more commonly housed within the Medicaid agency, including administration of the Children's Health Insurance Program (CHIP, 96 percent Medicaid) and long term services and supports for aged populations (LTSS, 70 percent Medicaid). (See Figure 7.)

Other functions are also sometimes handled by a non-Medicaid agency. Half of respondents indicated that another state entity, commonly a Department of Health, was responsible for provider licensing and credentialing. Over a third of respondents have their eligibility and enrollment processes managed by another state entity, with a similar amount delegating investigations and sanctions to another state entity as well.

Directors may also opt to delegate certain functions to non-state entities, such as private contractors or vendors. These functions are in many states critical to the overall functioning of the Medicaid program, making effective management of these relationships to ensure high quality and performance a critical concern.

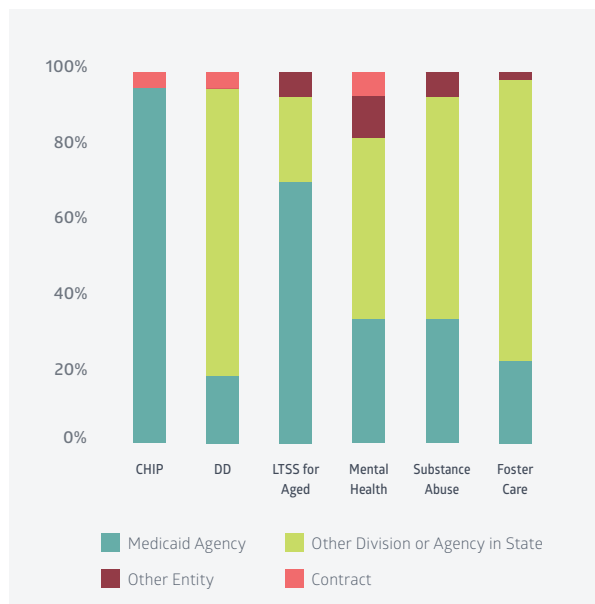


FIGURE 7. Medicaid Service by Operational Entity [2014]

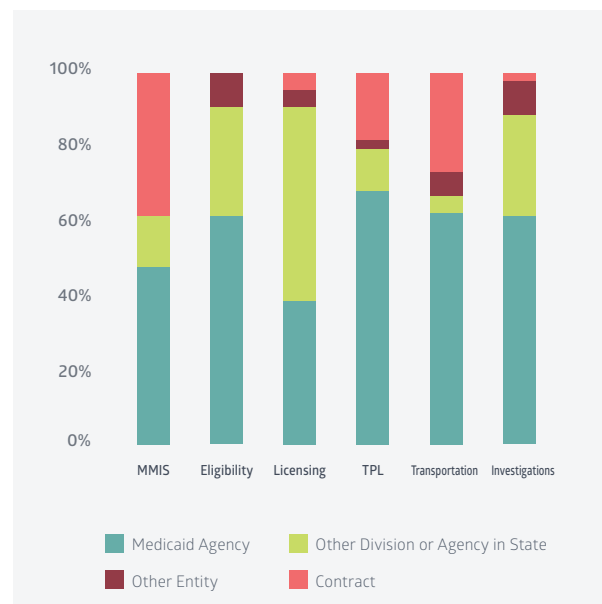


FIGURE 8. Medicaid Function by Operational Entity [2014]

For example, states using significant amounts of managed care must ensure that plans contracting with Medicaid are reporting data on service delivery and payment accurately and are providing efficient, high-quality care to beneficiaries. Contractors are also used to provide transportation services, a benefit which 27 percent of Medicaid programs task to private companies. In other cases, vendors operate key technical components of the Medicaid program. A third of Medicaid programs rely on a vendor to operate their MMIS, which is integral to the agency's day-to-day functioning.

The New Relationship with Marketplaces

In 2014, Medicaid Directors' relationship with Marketplaces entered into an operational phase, as open enrollment began. States coordinate now with either Federal or State Marketplaces, which have become one of the central entry points for Medicaid coverage, particularly for childless adults, families, and others whose eligibility is tied to income rather than disability status.

These Marketplace entities are new to the list of important partners for Medicaid, and in many ways the dynamics of coordination are still evolving. Only a handful of Medicaid Directors in State Based Marketplaces (SBM) states have a formal voice in Marketplace governance despite the important links around eligibility, plan selection and enrollment, and churn of individuals between Marketplace coverage and Medicaid. Of the Directors that responded, 3 indicated that they were on the Marketplace board in their own capacity, while 3 others indicated that their agency head had a role on the board. All Directors served as some sort of advisor or in a position to provide input to the Marketplace.

In regard to the Federally-Facilitated Marketplaces (FFM), Medicaid programs must coordinate efforts and align policies and business practices with the FFM, but some Directors are just one member of inter-agency teams serving with their respective insurance regulators, human services agencies, and other partners. This diffuse leadership structure is somewhat mirrored in federal operations, as different state entities work with the different staff in CMCS and Center for Consumer Information and Insurance Oversight (CCIIO) on the resolution of policy matters.

Marketplace interactions represent a new and important relationship Medicaid must maintain, involving multilevel intergovernmental and interagency coordination and alignment. Given that these collaborations impact Medicaid information systems, eligibility policy, and Medicaid enrollees, they must be given considerable attention.

The Changing Nature of Relationships

Medicaid's relationships with the many entities described above are constantly evolving, particularly in light of ongoing changes to the health care system prompted by the ACA and states' efforts in delivery system and payment reform. These many relationships and the policy developments may have contributed to 46 percent of Directors indicating that their jobs have become more political over the last two years.

Additionally, state reform efforts, particularly in the areas of behavioral health integration and LTSS, require recalibrating existing relationships with other state agencies, which are often responsible for managing service delivery in these areas. Linking Medicaid's policies, systems, and staff with these agencies may also put strain on both parties. Navigating these increasingly complex relationships to ensure positive outcomes for Medicaid beneficiaries is one of the many responsibilities Directors take on to be successful.

AGENCY CAPACITY, FUNCTIONS, AND WORKFORCE

In addition to the external and internal relationships that Medicaid Directors must manage, there is the considerable job of overseeing agency operations themselves. Medicaid agencies are finding that they must carry out an increasing array of complex functions and tasks in the administration of their programs.

Agencies effectively carry out these tasks and operate the program with a median staff of 359 full-time employees. Of the states that responded, the range of full-time employees spanned from a low of 46 to a high of 3,348. States also continue to utilize part-time employees to bring additional expertise to their work. But like many other aspects of the program, Medicaid agencies' use of part-time employees and contractors varies to a great degree from program to program; some states do not have any part-time employees while other states make up nearly a fifth of their workforce with part-time and contractor hires.

Workforce size and composition is ultimately tied to the functions that Medicaid agencies run in-house, as well as other historical and state-specific factors; it is rarely neatly aligned with agency needs because needs are constantly shifting and often multiplying. Medicaid agencies are in perpetual need of greater resources to keep up with the evolving demands of the program.

Workforce Needs

Directors face challenges in recruiting and retaining a workforce with the necessary skills and technical expertise to carry out the functions of these complex programs. The challenges are augmented by the fact that many funded

Medicaid positions remain vacant, as Directors seek to identify the appropriate expertise to fill them. On average, Medicaid agencies' vacancy rate is 9 percent, though it varies by state — from a low of 0 percent to a high of 30 percent. (See Figure 9.)

Further, the vacancy rate has generally held steady over the past three years, reflecting an ongoing issue. Directors' most frequently cited workforce challenges include issues with recruitment and retention, and low pay for Medicaid employees is commonly pointed to as a major contributing factor. Other workforce issues that Directors face include workforce development issues, staff exiting the workforce to retire, and challenges in the hiring process.

These workforce issues are compounded by the fact that the technical, specialized skill sets required in Medicaid are also highly sought after in the private sector. This is increasingly true as the private insurance market takes up the banner of payment and delivery system reform, and these employers are recruiting individuals with the same skills that are vital to Medicaid. From a state perspective, it is difficult to compete with these employers that can dedicate funds to recruitment, workforce development, and can offer much higher pay.

These unique barriers are further impacted by the shift in the skill set required by Medicaid for changes related to innovation, payment and delivery system reform, and the work to stand up new systems. These are skills that may not have existed in the agency previously.

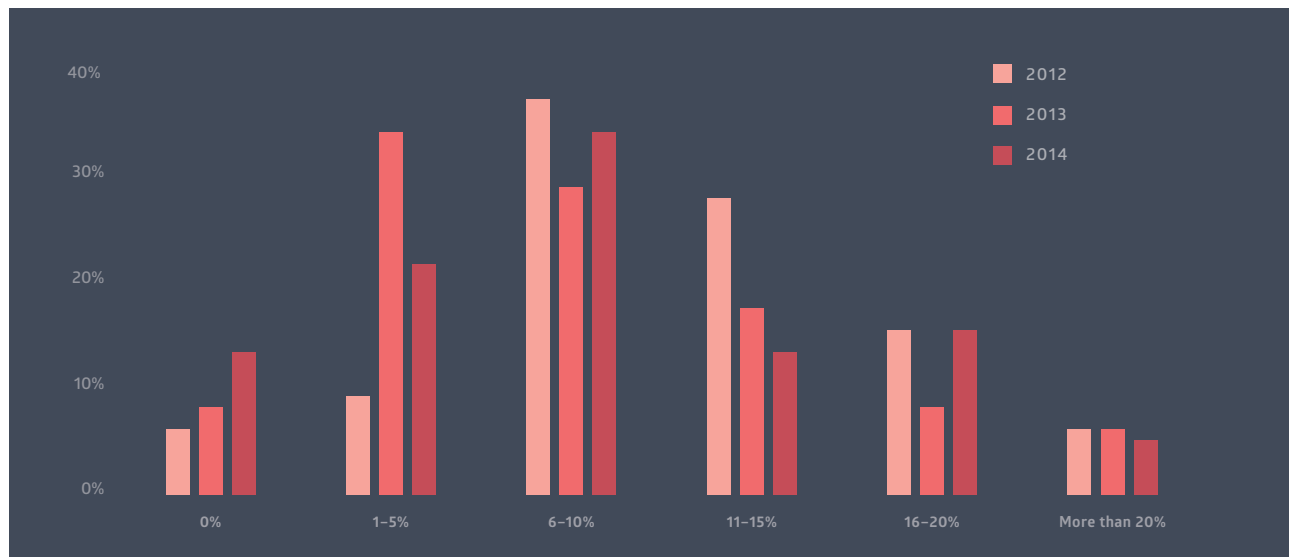


FIGURE 9. Percent of Funded Positions that Remain Vacant over Time [2012–2014]

The Workforce for Data Analytics

One of the most high profile and emblematic workforce issues for Medicaid programs is the interest in data analytics and challenges programs have in effectively applying that expertise. Agencies have long housed troves of internal data arising from claims, encounters, and eligibility determinations, but were not always historically able to use the data in ways to enhance the program. Programs increasingly have a need for data analytics for a host of operational issues, from quality improvement and payment/delivery system reform to program integrity to program monitoring and evaluation.

In 2014, 85 percent of Directors responding to this survey reported having some or all data and analytics capacity housed within the state. Of those with in-house capacity, 39 percent reported having their capacity generally contained in a centralized unit; the other 45 percent structured their data and analytics team so staff are distributed across the internal divisions of the agency or employed a hybrid internal structure. (See Figure 10.)

However, not all Medicaid agencies have data and analytics capacity generally in-house. Other Medicaid programs use vendors or other structures, such as leveraging the expertise of an academic institution, to provide capacity for Medicaid data and analytics.

Quality improvement is the most common function for data analytics capacity. Fifty-eight percent of those responding reported using data analytics to enhance the quality of care delivered in Medicaid in FY 2014. More than 53 percent of programs use this data analytics to support program integrity. Furthermore, this year, 32 percent of Directors reported using their data analytics capacity to support payment and delivery system reform.

While the use and prioritization of data analytics has accelerated greatly, significant challenges remain in bringing data analytics capabilities to agencies. Chief among the challenges is the issue of recruiting and retaining a workforce with this skill set. Data analytics skills are highly sought after in the private sector. States must compete with these higher paying entities to build this workforce. While it is a barrier states must address, many are confronting it through innovative practices to attract and retain staff, including through workplace flexibility — like telework — innovative hiring practices, greater responsibility, and other non-compensation benefits.

Program Integrity and the Medicaid Agency

Another function growing in importance for state Medicaid agencies is program integrity. While Medicaid agencies have long made it a priority in their programs, new policy developments and technological innovations have made program integrity an even more central initiative in Medicaid operations.

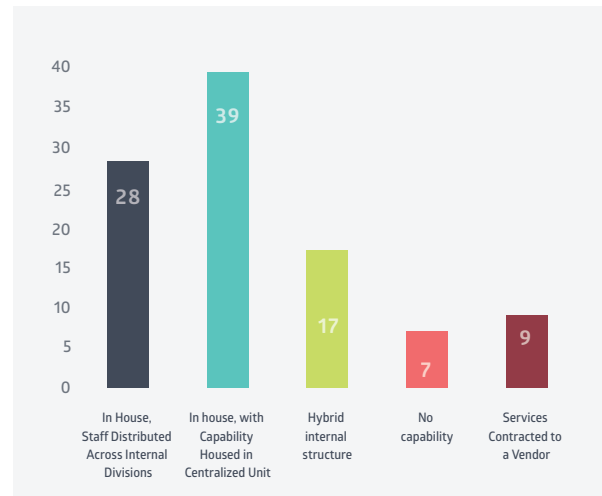


FIGURE 10. Percent of States with Data Analytics Supports [2014]

With more covered lives and greater expenditures, the interest of federal and state policymakers to find ways to increase program efficiency has grown as well. States view robust program integrity activities as a critical quality improvement strategy and a tool for improving health system performance. As such, program integrity is being interwoven more with other aspects of the Medicaid program, from prescription drug payments to managed care contract oversight to ensuring consumer protections and beneficiary safety in long-term care settings.

Program integrity remains a significant priority for Directors — 62 percent of Directors indicated that program integrity activities became a larger focus for their agency in 2014, as compared to 64 percent last year. The range of activities undertaken in the past year include increased emphasis on provider training and reporting, heightened electronic monitoring of care delivery settings, focused, data-driven audits of select providers, and the creation of program integrity task forces.

Technological advances in data analytics, program monitoring, and other areas have greatly augmented auditors' abilities to find and detect inefficient and illegal behavior. Now that the barriers to uncovering waste, fraud and abuse have been lowered, there are more opportunities and ways for programs and auditors to design program integrity measures.

States utilize several techniques for directing their program integrity efforts. Historically, states have analyzed claims in order to find problems in reimbursement. Now, many states utilize cutting-edge data analytics techniques to focus program integrity activities on certain areas of their programs likely to yield high-value results. This year, 7 programs noted they had either used or were planning to use predictive analytics to proactively identify efficiency issues.

However, fully leveraging the potential for data analytics in program integrity requires significant agency resources, resources which states do not necessarily have. Twenty-eight percent of responding Directors indicated scarce staff resources, especially staff with requisite analytic, clinical, and program knowledge, as a key operational challenge impeding their agency's program integrity activities. Thirty-five percent of Directors that responded indicated that access to appropriate data sources, including various federal databases and managed care datasets, was another challenge. (See Figure 11.)

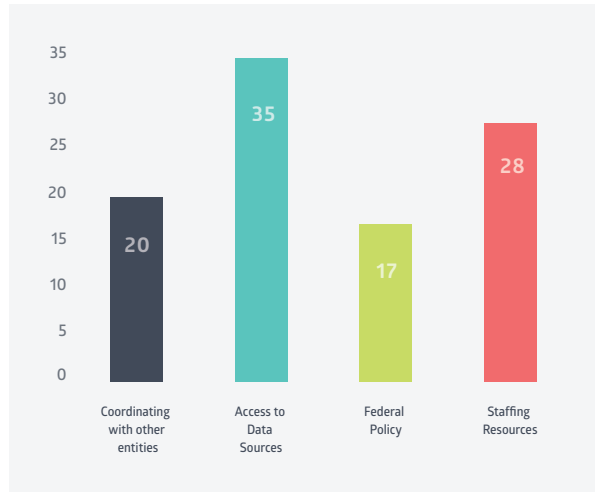


FIGURE 11. Percent of Major Operational Challenges to Program Integrity Work [2014]

In the new era of data-driven and enhanced program integrity, effective policies involve coordination with other state and federal entities, including Recovery Audit Contractors, Medicaid Fraud Control Units, Offices of Inspectors General, and law enforcement. While coordination has been a challenge, the increased emphasis on program integrity is leading toward greater policy and operational synchronization between different governmental agencies.

Work with Contractors and Outside Entities

Medicaid Directors often overcome workforce challenges by leveraging outside entities, such as universities, actuaries, and business consultants. These entities can fill the void where Medicaid agencies face difficulty recruiting and retaining staff with the appropriate skill sets. In addition, states may use contractors for a variety of other reasons, such as to provide flexibility in the workforce models or as a way to manage administrative expenses and overhead.

Although states use contractors for a wide variety of functions, Medicaid agencies most often use contractors to stand up and run eligibility and enrollment systems and processes. Specifically, 44 percent of programs with contractors utilize

them for this purpose. In addition, 30 percent of programs that utilize contractors receive information technology (IT) services and support from them. Contractors also often provide clinical expertise, with 26 percent of all programs that use contractors tapping them for this purpose. Other common functions that these outside entities carry out include operating call centers, providing pharmacy expertise, conducting administrative functions, and running claims processing and appeals. (See Figure 12.)

Workforce Outlook

Looking to the future, the Medicaid workforce continues to experience modest growth, but it is outpaced by the growth in responsibilities and functions taken on to implement the ACA, stand up innovation, and generally move their agencies forward. Medicaid programs are serving an increasingly diverse population of beneficiaries and must have the staff and expertise to ensure care across a range of delivery models within their program.

The need for a robust workforce is likely to increase. With only 25 percent of Medicaid Directors anticipating an increase in hiring authority in the year ahead, Directors will need to continue leveraging their staffs to meet new program challenges. In addition, the longstanding concerns around recruitment and retention of the Medicaid workforce remain a prominent issue for Medicaid agencies. Key skill sets — especially around contracting, data analysis, and program integrity — are becoming more important in the reform era, which puts pressure on Directors to find new and innovative ways to acquire and maintain the right staff to carry out these functions while operating the program within budget constraints.

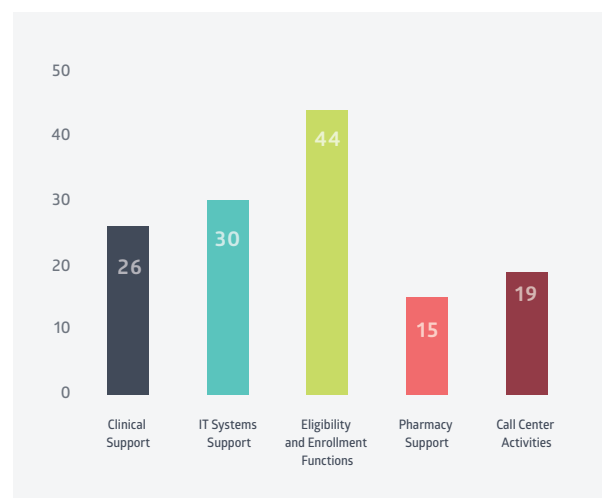


FIGURE 12. Percent of States' Top Functions for Contracted Employees [2014]

DIRECTOR PRIORITIES IN FY 2015

Looking toward the next fiscal year, Medicaid programs are increasingly coalescing around a handful of core priorities across all states, specifically the ongoing implementation of the Affordable Care Act (ACA), major payment and delivery system reform efforts, and upgrades in systems capacity.

Given the range of activities and different circumstances in which programs find themselves, this growing consistency across programs is in some ways remarkable. However, in another view, the influence of larger events and developments inside and outside of the Medicaid program — including payment and delivery system reform, the ACA, and the need for new tools to put these new policies into place — have perhaps predictably driven programs to view their priorities in similar ways. The growing similarity of priorities speaks to a common set of trends shaping Medicaid today.

Implementation of the Affordable Care Act

Medicaid programs continue to grapple with the many issues surrounding the implementation of the ACA. This is to be expected, as the ACA touched on many aspects of state Medicaid operations, for all states and involved significant operational and policy changes that must be accomplished in very tight timeframes. Chief among these were issues related to eligibility and enrollment, but the number of new business processes and developments related to the ACA also drove implementation to be an issue. It is no surprise that Medicaid Directors are still focused on implementing it a year later.

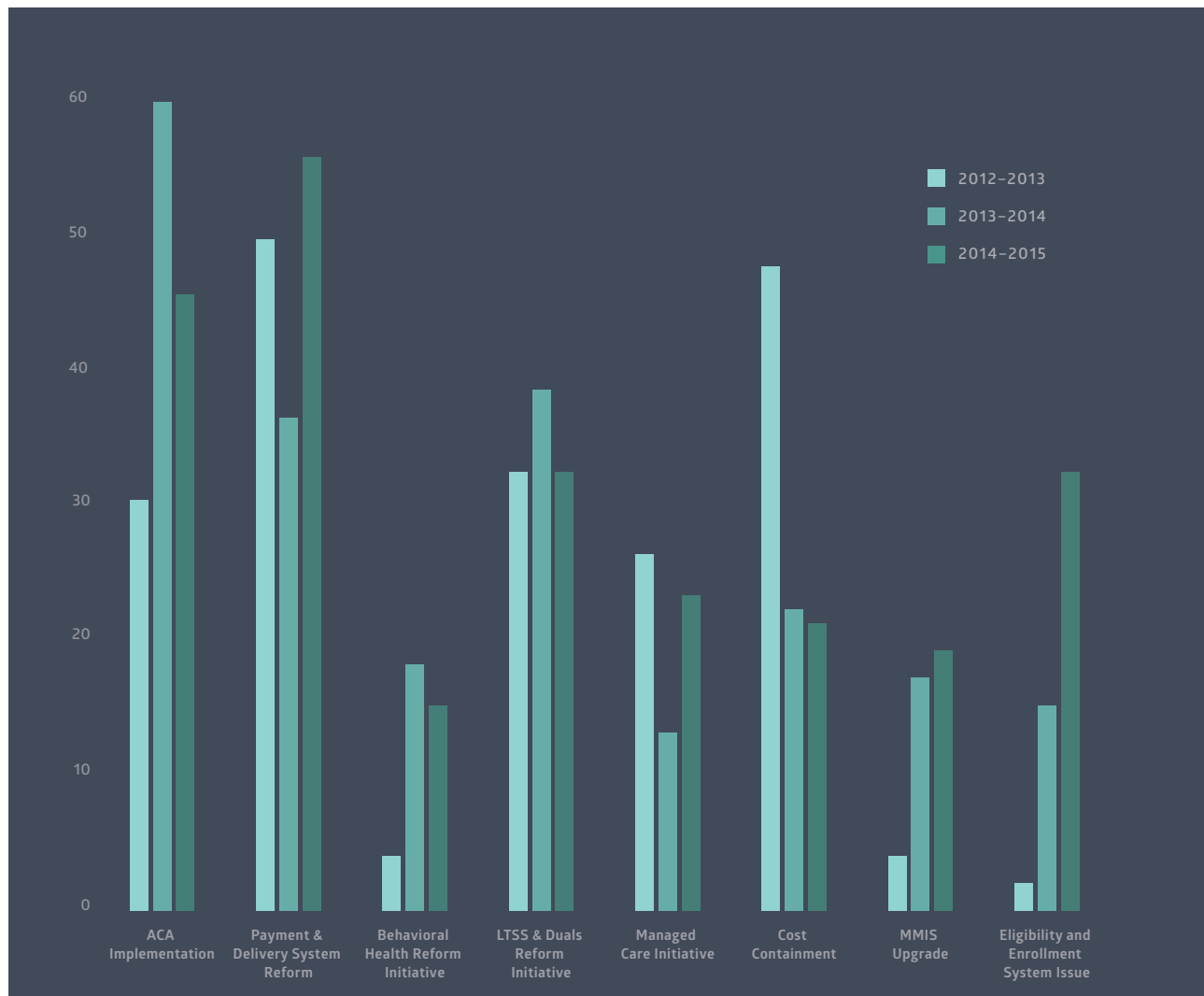


FIGURE 13. Percent of Director Top Three Priorities over Time [FY2013 - FY2015]

Forty-five percent of respondents that submitted their top three priorities named some aspect of the ACA— either preparing for a Medicaid expansion in the legislature, or an actual implementation issue — as their top priority. Many Directors who indicated ACA implementation was their top priority in FY 2014 also indicated it was their number one focus area for FY 2015; however, the percent of states indicating that it is their top priority did fall, signaling that for some Directors, the issue has become less of a priority.

Further, within the broader framework of priorities, the ACA became less of a priority. Only 4 percent now rank it as a second priority compared to 13 percent of the states last year.

It is likely that the ACA will continue to be important for Medicaid agencies. ACA implementation has always been a multi-year issue and presents challenges that require significant agency focus. These challenges are also evidenced by the fact that few Directors cited ACA implementation as their second or third priority in FY 2015. If it was a priority, it was generally the agency's top priority.

Innovation

As a program that serves a population that faces unique economic, social, environmental, and health factors, Medicaid programs have embraced different service models and payment approaches in order to better tailor care for beneficiaries.

This year all states that answered the survey were moving forward with some kind reform, whether it be bundled payment, accountable care organizations, health homes, managed care pay-for-performance, long term care reform, behavioral health reform, and/or initiatives targeting super-utilizers. States were in various stages of the reform, in planning, design, implementation or expansion of an existing reform and tapping different funding streams and authorities like Duals Demos, State Innovation Model (SIM) Grants, Delivery System Reform Incentive Payment (DSRIP) Programs, state dollars, and more.

Of particular interest is the number of reforms that Medicaid programs are taking on at once. Forty percent of the states reported engaging in at least five different reform efforts, which demonstrates that Medicaid programs are not seeking a one size fits all solution, but rather combining approaches into different, targeted initiatives. In total, nearly three-quarters of Directors are standing up 4 or more reforms simultaneously. (See Figure 14.)

This multitude of different options indicates a very busy and active space for Medicaid Directors and their staffs. It also shows potential flashpoints in Medicaid's relationships with sister agencies, MCOs and other vendors, and other entities. New initiatives impact Medicaid's partners, often requiring substantial change in Medicaid and other practices, and impacting relationships with providers, and other stakeholders.

Some Medicaid reform areas stick out because of their unique relationship to Medicaid populations. Long-term services and supports (LTSS) represents an area of interest and programmatic innovation for Medicaid agencies, including for the dual eligible population. Sixty-five percent of respondents indicated their states were planning, implementing, or actively working to improve their LTSS programs, with 31 percent of respondents naming LTSS as one of their top three priorities for FY2015. Efforts around the delivery of long-term services and supports and for the dual eligibles were primarily focused on efforts to leverage managed long-term services and supports for the delivery of care to this population. Some of the energy driving LTSS reform in particular may be tied to federal developments, including new regulations and implementation of decisions arrived to in litigation.

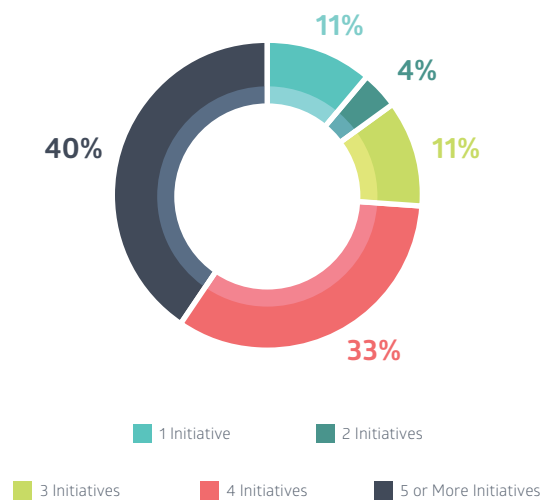


FIGURE 14. Number of Payment & Delivery System Reforms undertaken by State [2015]

Alongside LTSS, there is an increasing focus on behavioral health as another necessary and high value Medicaid-specific reform. Seventy-six percent of respondents indicated that their state either implemented or were otherwise engaged in exploring or implementing a behavioral health initiative. The majority of these initiatives center around delivering better coordinated care for Medicaid beneficiaries with behavioral health conditions, such as through health homes or risk-based managed care approaches.

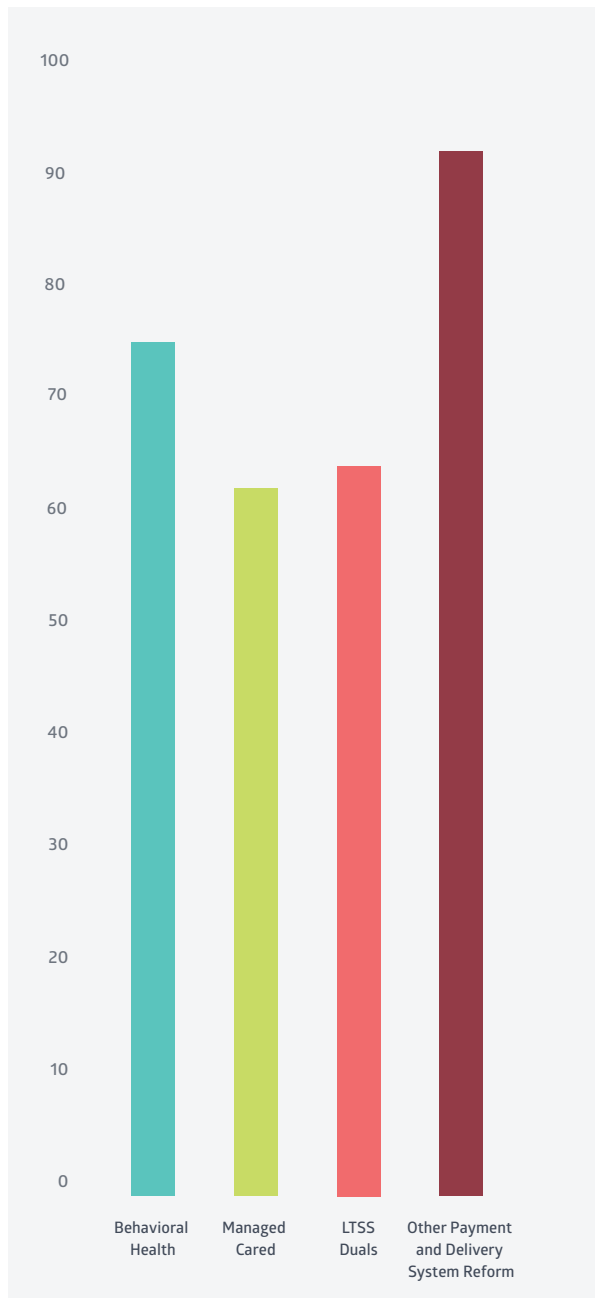


FIGURE 15. Percent of Programs with Reform Initiatives [2015]

Directors pointed to other payment and delivery system reform as a major activity area for FY 2015 as well, indicating that agencies are continuing to turn their energy and the resources to this work. Ninety-three percent of Directors responding indicated they were working on a bundled payment, accountable care organizations, health homes, managed care pay-for-performance, and/or initiatives targeting super-utilizers in FY 2015. (See Figure 15.)

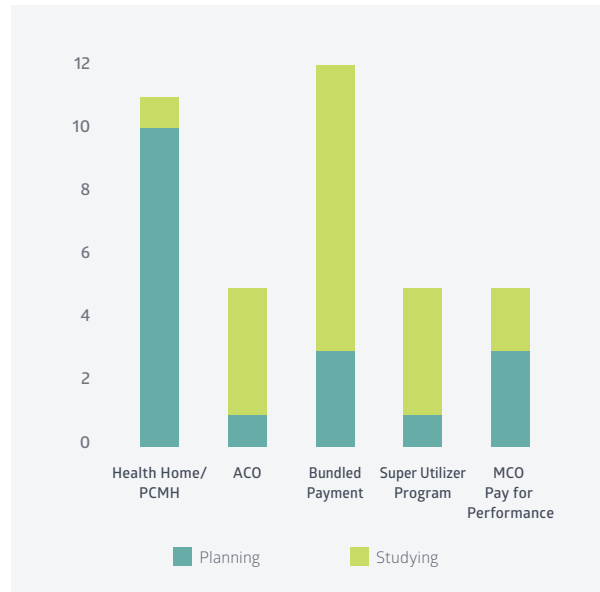


FIGURE 16. Number of States Studying or Planning a Payment/Delivery System Reform [2015]

This stepped up activity for broad payment and delivery reforms, behavioral health and LTSS reforms, and managed care initiatives is reflected in Directors' top three priorities. Nearly 85 percent of respondents were prioritizing a major program innovation in at least one of these areas in FY 2015.

Innovations in payment and delivery systems have also changed how Directors are treating cost containment. In 2012, 36 percent of Directors mentioned a cost containment initiative as a top priority — 11 percent of all Directors mentioned it twice. Now, for FY 2015, the number has fallen to 18 percent.

This change, as well as the change in how Directors approach reform as a priority, reflects the new way that Directors see solutions to these problems. Where Medicaid would have once treated budget crunches as issues to be solved through benefit reductions or provider rate cuts, Directors now see the upside of tackling the issue systemically through a change in payment and health care delivery.

The most significant challenge to Medicaid programs in regard to innovation is resources. States regularly cited staffing issues as an impediment to implementing reform. The start-up funds to get certain aspects of reform are also crucial — several states indicated that their reform designs were dependent upon enhanced federal funding, SIM grants, DSRIIP, and other sources. States are tapping state dollars as well, but the availability and amount of these funds are not always enough to ensure that reform can be implemented.

System Upgrades

System improvements, including Medicaid Management Information Systems (MMIS) and eligibility and enrollment systems, are a major area where Directors are dedicating their agencies' focus and energy in FY 2015. Approximately 50 percent of respondents said it was a top 3 priority for their agency to implement or plan to implement one or more system upgrades in FY 2015. Implementation of eligibility and enrollment systems was a priority for 32 percent of respondents, while 19 percent of these programs indicated that they are focused on procuring or implementing a new MMIS.

The significant focus in system improvements for eligibility and enrollment systems can be tied to the ACA's required overhaul of Medicaid eligibility, which resulted in Medicaid programs adopting new systems or amending their current systems to interact with their Marketplace. Although many states started work on these systems prior to this year, more Directors noted that eligibility and enrollment systems are now a priority, as compared to last year. Last year, only 15 percent of Directors mentioned their new eligibility and enrollment system was a priority, while this year it increased to 32 percent of Directors. This is largely the result of ongoing issues around these systems and the persistent effort needed to see through major improvements.

Other system overhauls, namely efforts to modernize information management systems in Medicaid, are likely sprouting from a range of factors. These include enhanced federal matching funds that are available for new or improved systems; the growing program focus on payment and delivery reform; and technological advances in the systems that are available. In addition, the ongoing state work to drive program integrity in Medicaid also requires the use of modernized information management systems which is also contributing to the trend. Whatever the impetus may be for procuring a new system, Directors must work through the complex, multi-year process of implementing these upgrades to support the future of the program.

CONCLUSION

FY 2014 has been among the busiest times for state Medicaid since the program's founding. Two major activities — the implementation of the Affordable Care Act and standing up various delivery system reforms — have been and continue to be significant multi-year endeavors of importance in 2014 and into 2015. Programs are meeting these challenges, among many others, head on.

The expanded activity of Medicaid programs is complicated by the resource challenges the programs face. Vacancy rates remain high and hiring outlooks remain problematic — and it can be difficult for states to develop the skill sets internally to tackle new functions. Furthermore, the need to balance and leverage relationships to effectuate programmatic change remain a perennial concern.

While these hurdles exist, Medicaid Directors are meeting the new demands and moving forward to position their programs for success in the short and long term.



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