

DECEMBER 2016

# STATE MEDICAID OPERATIONS SURVEY

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5TH ANNUAL  
SURVEY OF MEDICAID DIRECTORS



**NAMD**

National Association of  
Medicaid Directors

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## 2016: A YEAR OF DYNAMIC LEADERSHIP & INNOVATION

Now in its fifth year, the National Association of Medicaid Directors (NAMD)'s Operations Survey provides a glimpse into the unique circumstances and challenges Medicaid Directors face as the leaders of their agencies. Each year, Medicaid Directors and their staffs work with NAMD to develop a comprehensive understanding of the operational aspects of the Medicaid program at the state level, providing detailed information about their programmatic operations and forecasting leadership challenges and priorities going forward.

As in past years, this year's survey paints a picture of strong leadership among Directors. Even in the face of ever-mounting operational challenges and an increasingly crowded landscape of interests and stakeholders, Directors continue to serve as champions of reform, transforming the health care system's core incentives away from volume and towards value. Summarizing the responses of 47 Medicaid programs,<sup>1</sup> this year's survey reveals that Medicaid leadership was primarily centered around two pivotal trends in fiscal year 2016 (FY2016):

*Even in the face of ever-mounting operational challenges and an increasingly crowded landscape of interests and stakeholders, Directors continue to serve as champions of reform, transforming the health care system's core incentives away from volume and towards value.*

- **Directors are fundamentally transforming the health care system from volume to value through innovation that reflects each state's unique administrative structure, budgetary landscape, and sociopolitical context.** This innovation includes delivery system and payment reform, behavioral health improvements, and initiatives to enhance long-term services and supports (LTSS).
- **Medicaid operations are evolving to continue to drive program performance and support innovation in many ways,** including through the development of IT systems to more holistically track, measure, and analyze health information, and enhanced coordination with external entities like sister state agencies, contractors, and state and federal policymakers.

The following report offers an in-depth look at the landscape of state Medicaid programs and their operations in FY2016, providing major findings in four sections: 1). Medicaid agency priorities; 2). Medicaid innovation through payment reform, behavioral health integration, and LTSS; 3). Medicaid agency roles, responsibilities, and relationships; and 4). The operational challenges Medicaid Directors face. In shedding light on these issues, the report provides critical insight into the size, scope, and diversity of state Medicaid programs. Especially during this time of momentous political change, it serves as a crucial tool with which to support Directors in tackling challenges and operationalizing reform, helping policymakers and the Medicaid stakeholder community to identify, understand, and protect what matters most to states.

<sup>1</sup> Not all 47 state respondents answered every question in the survey; this is accordingly indicated throughout the report.

# MEDICAID AGENCY PRIORITIES

In FY2016, Medicaid agencies continued to undergo considerable operational change, assuming responsibility for new grants and programs, while driving value-based reform for their most vulnerable beneficiaries. Directors identified a multitude of priorities in this year's survey, with **delivery system and payment reform, systems management, and behavioral health emerging as the most commonly cited priorities across states for the coming year.**

## THE REACH AND IMPACT OF THE MEDICAID PROGRAM

In FY2016, the expansive reach of the Medicaid program continued to shape priorities, as growth in program enrollment, as well as increased fiscal responsibility, opened doors to new opportunities and challenges. As of August 2016, **73.1 million** individuals were receiving Medicaid services, an increase of more than 15 million individuals since Fall 2013.<sup>1</sup> In this year's survey, 28 agencies reported providing coverage for an additional 1.42 million individuals through **separate, state-funded programs**,<sup>2</sup> including supportive housing, old age pensions, immigrant services, non-emergency transportation, and telehealth.

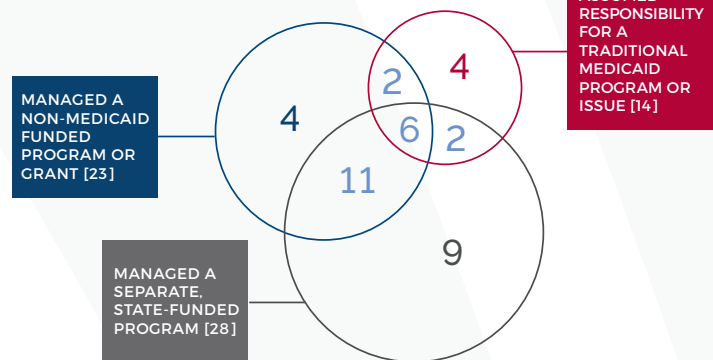
Commensurate with these enrollment increases, Medicaid fiscal responsibility also continued to grow: Among the 47 state respondents, 28 increased their operating budgets between FY2015 and FY2016. With this growth, the median budget across the states surveyed was **\$7.02 billion**,<sup>3</sup> representing a 3% increase over FY2015 and a 15% increase over FY2014.

**As in past years, Medicaid agencies also continued to maintain their programmatic breadth, managing grants funded with non-Medicaid federal dollars, or assuming responsibility for programs that were previously under the purview of other state agencies.**

In the past year, nearly half of the states surveyed (23) oversaw grants under the Center for Medicare and Medicaid Innovation's (CMMI) State Innovation Model (SIM) program, or funds from other federal agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Office of Refugee Resettlement (ORR), and the Children's Health Insurance Program (CHIP). Further, 14 states reported undergoing a major structural change, assuming responsibility for services related to behavioral health, children and family care, Autism Spectrum Disorder (ASD),<sup>4</sup> and/or care for the aging or disabled. Such structural changes have offered opportunities to drive health system transformation and optimize programmatic efficacy, but have also presented new challenges for Medicaid Directors in leading a more complex agency and diverse set of programs. [Figure 1].

**[Figure 1]**

**NUMBER OF STATES THAT EXPANDED RESPONSIBILITIES BEYOND THE CONVENTIONAL MEDICAID REALM**



<sup>2</sup> Six of the 28 states that reported to manage programs funded solely with state dollars declined to offer any enrollment figures, making the auxiliary enrollment figure greater than 1.42 million.

<sup>3</sup> This figure reflects information from all 47 states that completed the survey; it represents a combination of state and federal dollars.

<sup>4</sup> Please note that there is a distinction between ASD and larger behavioral health integration work, as ASD represents one condition; responsibility for ASD services does not necessarily imply the fusion of Medicaid and behavioral health work more broadly.

## COMING INTO FOCUS: NEW CHALLENGES & SHIFTING PRIORITIES

Medicaid Directors continue to pursue diverse strategies to effectively administer these vital and complex programs. When Directors were asked about their top priorities for the coming year, more than 20 issues materialized, engendering a complicated patchwork of operational, financial, and consumer areas of focus **[Figure 2]**. Directors were also asked about the innovations underway in their programs – Not surprisingly, there was great alignment between state priorities and innovations, the details of which are discussed later in this report.

Despite the myriad priorities topping Directors' agendas, NAMD identified several shared priorities among the states responses. **Of all issues, delivery system and payment reform was the most frequently cited priority for the coming year, followed by systems development and management and behavioral health improvements**

**[Figure 3]**. Of the states prioritizing these issues, two-thirds noted that at least one of them represented a new priority, suggesting an evolving set of dynamics and challenges facing the modern Medicaid program.

**[Figure 2]**  
DIVERSITY OF STATE PRIORITIES



**[Figure 3]**  
NUMBER OF STATES PRIORITIZING CRUCIAL ISSUES

PRIORITY	NUMBER OF STATES
DELIVERY SYSTEM AND PAYMENT REFORM	20
SYSTEMS/IT	18
MENTAL HEALTH/SUD	15
MANAGED CARE (GENERAL)	12
POPULATION HEALTH	10
LTCSS	6
1115 WAIVERS	5
BUDGETARY CONSTRAINTS/SHORTFALLS	4
ACCESS TO SERVICES	3
POTENTIAL MEDICAID EXPANSION	3
ID/DD SERVICES	3
COST CONTAINMENT	2
STAFFING	2
JUSTICE-INVOLVED POPULATIONS	2
ELIGIBILITY PROCESSES	1
REDUCING CHRONIC HOMELESSNESS	1
TELEHEALTH INITIATIVES	1
DUALS	1

## DELIVERY SYSTEM AND PAYMENT REFORM

Nearly half (20) of the states surveyed identified delivery system and payment reform as one of their top three priorities for the coming year,<sup>5</sup> making it the most common area of focus among states in FY2017 (as it was in FY2016).<sup>6</sup> Because of the importance and complexity of this work, Directors dedicated much of their own time and leadership to these initiatives: Roughly two-thirds of Directors reported that they spent at least half of their time on delivery system and payment reform throughout FY2016.

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This innovation, much like the Medicaid program, is designed to reflect the diversity in the health care landscape and the populations served by the program. Currently, Medicaid programs differ considerably in terms of their scope, covering anywhere between 10% and 38% of each state's population,<sup>7</sup> while managing budgets that range from 7% to 37% of state expenditures.<sup>8</sup> Likewise, there are significant differences among state health care markets, provider landscapes, and political contexts.

Responding to this diversity, Directors in this year's survey reported using a wide array of strategies to move from a volume-based to value-based system of care. These strategies included alternative payment methodologies, new care delivery models (such as accountable care organizations and patient-centered medical homes), and various quality improvement tools, in addition to Delivery System Reform Incentive Payment (DSRIP) programs to support health system transformation. *Specific value-based payment strategies are discussed in more detail in the section of this report entitled "Medicaid Innovation and Reform"* [\[Page 10\]](#).

Directors recognize that transforming the health care system will require a multi-year effort. This year's survey reveals that eight states identified delivery system and payment reform as one of their chief long-term strategic priorities for 2018-2021, making it the most common of all long-term objectives. In addition, two out of every five states indicated plans to increase capacity for value-based purchasing in FY2017.

## SYSTEMS AND INFORMATION TECHNOLOGY (IT) MANAGEMENT

Across the states surveyed, systems and IT management emerged as the second most common priority among states, with 39% of states citing it as a top focus for the coming year, up from 33% in FY2016. As an increasingly complex and foundational component of Medicaid programs, systems required more staff capacity than many other Medicaid functions in FY2016. This trend is anticipated to continue, with 20 states reporting that they plan to add capacity to support their systems and IT efforts in FY2017. Looking to the coming year, most of the states prioritizing systems and IT management

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<sup>5</sup> 46 states answered the survey's question on priorities for FY2017.

<sup>6</sup> Last year's survey showed that 39% of the states surveyed planned to prioritize delivery system and payment reform in FY2016; 36% of states planned to prioritize behavioral health; and 33% of states planned to prioritize systems development and management. These numbers are fairly in line with FY2017 priorities.

# MEDICAID AGENCY PRIORITIES (CONTINUED)

will continue to focus on the construction, refinement, and certification of the **Medicaid Management Information System (MMIS)**, a federally funded instrument employed by states to verify eligibility, process claims, and reimburse providers. MMIS and other similar investments are being designed to not only modernize claims and encounter data, but also support quality improvement and delivery system and payment reform initiatives in states.

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## BEHAVIORAL HEALTH IMPROVEMENTS

Fifteen Directors cited behavioral health reform as a top priority for the coming year (up from 12 in FY2016), making it the third most prevalent area of focus among the states surveyed. In prioritizing behavioral health, Directors remain continually focused on serving those with mental illness and substance abuse disorders (SUDs) in more integrated, person-centered, and community-focused ways, as well as leveraging evidence-based practices to improve outcomes. Going forward, tackling mental illness and SUDs will continue to represent an increasingly relevant priority for states, with 14 states adding new staff to support behavioral health efforts in FY2016, and 19 states planning to do so in FY2017. *More detailed information on state behavioral health innovations is provided in the section of this report entitled, "Medicaid Innovation and Reform" [\(Page 11\)](#).*

## PRIORITY SHIFTS OVER TIME

This set of common priorities represents a shift from years' past, as the Medicaid program, state innovation, and the broader health care landscape have evolved. In the FY2014 survey, for instance, states focused on the implementation of the **Affordable Care Act (ACA)**, with 45% of respondents naming some aspect of the ACA as one of their top three priorities for the year. In FY2015, the proportion of Directors reporting ACA implementation as a top priority dropped to 22%; and this year, only two states listed the ACA as one of their top priorities. This shift, it is important to note, does *not* suggest a de-prioritization of the legislation but rather programmatic maturation. As ACA implementation has become a more regular part of the Medicaid program, states have adopted the legislation's requirements around eligibility and quality improvement, and many have also implemented the optional expansion of coverage to childless adults. State priorities, in effect, have shifted from ACA implementation to innovation.

Another such shift can be seen in **program integrity**. As Directors have invested in program integrity capacity, it has become an integral component within each Medicaid agency function, becoming less of a priority in and of itself and more of an applicative tool to assist and optimize other efforts. Consider, for example, how Directors' program integrity initiatives have helped support efforts surrounding this year's top three priorities among states:

- In FY2016, 33 states undertook provider training and education to support program integrity, and 32 states undertook



# MEDICAID AGENCY PRIORITIES [CONTINUED]

systematic audits to uncover fraud and abuse (Figure 4). As states proactively educate and train providers on potential manifestations of waste and fraud, they guarantee more **quality-based delivery and payment of services**. Several Directors also plan to implement provider self-audits and peer-to-peer comparison reporting in FY2017 to further this work.

- Program integrity and **systems development** efforts also have a very synergistic relationship.

In this year's survey, 21 states reported investing in improved and more accessible data to promote program integrity in FY2016, and 28 states indicated that they work with data analytics vendors to achieve said aim.

- Finally, this year's survey reveals that more than quarter of states used Prescription Drug Monitoring Programs (PDMPs) to promote program integrity in FY2016, while also tackling **substance abuse issues**. With PDMPs, states can track pharmaceutical usage to determine when prescriptions are fraudulent, wasteful, or altogether improper and address over-prescription of potentially harmful medications – including opioids and other narcotics.

In this year's survey, more than 80% of Directors reported plans to pursue additional program integrity efforts in FY2017, proving that Medicaid agencies will continue to invest in program integrity as an instrument to optimize delivery system and payment reform, systems development, and behavioral health in the coming year.

**[Figure 4]**

**PROGRAM INTEGRITY ACTIVITIES IN FY2016**

<b>PROGRAM INTEGRITY ACTIVITY</b>	<b>NUMBER OF STATES</b>
PROVIDER TRAINING AND EDUCATION	33
SYSTEMATIC FRAUD AND ABUSE AUDITS	32
BETTER QUALITY/MORE ACCESSIBLE DATA	21
ELECTRONIZATION OF HEALTH RECORDS AND/OR ENROLLMENT	17
PREDICTIVE MODELING TO DETECT FUTURE FRAUD AND ABUSE	17
ADDITIONAL STAFFING	16
ROUTINE SURVEYS	16



# MEDICAID INNOVATION & REFORM

Serving the most complex – and the costliest – individuals, **Directors continue to drive solutions that improve care in the context of their unique state landscape.** After examining the diversity among state programs, this section explores the state-based reforms implemented by agencies in FY2016, including new value-based payment models, behavioral health integration initiatives, and LTSS innovations. These efforts largely reflect the major program priorities Directors outlined and which were highlighted in the previous section.

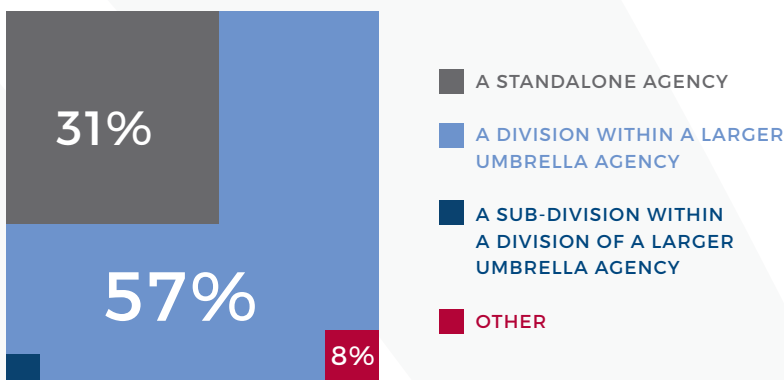
## DIVERSITY AMONG STATES

To improve care delivery and maximize the value of the health care dollar, Directors are increasingly driving innovations that reflect the enormous heterogeneity among states and their programs. The Medicaid program is not a uniform entity like Medicare, but rather a complicated and highly variable assemblage of states, each accountable to their own political, historical, structural, geographical, and epidemiological pulls.

This past year, for example, operating budgets among the states surveyed fell anywhere between \$657 million and \$87 billion, while state enrollment figures ranged from 64,000 to 12 million individuals.<sup>iv</sup> Depending on the size and scope of their programs, the number of full-time employees working for state Medicaid agencies fell anywhere between 40 to more than 16,000 individuals.

Medicaid program structure also varied considerably in FY2016. Today, Medicaid programs exist as either a standalone agency, a division within a larger umbrella agency, a sub-division within a division of a larger umbrella agency, or a department within a state cabinet structure (Figure 5). Each of these structures brings its own set of diverse partners, interests,

**[Figure 5]**  
POSITION OF MEDICAID AGENCIES IN STATE GOVERNMENTS



*The Medicaid program is not a uniform entity like Medicare, but rather a complicated and highly variable assemblage of states, each accountable to their own political, historical, structural, geographical, and epidemiological pulls.*

and demands for Directors, affecting the ways they interact with their governors, state legislatures, and other stakeholders.

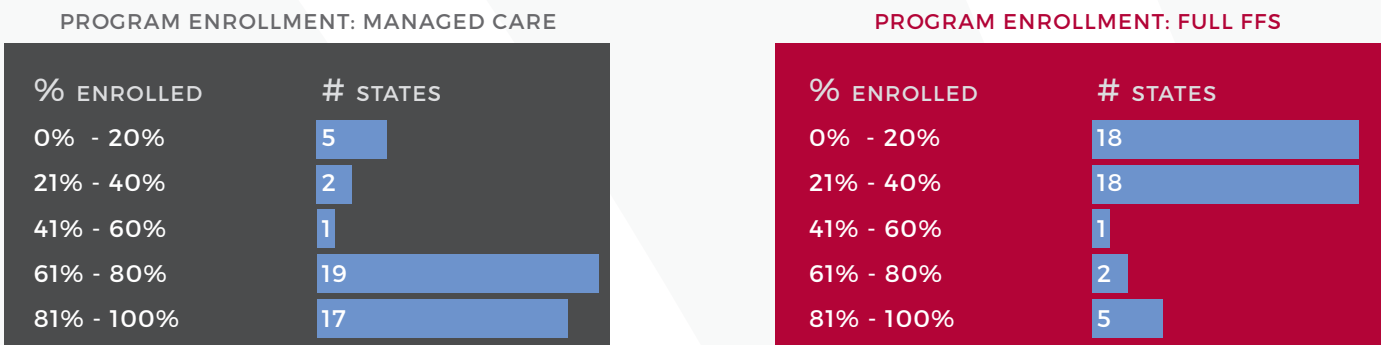
Similarly, states leveraged various care delivery structures. Thirty-seven of the states surveyed<sup>7</sup> reported that the majority of their beneficiaries were enrolled in managed care, a framework in which Medicaid benefits and services are delivered through contracted arrangements between state Medicaid

<sup>7</sup> 44 states answered the survey's question on program enrollment in managed care versus fee-for-service (FFS).

agencies and **managed care** organizations (MCOs) that accept a set per member per month (capitation) payment.<sup>v</sup> Managed care can be very beneficial for state Medicaid programs, as it provides more operational capacity, budget certainty, and entrance into competitive markets.

While most states have moved towards managed care, several states continued to rely on a **fee-for-service (FFS) delivery system**, by which Medicaid agencies pay health care providers for visits, tests, procedures, and other services [\(Figure 6\)](#).<sup>vi</sup> Some of these states are largely rural or frontier, making managed care penetration more difficult than in more populated areas of the country. Meanwhile, other states decide not to move to private health insurance plans, maintaining that the state agency is better equipped and structured to accomplish core functions and provide key services. It is important to note that even in states with little to no traditional managed care, the core philosophy of reform aimed at better managing the care of patients remains universally paramount.

**[Figure 6]**  
DISTRIBUTION OF PROGRAM ENROLLMENT IN MANAGED CARE VS. FEE-FOR-SERVICE (FFS)



## STATE-BASED INNOVATION

Conscious of these differences, Directors pursued an impressive set of state-based innovations in FY2016, embedding reform in their states' unique programmatic, structural, and political contexts. Prioritizing value over volume, they continued to reframe how health care reforms are approached and implemented in their states, with a particular emphasis on value-based payment reform, behavioral health, and LTSS.

## VALUE-BASED PAYMENT REFORM

Medicaid payment reform takes many shapes, and can range from a targeted alternative payment model for one population or disease to comprehensive, multi-payer payment reform. Medicaid is just one component of the vast health care system, but in covering more than 70 million of the nation's most vulnerable individuals, it has become an increasingly important driver of health system reform.

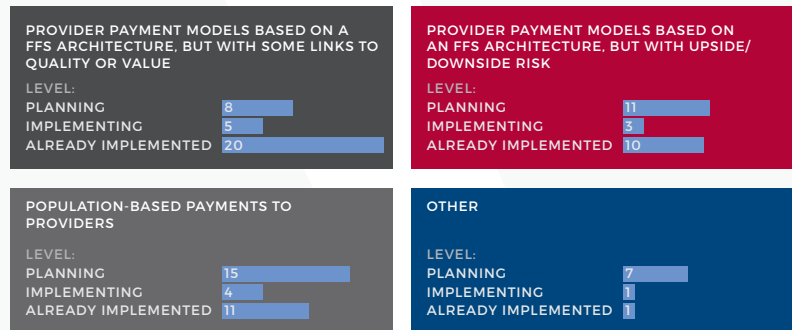
Prioritization of payment and delivery system reform has engendered a wide variety of state-based innovations aimed at transforming the health care system from volume to value. In an effort to better link provider payment with patient outcomes, for example, states have implemented a number of **alternative payment models (APMs)**, such as patient-centered medical homes (PCMHs) and episodic payments.

As discussed in NAMD's recent report, [The Role of State Medicaid Programs in Improving the Value of the Health Care System](#), there is significant variability in the type of APMs states use, as they consider their own marketplaces, cultures, and environments.

This year's survey asked states to report their payment reforms under the framework of **The Health Care Payment Learning and Action Network**, or [LAN](#). The survey found

that in FY2016 more than one-third of states (20) had already implemented provider payment models based on a FFS Architecture that includes some linkages to quality or value. Meanwhile, 11 states were planning to implement payment models with upside/downside risk, and 15 states were planning to and 11 had already implemented population-based payments with providers [\(Figure 7\)](#).

**[Figure 7]**  
**INNOVATION: VALUE-BASED PURCHASING**

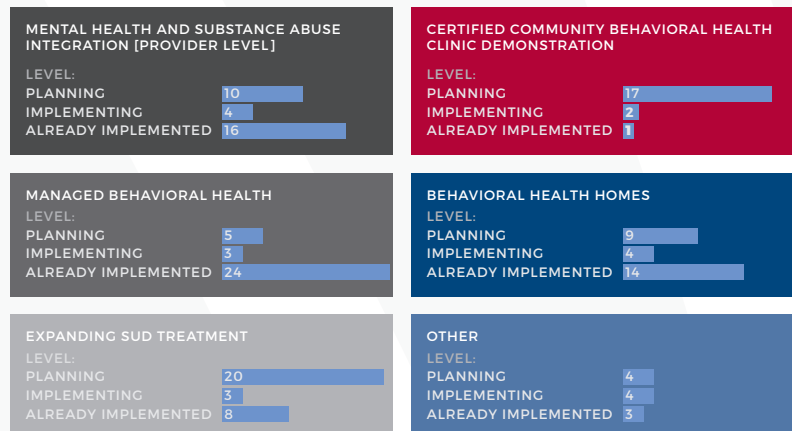


## BEHAVIORAL HEALTH INNOVATION

Medicaid is the nation's largest payer of behavioral health care, which, as noted earlier, made it a top priority and a source of widespread and diverse innovation for FY2016 and FY2017. **In FY2016, all but three states were reportedly planning, implementing, or had already implemented some form of behavioral health reform** aimed at repairing our nation's bifurcated health care system

and addressing poor outcomes for those with mental health and substance abuse disorders. To advance these goals, more than half (24) of all states surveyed had implemented managed behavioral health by FY2016, while 16 had implemented the integration of mental health and substance abuse services at the provider level, and 14 had implemented behavioral health homes. Going forward, 17 states indicated that they were planning to pursue the federal certified community behavioral health clinic (CCBHC) demonstration, and 20 reported that they were planning to administer enhanced SUD treatment services [\(Figure 8\)](#).

**[Figure 8]**  
**INNOVATION: BEHAVIORAL HEALTH**



## THE OPIOID EPIDEMIC IN MEDICAID

When discussing behavioral health priorities in this year's survey, many states emphasized a specific focus on opioid abuse, which has become one of the deadliest drug epidemics in U.S. history. Recent data suggest an estimated 1.9 million people in the United States suffer from SUDs related to prescription opioids; yet, only 20% of people living with an opioid use disorder are receiving treatment, often leading to overdose and death. Between 2001 and 2014, there was a 200% increase in the rate of overdose deaths involving prescription opioids and heroin.<sup>vii</sup>

**In this year's survey, 75% of respondents indicated that they had implemented reforms targeting opioid prescribing practices, abuse, and misuse, making it the most prevalent reform area in FY2016.** Specifically, states worked to strengthen prescription monitoring for opioids, implement prior authorization requirements, set quantity limits on prescriptions, and expand access to naloxone to reverse overdose and prevent deaths. Medicaid agencies also worked to ensure the provision of substance use disorder treatment in more inclusive and holistic ways.

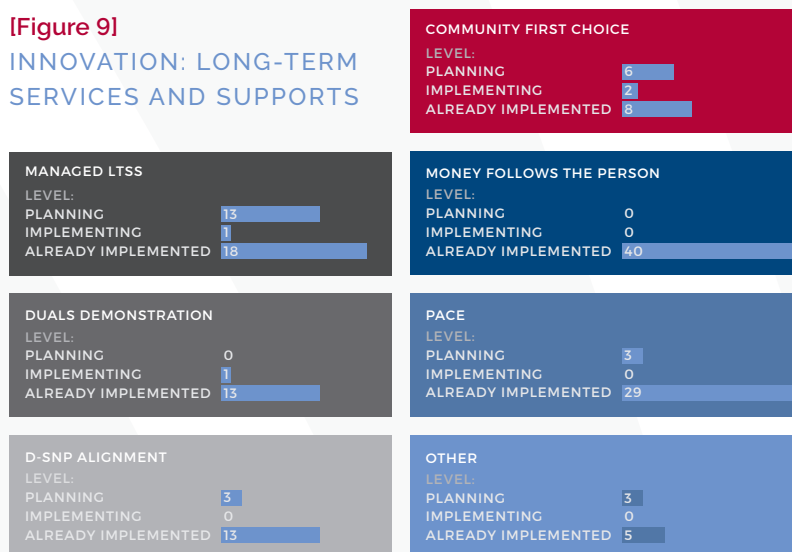
## IMPROVEMENTS IN LONG-TERM SERVICES AND SUPPORTS

Medicaid is also the nation's largest payer of long-term services and supports (LTSS), defined as health care and supportive services for individuals who are unable to manage the tasks of daily living (eating, bathing, dressing, preparing meals, housekeeping, etc.) due to aging, chronic illness, or disability.<sup>viii</sup> Recent data show that more than 4 million Medicaid beneficiaries use LTSS, costing the program \$170 billion annually, or more than 40% of all Medicaid spending.<sup>ix</sup> As we

look forward, use of LTSS will become increasingly prevalent, with the number of elderly Americans expected to more than double in the next 40 years.<sup>x</sup> Accordingly, more and more states are seeking ways to deliver LTSS in more innovative, cost-effective, and impactful ways. In FY2016, 85% of the states surveyed reported that they had implemented Money Follows the Person, a demonstration that helps states transition individuals needing LTSS to home- and community-based settings. Meanwhile, 29 states had implemented Program of All-Inclusive Care for the Elderly (PACE), a comprehensive medical and social

delivery system for elderly individuals; 18 states had implemented managed LTSS; 13 states had implemented the duals demonstration; and 13 states had implemented Dual Eligible Special Needs Plans (D-SNP) alignment **[Figure 9]**. In combination

**[Figure 9]**  
**INNOVATION: LONG-TERM SERVICES AND SUPPORTS**



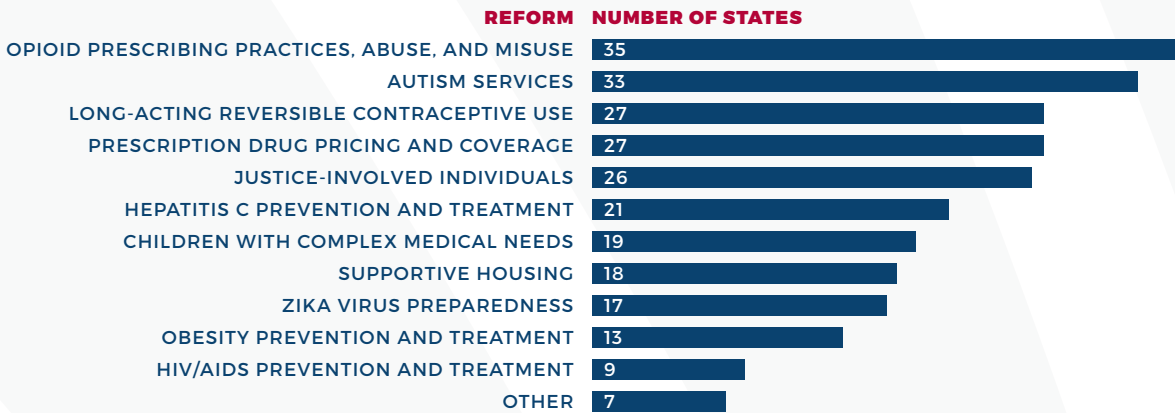
with these efforts, states have also worked to streamline eligibility for LTSS, removing waitlists and other administrative protocols that delay or suspend essential care delivery. They have also worked to fortify monitoring efforts to improve program integrity and enhance quality in LTSS settings.

## OTHER TARGETED REFORM EFFORTS

In addition to the broad-based value-based purchasing, behavioral health, and LTSS efforts, states remained invested in a host of other innovations targeting specific populations or health challenges. Among these targeted reform areas, a substantial number of states indicated that they have worked on innovations related to opioid abuse (35 states); Autism services, including Applied Behavioral Analysis therapy (33 states); prescription drug pricing and coverage (27 states); long-acting reversible contraceptive (LARC) use (27 states); and transitioning justice-involved individuals back to the community (26 states) [\(Figure 10\)](#).

**[Figure 10]**

### MANY OTHER HEALTH ISSUES ARE BENEFITING FROM TARGETED REFORM



# ROLES, RESPONSIBILITIES, & RELATIONSHIPS

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While accountability for Medicaid programs and functions must predominantly reside within the agency, **Directors are increasingly coordinating with outside entities to support Medicaid operations, as well as tackle the social determinants of health which underpin key delivery system and payment reform initiatives.** Managing relationships with state and federal policymakers, private contractors, and other stakeholders, Directors must be skilled negotiators, manage complex and large-scale contracts, and constantly work to secure alignment in the face of competing priorities and demands. The nature and demands of these relationships are discussed in the following section.

## COORDINATING WITH EXTERNAL ENTITIES

Over the last two decades, Medicaid has evolved from a passive payer of claims to an active purchaser of health, replacing outdated structures with sophisticated strategies to deliver care that reflects the medical as well as the social determinants of health. As Medicaid responsibilities have grown larger, more complex, and more diverse, Directors have had to more creatively tailor their operations to best fit the environment of their states. In doing so, many have begun to look outside the confines of their agencies and partner with external entities to perform key responsibilities. A significant number of states, for example, supervise or partner with private contractors to manage care for key populations or implement crucial functions like claims processing and MMIS. While, in many ways, these relationships render Medicaid an evolving "public-private partnership" of sorts, it is also clear that Medicaid represents a "public-public partnership," as Medicaid agencies work with sister state agencies and other key governmental stakeholders to provide services for complex populations.

There are many key reasons why states seek to leverage these partnerships, and why they help to improve the delivery and quality of services. It is important to note, however, that while these partnerships can be hugely beneficial, they also bring their own set of administrative challenges, requiring Directors to be more dexterous and integrative as they manage blending disparate cultures, approaches, and priorities. More importantly, these partnerships do not relieve Directors of their role in managing Medicaid programs and functions: **No matter how many entities are brought to the table, ultimate responsibility for a high-functioning, effective, and efficient program always resides with the Medicaid agency and the Director as its lead.**

## WORKING WITH SISTER STATE AGENCIES

Medicaid Directors frequently coordinate with sister states agencies for the services provided to certain Medicaid populations. In FY2016, this included **foster care programs** (operated or co-operated by sister state agencies in 31 states) and **intellectual and developmental disabilities (ID/DD) programs** (operated or co-operated by sister state agencies in



30 states) [Figure 11].<sup>8</sup> These cross-agency connections underscore the inherent complexity in operating the Medicaid program, as they require Directors to consider the cultures, goals, and demands of their agencies alongside the often-different cultures, goals, and demands of others. At the same time, sister state agency partnerships offer an opportunity to support delivery system and payment reform, including by building the linkages needed to address the social determinants of health.

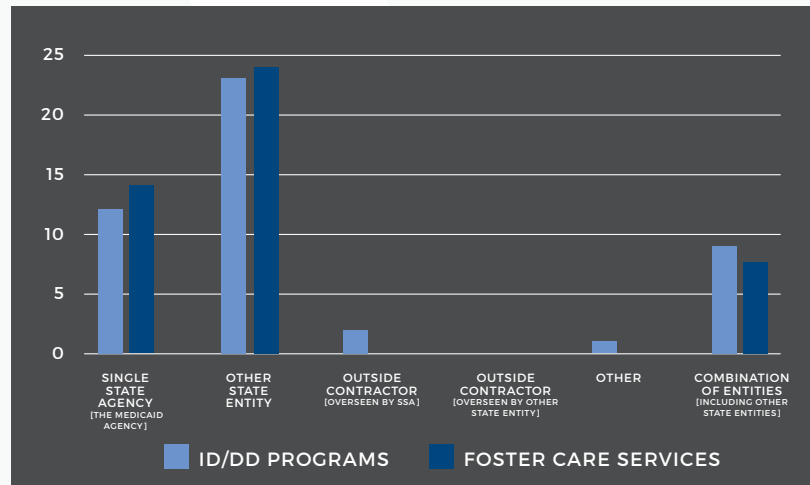
## WORKING WITH CONTRACTORS

In addition to sister state agencies, external contractors play a critical role in the day-to-day operations of Medicaid functions. This year, state Medicaid agency use of contractors varied from state to state, with all states contracting with an external entity to support at least one function.

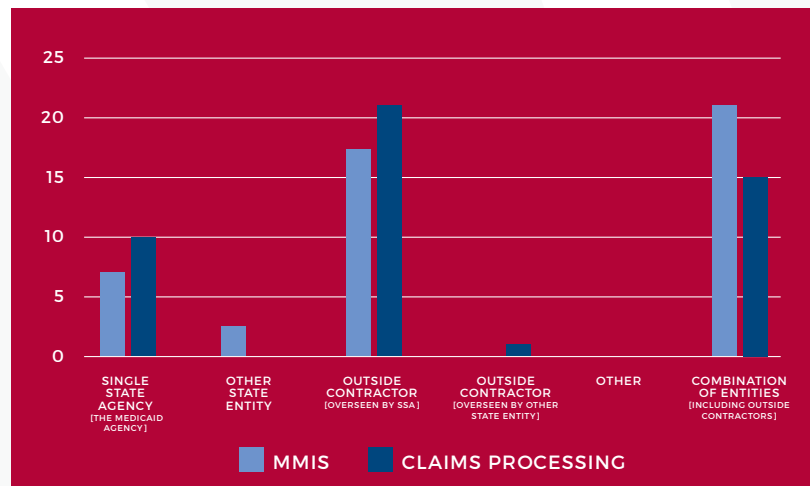
Traditionally, states have contracted with external entities to carry out administrative or “back-office” functions. In FY2016, for example, the functions where states most frequently engaged contractors included **MMIS** (38 states) and **claims processing** (37 states) [Figure 12].

In addition, agencies are increasingly partnering with contractors to support certain public-facing functions. In FY2016, 31 agencies reported having contractors support provider relations activities, as did 27 agencies for beneficiary communications.

**[Figure 11]**  
PROGRAMS FOR WHICH STATES MOST FREQUENTLY COORDINATED WITH OTHER STATE ENTITIES



**[Figure 12]**  
FUNCTIONS FOR WHICH STATES MOST FREQUENTLY ENGAGED OUTSIDE CONTRACTORS



<sup>8</sup> Examples of these sister state agencies include the Department of Social Services, the Department of Families, the Department of Education, the Department of Human Resources, the Department of Mental Health, the Department of Aging, and the Department of Child Safety.



# ROLES, RESPONSIBILITIES, & RELATIONSHIPS (CONTINUED)

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Collaboration between state agencies and contracted entities is an important and advantageous feature of the Medicaid program, as contractors help enhance state capacity to design and operationalize delivery system and payment reforms. That said, working with contractors also presents its own set of unique challenges for states, requiring Directors and their staffs to work with complex procurement, contract, and oversight processes all while reconciling varying cultures and objectives.

## STATE AND FEDERAL POLICYMAKERS

Medicaid Directors must also manage many relationships with state and federal policymakers to operationalize the program. Most notably, Directors coordinate with governors' offices to shape the state policy agenda, including Medicaid priorities. Likewise, Directors engage with state legislatures, which appropriate funding for the program and provide oversight. County and local governments also have an important stake in the program. In this year's survey, 13 Directors indicated that they work with county governments to implement eligibility and enrollment, and 10 Directors indicated that they work with regional governments to provide transportation services.

Another important relationship is the one between Medicaid Directors and federal policymakers at the **Centers for Medicare and Medicaid Services (CMS)**. As a program jointly financed by states and the federal government and operated by states under federal parameters, Medicaid requires a strong federal-state partnership to ensure successful operation of the program.

In addition to CMS, Directors engage with numerous other federal partners, including the Health and Human Services Office of the Inspector General (OIG), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Finally, Medicaid Directors coordinate with providers, consumers, and taxpayers to maximize value for the health care dollar and deliver high quality care for beneficiaries.

# THE CHALLENGES MEDICAID DIRECTORS FACE

Faced with endless pressures and responsibilities, **Directors face numerous challenges that may delay or impede their efforts to reframe the health care system around quality-based, cost-effective care.** These challenges frequently include insufficient budget, staffing, and low compensation – for themselves and for their employees. To support Directors in leading health system transformation, policymakers should identify strategies to mitigate these challenges and support the operational structures needed for this work.

## RESOURCES AND CAPACITY

In the past year, Medicaid Directors continued to face sizable resource and staff shortages, with harmful implications for reform. In this year's survey, 31 states cited budgetary constraints at the administrative, agency, or state level as a major impediment to reform. Even more states (38) indicated that they experienced staffing challenges in the past year, with 12 states citing insufficient compensation, 12 states citing poor recruitment, and seven states citing limited professional development as reasons why it is hard to attract and keep employees. Due to these challenges, the average vacancy rate across states stood at 14%, and several of the states surveyed indicated that more than quarter of their agency's positions remained unfilled. Often, staff recruitment and retention is most problematic around delivery system and payment reform. Individuals with the skill sets to drive innovation are highly sought after in the private sector, which offers higher compensation.

### STAFFING CHALLENGES INDICATED BY MANY STATES



## MEDICAID DIRECTORS' EXPERIENCE AND COMPENSATION

Medicaid Directors bring a wealth of knowledge and diverse experience to their roles, including experience working within a state Medicaid agency. This year, 73% of Directors indicated that they had previously served in other positions within a Medicaid agency (either in the same state or another state) before becoming Director. The remaining 27% of Directors referenced other policy, managerial, and clinical backgrounds in other fields, such as pharmacy, medicine, nursing, law, hospital administration, international non-profit work, higher education, and consulting.

# THE CHALLENGES MEDICAID DIRECTORS FACE (CONTINUED)

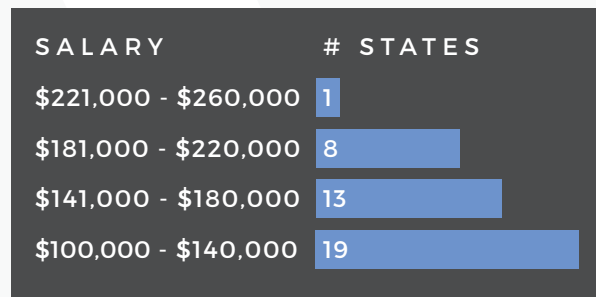
Despite the expertise they bring to the program, Medicaid Directors' salaries are often not commensurate with the work that they do or the considerable complexity of the job. **The median annual salary for Medicaid Directors in FY2016 was \$142,000, with compensations ranging from \$105,000 to \$260,000 per year** (Figure 13).<sup>9</sup> Although an improvement from last year, when the median salary was \$139,000, **Medicaid Director compensation falls far behind what their peer equivalents in the private sector make.**

## MEDICAID DIRECTOR TENURE REMAINS LOW

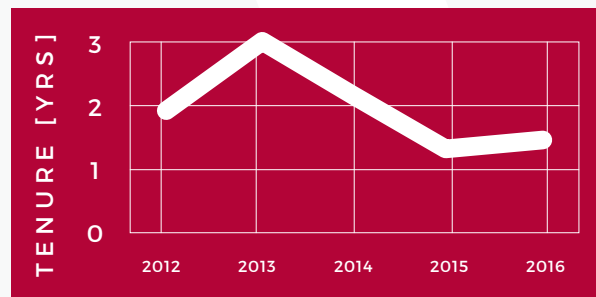
In FY2016, the median tenure for the Medicaid Director stood at about one year and seven months, a slight increase from FY2015 when the tenure was one year and five months (Figure 14).<sup>10</sup> Of those states for which tenure information is available, nearly two-thirds (62%) of Directors have been in their position for less than two years, and only six individuals have more than five years' experience as their state's Medicaid Director (Figure 15).

These short tenures, as well as the fact that most Medicaid Directors come from within their own agency, underscore the need for leadership development and training for new Directors and staff within the agency. Regardless of previous experience, assuming the role of Medicaid Director represents a mammoth transition, requiring a broadening of issue areas and the adoption of new skills and knowledge.

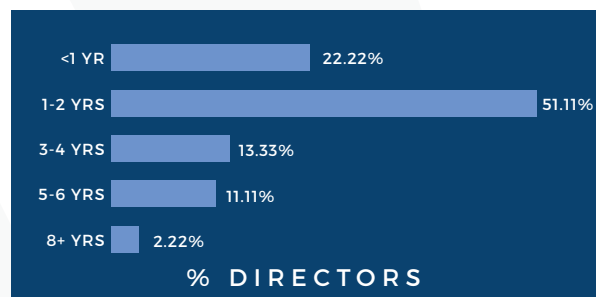
**[Figure 13]**  
MEDIAN DIRECTOR SALARY STOOD AT JUST UNDER \$142,000



**[Figure 14]**  
MEDIAN MEDICAID DIRECTOR TENURE REMAINS LOW



**[Figure 15]**  
THE MAJORITY OF MEDICAID DIRECTORS ARE NEW TO THEIR POSITION



<sup>9</sup> 41 states answered the survey's question about Director salary.

<sup>10</sup> 45 states answered the survey's question about Director tenure.

# LOOKING FORWARD

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In FY2016, Medicaid Directors continued to overhaul the health care delivery system, and did so in the face of significant complexity and operational challenges, including staff shortages and limited resources. Directors were keenly focused on moving the health care system from volume to value through innovation that reflected the unique landscape of each state and its beneficiaries.

To support this value-based system of care, Directors worked to re-shape Medicaid program operations, including through new or enhanced IT systems and greater coordination with external entities.

Despite the challenges, Directors expressed a clear commitment to this work. As one Director noted, "Even after 30 years [of working in Medicaid], I learn new things every day... I would be hard-pressed to think of a more rewarding job."

*"Even after 30 years [of working in Medicaid], I learn new things every day... I would be hard-pressed to think of a more rewarding job."*

Looking to 2017, delivery system and payment reform will continue to be a defining feature of the Medicaid program and is expected to continue to top the list of Medicaid Directors' priorities in years to come. While changes may occur at the federal and state level, the shift towards value-based care will be a constant as policymakers confront rising health care costs and seek to improve quality. Most importantly, Medicaid Directors will continue to be at the helm of this transformation as they drive innovation for the nation's most complex and costly beneficiaries.

## APPENDIX A: METHODOLOGY

Each year, Medicaid Directors and their staffs work with NAMD to develop a wide-ranging and all-inclusive understanding of the operational aspects of the Medicaid program at the state level, offering detailed information about their programmatic operations and forecasting leadership challenges and priorities going forward. This year, between July 5 and Sept. 15, 2016, states completed the PDF or online version of NAMD's operations survey. Divided into ten sections, the survey contained 57 questions, many of which were multi-part and required qualitative description. Ultimately, 47 state agencies submitted the survey by mid-September. NAMD compiled and analyzed the state responses with the aim of providing an overview of each state's unique and dynamic structure and focus.

It is important to note that, while 47 states submitted the survey, not every state answered every question. This has been noted for relevant findings throughout the report.

## SOURCES

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<sup>ii</sup> Kaiser Family Foundation (KFF), "State Health Facts" (Accessed November 1, 2016): <http://kff.org/statedata/>.

<sup>iii</sup> National Association of State Budget Offices (NASBO), *State Expenditure Report: FY2015* (Published 2015): <http://www.nasbo.org/reports-data/state-expenditure-report>.

<sup>iv</sup> CMS, "State Medicaid and CHIP Profiles" (Accessed November 2, 2016): <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>.

<sup>v</sup> CMS, "Medicaid Managed Care Overview" (Accessed November 1, 2016): <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

<sup>vi</sup> CMS, "Fee-for-Service" (Accessed November 1, 2016): <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html>.

<sup>vii</sup> National Governor's Association, *Finding Solutions to the Prescription Opioid and Heroin Crisis: A Road Map* (July 2016): <https://www.nga.org/files/live/sites/NGA/files/pdf/2016/1607NGAOpioidRoadMap.pdf>.

<sup>viii</sup> KFF, *Medicaid and Long-Term Services and Supports: A Primer* (December 2015): <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

<sup>ix</sup> Medicaid and CHIP Program and Access Commission (MACPAC), "Exhibit 20: Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2013" (December 2015): <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-20-Distribution-of-Medicaid-Enrollment-and-Benefit-Spending-by-Users-and-Non-Users-of-Long-Term-Services-and-Supports-FY-2013.pdf>.

<sup>x</sup> Ibid.