STATE MEDICAID
OPERATIONS SURVEY

Sixth Annual Survey of Medicaid Directors
FY 2017

NAMD
National Association of
Medicaid Directors

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Executive Summary

Established in 2011, the National Association of Medicaid Directors (NAMD) is an independent, non-profit, and professional organization for Medicaid Directors. Each year, NAMD administers its Operations Survey to Medicaid Directors and presents the information collected in an annual Operations Survey Report. Between January and April of 2018, 45 state Medicaid Directors completed the latest iteration of NAMD's Operations Survey, evaluating Medicaid agency operations in state fiscal year (FY) 2017. This corresponding report reveals four major themes defining Medicaid operations across states in FY 2017:*

1 **Medicaid Directors reported intensified expectations with regard to their roles in FY 2017, particularly in the areas of public scrutiny, political pressure, and accountability to stakeholders.** As Congress considered changes to Medicaid's financing and coverage, Directors led their agencies in both strategic and pragmatic ways, laying the groundwork for future potential reform all while managing the day-to-day operations of their programs.

2 **Medicaid Directors are continuing to prioritize the transition from volume-based to value-based care in their programs, in addition to investments in data systems, information technology, and behavioral health reform.** A high percentage of Directors also prioritized seeking greater state flexibility from Section 1115 waivers and advancing robust strategies to ensure Medicaid's programmatic integrity.

3 **While increasing from the last iteration of NAMD's Operations Survey, Medicaid Director tenure remains problematically low, with implications for Medicaid agency operations.** At the conclusion of this year's survey period (April 2018), the median Director tenure was 26 months, and nearly two-thirds of Directors surveyed had been in their positions for under three years. This reality can interfere with states' implementation of delivery system and payment reform, investments in stakeholder engagement, and the development and materialization of a strategic vision—all of which require multi-year commitment. With 36 state gubernatorial elections occurring in fall 2018, it remains critical that Directors and their teams are well-supported, especially in the areas of succession planning and transition management.

4 **Operating a program as complex as Medicaid entails extensive collaboration with a vast network of public and private partners.** Medicaid agencies continued to partner with an array of sister state agencies to run the day-to-day operations of Medicaid programs for children, individuals with mental health or substance use issues, and individuals living with physical, developmental, or intellectual disabilities. As in past years, Directors also continued to rely heavily on external contractors to run the day-to-day operations of Medicaid functions, particularly utilization management, transportation, provider relations, and decision support and analytics.

*Note on methodology: The data in this report correspond to FY 2017 unless otherwise stated.

Introduction

As the single largest source of public health coverage in the United States, Medicaid provides health insurance coverage for nearly 68 million individuals[1,*]—representing more than 20 percent of all Americans—while accounting for 17 percent of the nation's total health expenditures.[2] Created in 1965 to support the medical costs of low-income Americans, the Medicaid program has continually evolved in size and scope, today serving as a principal insurer for individuals with a complex array of health care and social needs, including pregnant women, elderly adults, people with disabilities, and children. According to recent data, Medicaid covers more than 30 percent of nonelderly adults with disabilities[3] and 20 percent of adults with mental illness.[4] Together with the Children's Health Insurance Program (CHIP), it also covers 48 percent of children with special health care needs, ranging from Down Syndrome to Autism to emotional trauma.[5] Access to Medicaid services improves the lives of these individuals, putting them in positions to more fully contribute to their families, communities, and the nation at large.

At the helm of this vital, complex program are Medicaid Directors, the individuals responsible for administering Medicaid in each of the 50 states, the District of Columbia, and the five U.S. territories.[†] As overseers for an average of 29 percent of total state expenditures, Medicaid Directors are responsible for managing states' largest functional area as a proportion of total state spending.[6] As such, they work to provide not only health care to millions of vulnerable Americans, but also proper, transparent, and accountable stewardship of taxpayer dollars. This dual responsibility requires a sophisticated operational infrastructure, demanding well-trained teams, administrative support, access to resources, and the strategic and visionary leadership of Medicaid Directors.

Now in its sixth year, the National Association of Medicaid Directors (NAMD) Annual Operations Survey Report provides a look into Medicaid operations from the Medicaid Director perspective. Between January and April of 2018, 45 state Medicaid Directors completed the latest iteration of NAMD's Operations Survey, evaluating Medicaid agency operations in state fiscal year (FY) 2017.[‡] This corresponding report reveals four major themes defining Medicaid operations across states in FY 2017 (unless otherwise stated):

1 **Medicaid Directors reported intensified demands and expectations with regard to their roles in FY 2017, particularly in the areas of public scrutiny, political pressure, and accountability to stakeholders.** Although Congress's proposed changes to Medicaid's financing and coverage under the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA) were not enacted, Directors increasingly found themselves in the public spotlight, facing new expectations, relationships, and priorities. As they led their teams amid uncertainty, Directors prepared for potential changes to Medicaid, all while managing the day-to-day operations of their programs as smoothly, cost-effectively, and sustainably as possible.

2 **Medicaid Directors are continuing to prioritize the transition from volume-based to value-based care in their programs**. The two strategic priorities most commonly cited by states for the coming year (FY 2018) were 1) Delivery system and payment

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* **Note on Medicaid enrollment:** As of April 2018, 73,765,374 individuals were enrolled in Medicaid and CHIP in the 51 states reporting April 2018 data. 67,305,506 individuals were enrolled in Medicaid, and 6,459,868 individuals were enrolled in CHIP (*Centers for Medicare and Medicaid Services (CMS) April 2018 Medicaid and CHIP Application, Eligibility Determinations, and Enrollment Report*).

† **Note on U.S. territories:** Data from the five U.S. territories—American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands—are not included in this report.

‡ **Note on state fiscal years:** For all but four states, state fiscal year 2017 ran from July 1, 2016 through June 30, 2017. Alabama's fiscal year 2017 ran from October 1, 2016-September 30, 2017; Michigan's fiscal year ran from October 1, 2016–September 30, 2017; New York's fiscal year ran from April 1, 2016–March 31, 2017; and Texas's fiscal year ran from September 1, 2016–August 31, 2017.

reform; and 2) Investments in data systems and information technology (IT). Consistent with past years' data, Directors are investing in innovations to realign provider incentives, reward performance, and coordinate care delivery via patient-centered medical homes (PCMHs), episode-based payments, and accountable care organizations (ACOs). As Medicaid continues this shift from volume- to value-based frameworks of care, Directors are also working to modernize Medicaid information storage and use, developing systems to provide states, providers, and plans with accurate, timely, and action-oriented data. Central to this modernization of Medicaid data and systems are Director efforts to address fraud, waste, and abuse through effective program oversight. As in past years, Medicaid Directors are continuing to invest in robust strategies to ensure the integrity of their programs, such as data mining, provider education, and predictive modeling.

3 **Medicaid Directors recognize that the high incidence of turnover in Director positions demands continuous development of deputy-level staff and succession planning.** As of April 2018, the median tenure of Medicaid Directors surveyed was just over two years (26 months). While an uptick from the median tenure reported in NAMD's last iteration of the Operations Survey (19 months as of September 2016), the current median Director tenure remains low, with two-thirds of Directors having been in their positions for under three years. This becomes particularly problematic when one considers the multi-year process of operationalizing strategic plans, investing in relationships, communicating a common vision, and implementing systems and infrastructure, not to mention workforce culture and morale. Given the high number of survey respondents who were political appointees in FY 2017 (30) and the heightened political nature of the Director position, there is potential for additional turnover in the coming months, with 36 state gubernatorial elections occurring in November 2018. It therefore remains critical that Medicaid Directors and their teams are well-supported, especially in the areas of succession planning and transition management.

4 **Operating a program as complex as Medicaid entails collaboration with a vast network of public and private partners.** Medicaid agencies continued to partner with an array of sister state agencies to run the day-to-day operations of Medicaid

programs for children, individuals with mental health or substance use issues, and individuals living with physical, developmental, or intellectual disabilities. Collaborating with these other state entities, Medicaid Directors were better equipped to manage their programs, as they led with an eye on the social determinants of health. As in past years, Directors also continued to rely heavily on external contractors—including managed care organizations (MCOs)—to run the day-to-day operations of Medicaid functions, rendering the Medicaid program a veritable public-private partnership.

The remainder of this report is organized in the following sections:

- **Medicaid in the Context of State Government:** Where were Medicaid agencies positioned within state government in FY 2017? To whom did the Medicaid Director report? What structural changes did Medicaid agencies undergo?

- **Medicaid Leadership and Team Development:** How did the role of the Medicaid Director change in FY 2017? What factors were critical for Directors'—and their teams'—success?

- **Strategic Priorities of Medicaid Directors:** What strategies did Medicaid Directors seek to prioritize in order to provide access to high-quality health care and support services in fiscally responsible, sustainable ways?

  - **Section 1115 Waivers:** What flexibilities did Directors seek to plan or implement?

  - **Program Integrity:** How did Directors tackle fraud, waste, and abuse in their programs?

- **Roles and Responsibilities Across Medicaid Programs and Functions:** Through which mechanisms and with what partners were Medicaid programs and functions operated in FY 2017?

It is important to note that NAMD's Operations Survey does not capture information regarding Medicaid budget, eligibility, enrollment, benefits, or managed care as this information is collected in the Kaiser Family Foundation and Health Management Associates (HMA)'s annual Medicaid Budget Survey Report, developed in collaboration with NAMD. The most recent of these reports—*Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*—can be found here.[7]

Section 1:
Medicaid in the Context of State Government

Enacted as part of the Social Security Amendments of 1965, Medicaid has evolved from a welfare-based insurer for low-income individuals and families to a central payer in the U.S. health care system. The program is jointly financed by states and the federal government and operated under federal authority. While similar in many ways, state Medicaid programs are also incredibly distinctive, marked by their own operational structures and institutional protocols.

Medicaid's Position Within State Government

In FY 2017, 31 Medicaid agencies were structured as a division or a sub-division within a larger umbrella agency, while more than a quarter of agencies surveyed (13) were structured as a standalone state agency; interestingly, one agency reported that its operations were separated across two divisions of a larger umbrella agency **(Figure 1)**. Each of these structures created certain administrative parameters shaping the Medicaid Director role as well as Directors' relationships with other state agencies and departments, state legislatures, and agency leadership. This year's survey revealed that two-thirds of Directors surveyed (30) were political appointees in FY 2017, seven of whom had required confirmation. The remaining 15 Directors surveyed were civil servants or career executives. Of the 30 politically appointed Directors, 20 reported to a political officeholder, such as their state's Governor or Secretary of Health. Another six Directors hired as civil servants or career executives indicated that they too reported to a political officeholder.
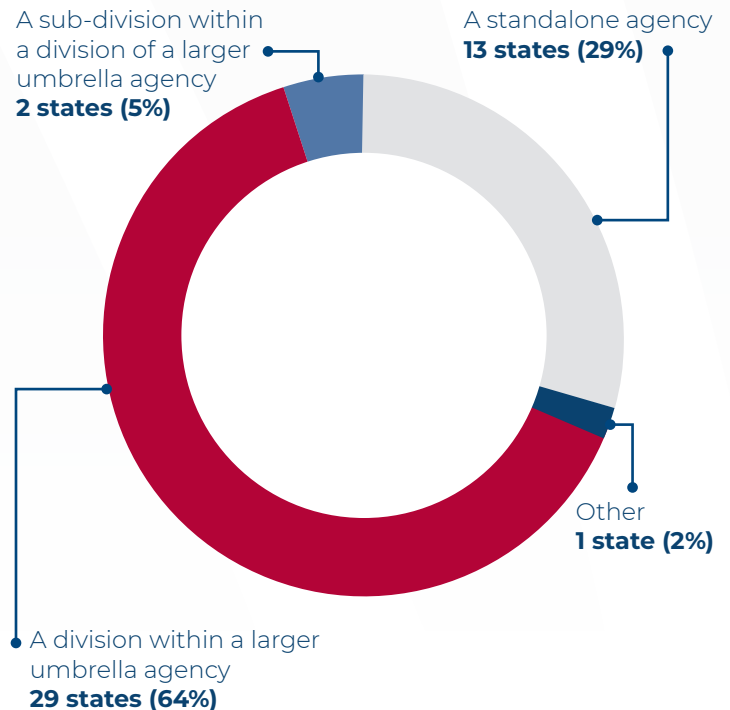
Structural Changes to Medicaid Agencies in FY 2017

From year to year, Medicaid agencies are subject to political, administrative, and structural changes, with implications for the way programs are operated. In FY 2017, 15 Medicaid Directors reported a change in their states' leadership at either the Medicaid Director, cabinet, or Governor level. These changes, Directors communicated, often impacted progress on established strategic priorities and, in some instances, created a new vision for their agencies.

Other major structural changes reported in FY 2017 included:

- The integration of Medicaid into an umbrella department;
- The consolidation of numerous health and human services agencies into one agency or department;
- The reassignment of a population and/or service category to a different department; and
- The reorganization of reporting structures and, by extension, the creation of new positions within the agency.

As with changes to agency leadership, these changes affected Directors' and their teams' work, altering agency goals, responsibilities, reporting structures, and workflow.

Figure 1:
Breakdown of Medicaid Agency Positions in State Government

A sub-division within a division of a larger umbrella agency
2 states (5%)

A standalone agency
13 states (29%)

Other
1 state (2%)

A division within a larger umbrella agency
29 states (64%)

Historically, investments in the leadership and development of Medicaid Directors and their teams have been limited, particularly when compared to those made in the private sector. Over the past year, NAMD has joined other organizations in trying to address this gap, providing Directors and their staffs with the resources to enhance core leadership competencies, including relationship building, time management, delegation, conflict resolution, and employee satisfaction. As part of this work, NAMD dedicated a portion of the FY 2017 Operations Survey to Medicaid leadership as a critical component of agency operations.

Reflecting on Health Care Reform in 2017

As managers of the nation's largest public health insurance program as well as a major state employer, Medicaid Directors have always held a critical leadership role. Yet heightened attention surrounding health care reform in 2017 raised the stakes, putting Directors in the crucial position of having to respond to new expectations and uncertainties while still managing the day-to-day operations of their programs. Significant political contingencies at the federal level, said one Director, "led our team to both have to keep running the everyday programs we run and were implementing" while also "providing information to [the] Governor's office, state and national representatives, and stakeholders."

As they managed their programs in the face of considerable uncertainty, Directors met intensively with their Governors, senior leadership at sister state agencies, state legislatures, and stakeholders, working to cultivate a clear understanding of—and an operational game plan for—various models of reform proposed under the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA). In laying the groundwork for potential change, many Directors oversaw predictive impact assessments, constructing "what if" simulations reflecting new financing models proposed under AHCA and BCRA. Several others requested legislative flexibility to move dollars between state fiscal years and budget accounts in anticipation of these potential funding changes.

Figure 2: How Have Director Expectations Changed in the Past Year?

Many Directors reported that these courses of action often made it harder to effectively lead their programs, diverting significant energy from other areas of agency operations. Directors indicated, for example, that responding to proposed reform:

- Demanded increased travel, presentations, and public speaking of agency leadership;
- Delayed long-term investments in systems, staff, and programs;
- Upended agency succession planning; and
- Created challenges regarding the way Directors manage their teams, cultivate a shared vision, and foster community.

Figure 2 provides a look at the ways in which the past year changed the expectations of the Medicaid Director role, including increased public visibility, accountability to the state legislature, and political pressure.

A Closer Look at Medicaid Directors: Past Experience, Salary, and Tenure

Medicaid Directors represent a diversely experienced group of individuals. Of all Directors who submitted a survey in FY 2017, two-thirds (30) held a position within their own state Medicaid agencies before becoming Medicaid Director, with nine* of these previously serving as Deputy Director. A third of Directors surveyed came from outside of the Medicaid agency, reporting other experience within state government, the federal government, community advocacy, law, clinical health care, consulting, and the military.

In FY 2017, the salaries of the Medicaid Directors surveyed ranged from $90,000 to $300,000, averaging at approximately $155,000 **(Figure 3)**. Almost half of surveyed Directors (21) reported that their salaries were set under civil service rules with meaningful discretion; 13 Directors reported that their salaries were set with full and formal discretion; and six Directors reported that their salaries were set under statute or civil service rules with little or no discretion.

Due to a host of reasons reported by Directors, ranging from resource constraints and burnout to political contingencies within the state, the median tenure of the Medicaid Directors

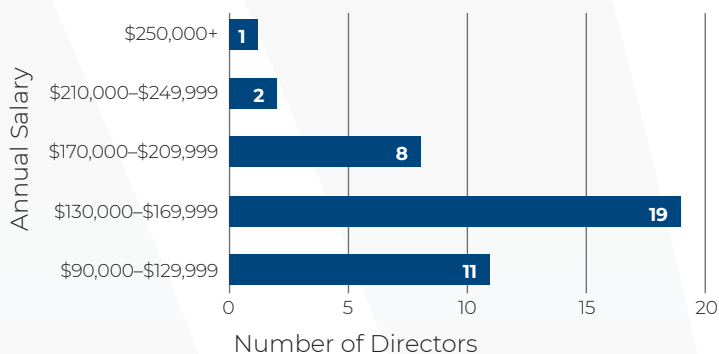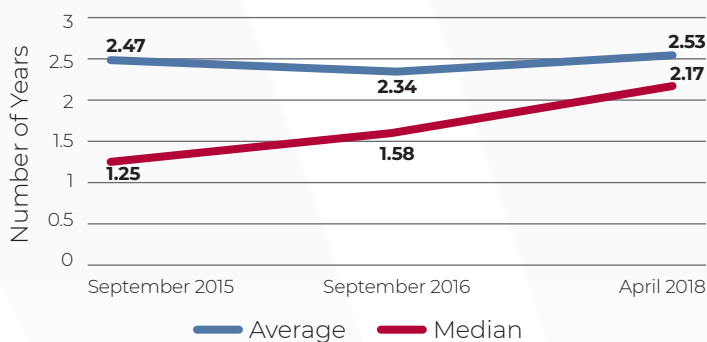**Figure 3:** Medicaid Director Salaries in FY 2017

Figure 4: Medicaid Director Tenure Over Time

surveyed was just a little over two years (26 months) as of April 2018.[†] While it increased since the collection of NAMD's FY 2016 Operations Survey in September 2016 **(Figure 4)**, median Director tenure remained problematically low, particularly considering the multi-year nature of reform initiatives. With nearly two-thirds of Directors surveyed (28) having been in their positions for under three years at the close of this survey, and with further churn anticipated in the year ahead, it remains critical to ensure that Directors and their teams have the full range of support in order to invest in relationships, vision, communications, systems infrastructure, and workforce culture **(Figure 5)**.
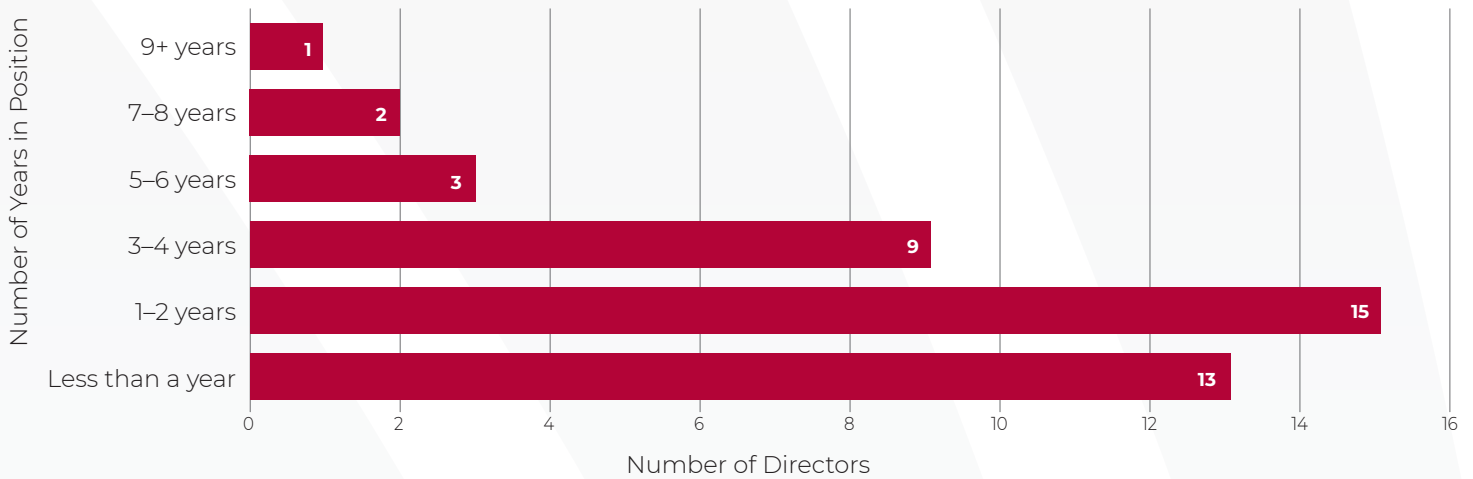
Medicaid Agency Staff

On average, the Medicaid Directors surveyed were responsible for 1,050 full-time employees (FTEs) within their agencies in FY 2017, with 21 Directors—generally reflecting more highly populated states—reporting 500 or more FTEs in their Medicaid agencies **(Figure 6)**. Looking at their senior leadership teams, Directors reported an average

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Figure 5: Medicaid Director Tenure as of April 2018

of seven direct reports, with many including Deputy Directors, Division Heads, Chief Financial Officers, and Medical Directors as the most important members of their "bench." As in past years, Directors cited critical challenges with regards to the recruitment of highly-qualified staff, crediting their agencies' workload demands and limited compensation relative to the private sector. Across states, this was particularly true for the recruitment of individuals with data/analytics and clinical experience.

Figure 6: Medicaid Staffing—Key Metrics*

Staff Metric	Minimum	Average	Maximum
Direct reports	1	7	12
Full-time employees	31	1,050	15,741
Part-time employees	0	31	570
Vacancy rate	0%	11%	30%

*Note: The numbers in this table have been rounded to whole numbers.

SIDEBAR 1: HIGHLIGHTING STATE LEADERSHIP INITIATIVES

As leaders of their agencies, Medicaid Directors are spearheading new leadership initiatives to invest in the development of their teams. Two such initiatives are highlighted here:

Florida's Medicaid University

Florida's Medicaid agency has developed a "Medicaid University" designed to educate internal agency staff on various components of the federal and Florida Medicaid program. Available in 101 and 201 iterations and lasting between six to eight weeks, the Medicaid University trainings are offered to internal agency staff at Florida Medicaid's headquarters office and field offices located throughout the state.

At the end of each series, there is a graduation ceremony, in which each participant who completed the series in its entirety receives a "Certificate of Completion" from his/her supervisor and/or Bureau

Chief. The graduates also receive a bound book including all the presentations from each session to keep for future reference.

California Career Development Initiatives

Last year, California's Medicaid agency introduced its first career development workshop to assist staff with the development of their resumés and interview skills. This has aided the growth of internal talent, putting more individuals into leadership positions throughout the department. Additionally, the agency has developed a competency model designed to help increase upward mobility, outline employee development paths within the organization, and provide clear direction for learning new job skills. From this model, California Medicaid has successfully launched its Analyst Certification Program and Leadership Development Training series.

Figure 7: Percent of Medicaid Agency Staff Within 5 Years of Retirement
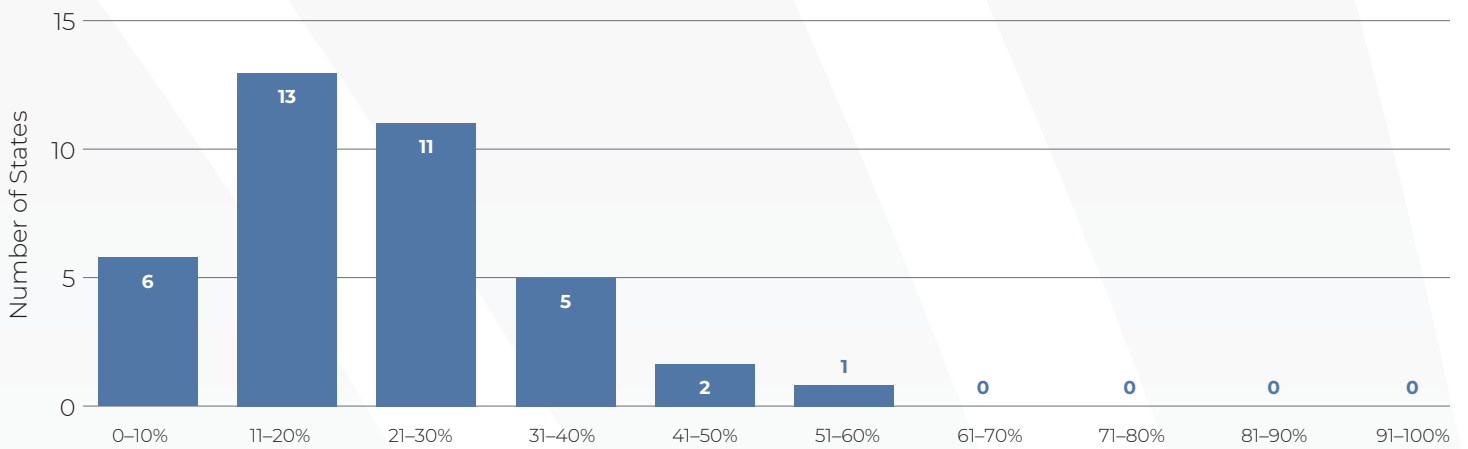
Medicaid Directors also confronted retention challenges, citing salary constraints and the stress that accompanies working in Medicaid as common reasons why people leave their agencies to work elsewhere. In the words of one Director, "Working [in] Medicaid is extremely stressful with various initiatives and deadlines. People leave to other agencies as they can make the same amount of money and not work so hard under less stressful circumstances." Perhaps as a result of these challenges, the average vacancy rate across states surveyed was nearly 11 percent in FY 2017, with several Directors reporting vacancy levels of up to 30 percent. Adding to this, eight Directors reported that between 31 and 60 percent of their staff was within five years of retirement **(Figure 7)**.

Responding to these staffing challenges, Medicaid Directors have crafted innovative solutions to recruit and retain employees. In this year's Operations Survey, Directors reported emphasizing the value of state employee benefits, a healthy workplace culture, and workplace flexibility (e.g., telework and work-from-home policies) during the recruitment process to attract strong candidates. Directors further recommended employing a mission-based recruitment strategy to identify candidates who are "attracted by the mission of the agency and by the challenges presented by reform." Equipped with these strategies, nearly half of Directors surveyed (21) indicated they planned to see an increase in FTEs in the coming year, with many anticipating added capacity in the areas of delivery system and payment reform, data systems and analytics, managed care, policy research, provider enrollment, claims processing, eligibility, and project management.

Directors also shared several strategies they employ to invest in and retain employees. These ranged from one-off activities, such as staff retreats, book clubs, topical lunches, and staff appreciation days to foster bonding, social camaraderie, and employee satisfaction, to more strategic, long-term initiatives like state-sponsored leadership academies and professional development opportunities, such as in-house training, resumé and interview assistance, and tuition reimbursement.

Section 3:
Strategic Priorities of Medicaid Directors

In NAMD's FY 2017 Operations Survey, Medicaid Directors were asked to list the three priorities that will most substantially shape their work in the coming year. Nearly 20 issues were reported by Directors, reflecting the expansive and dynamic focus of the program **(Figure 8)**. Consistent with past years' data, the most common priorities across states were: 1) Delivery system and payment reform (20 states); 2) Data systems and information technology (IT) (20 states); and 3) Behavioral health reform (18 states).

In answer to "Who or what is making this a priority?", 90 percent of Medicaid Directors surveyed cited themselves as the principal driver for at least one of their priorities, underscoring the critical role Directors play in identifying strategies to make the program as effective and efficient as possible. Several other Directors also listed the Cabinet Secretary/Administrator, the Governor, federal policy changes, and the state legislature as principal drivers. Directors were also asked to consider what factors most influentially dictate the success or failure of their priorities.
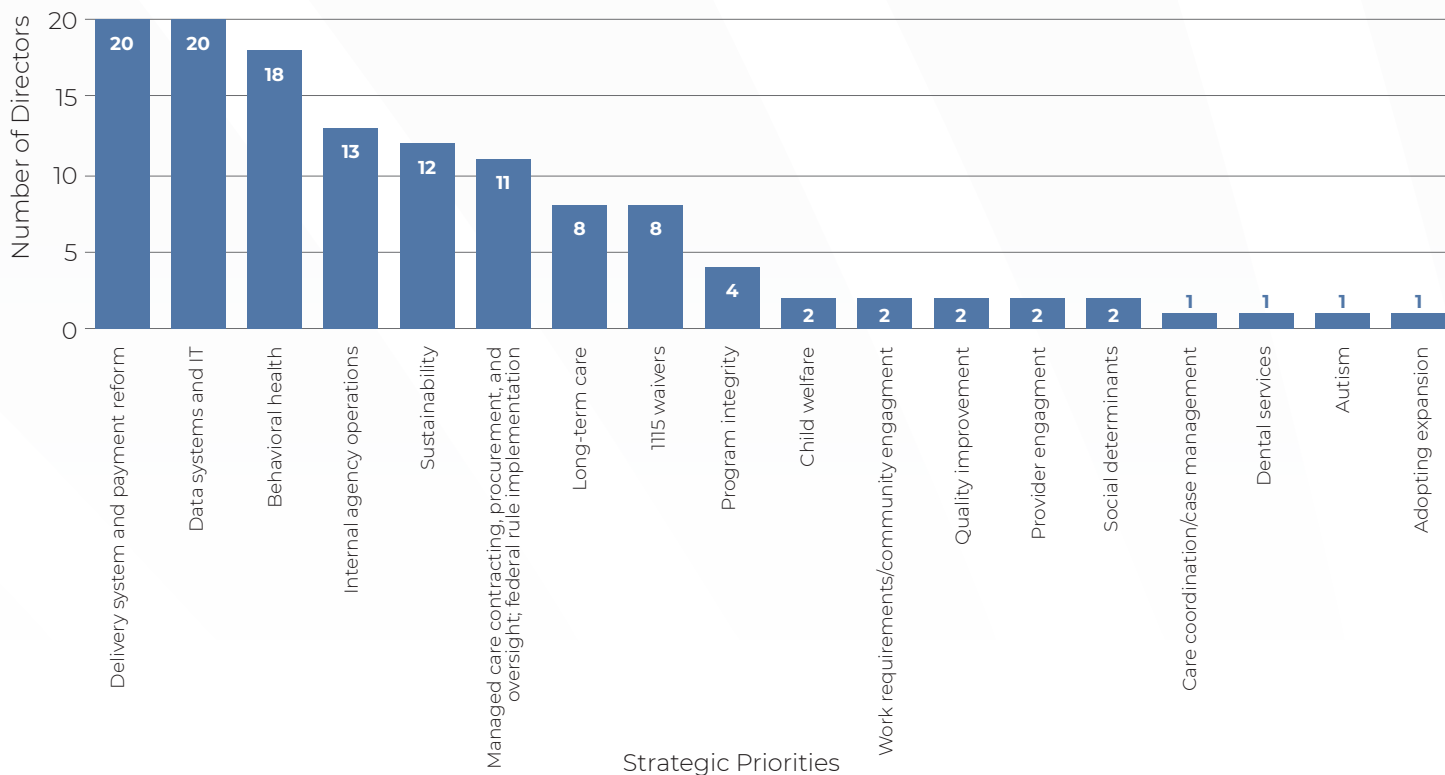
Of these so-called "make it or break it" factors, Directors most commonly cited the technical skills and expertise of their teams, political will, their states' data/IT infrastructures, and their own leadership skills. A few Directors also cited competing compliance deadlines, multi-payer alignment, and their teams' ability to foster emotional resonance around a priority via public storytelling.

Delivery System and Payment Reform

In line with previous years' data, 20 Directors cited **delivery system and payment reform** as one of their top three priorities for the upcoming year. As they continue to improve value by realigning incentives and rewarding performance, Directors indicated plans to pursue and/or implement varied innovation models, including:

- Alternative payment models (APMs), such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs); bundled payments; and other population-based payment models;
  - These included Medicaid APMs with the Advanced Alternative Payment Model option available under the Medicare Access and CHIP Reauthorization Act (MACRA).
- Managed long-term services and supports (LTSS) and rebalancing from institutional care to home- and community-based delivery systems;

Figure 8: Strategic Priorities That Will Shape Agency Work in the Coming Year

Figure 8 bar chart — Number of Directors (y-axis) by Strategic Priorities (x-axis):
- Delivery system and payment reform: 20
- Data systems and IT: 20
- Behavioral health: 18
- Internal agency operations: 13
- Sustainability: 12
- Managed care contracting, procurement, and oversight; federal rule implementation: 11
- Long-term care: 8
- 1115 waivers: 8
- Program integrity: 4
- Child welfare: 2
- Work requirements/community engagment: 2
- Quality improvement: 2
- Provider engagment: 2
- Social determinants: 2
- Care coordination/case management: 1
- Dental services: 1
- Autism: 1
- Adopting expansion: 1

- Delivery System Reform Incentive Payment (DSRIP) waiver implementation; and

- State Innovation Model (SIM) program implementation.

Data Systems and Information Technology (IT)

As they advance delivery system and payment reform, Directors are met with the challenge of ensuring that said reform is being implemented in measurable and accountable ways. To be sure, one of the most fundamental cornerstones of a well-functioning Medicaid program is the availability of **well-organized and actionable data systems and IT**, named by 20 Directors as a top priority for the upcoming year. As with delivery system and payment reform, Directors planned to pursue and/or implement an array of data systems and IT improvements in FY 2018: Seven Directors, for instance, described their agencies' plans to optimize systems platforms for eligibility and enrollment by computerizing historically manual processes; integrating

Medicaid data with that of the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF); and/or building various interactive platforms for providers and members, such as web portals

and mobile apps. Meanwhile, 14 Directors indicated their agencies are (or soon will be) undertaking a modular replacement of their Medicaid Management Information Systems (MMIS). In line with the Centers for Medicare and Medicaid Services (CMS)'s Medicaid Information Technology Architecture (MITA) 3.0 Framework,[9] Directors are striving to replace monolithic, outdated systems with interoperable platforms, with the goal of making their agencies more nimble, responsive, and accountable (Please refer to **Sidebar 3** for more information on state efforts regarding MMIS and modularity).

Such changes to data systems and IT have several operational components, requiring, in the words of one Director, "strategic planning, a new governance structure, multiple procurements, and change management." On this note, half of the surveyed Directors prioritizing data systems and IT indicated plans to enhance staffing in this area in the coming year. This investment suggests not only that Directors are effectively responding to federal guidance, but also that they recognize the vital role systems play in modernization. This modernization, said one Director, "will enhance our ability to gather quality data that will be able to drive information-based decision making," achieving the best care while responsibly managing taxpayer dollars.

Behavioral Health Reform

Medicaid covers 20 percent of American adults with mental illness; 24 percent of adults with serious mental illness (SMI); 16 percent of adults with substance use disorder (SUD);[10] and, together with CHIP, half of children living with at least one emotional or behavioral difficulty.[11] These individuals collectively account for almost half of total Medicaid expenditures,[12] making Medicaid the single largest payer for behavioral health services in the United States.[13] Consistent with previous years' data, a high number of Directors in NAMD's FY 2017 Operations Survey (18) identified **behavioral health reform** as one of their top three strategic priorities for the coming year.*

The behavioral health reforms cited by Directors for the coming year were complex and wide-ranging, reflecting states' unique socioeconomic, political, and public health contexts as well as the diversity of behavioral health challenges present in the Medicaid population. They included:

SIDEBAR 4: THE OPIOID CRISIS

Data from the Centers for Disease Control and Prevention (CDC) suggest that two-thirds of drug overdose deaths involve an opioid,[14] meaning that more than 100 Americans die from an opioid overdose every day.[15] Increasingly, states are responding to the opioid crisis in more proactive and comprehensive ways—as of early 2018, eight states (Alaska, Arizona, Florida, Maryland, Massachusetts, Pennsylvania, South Carolina, and Virginia) had declared the crisis a public health emergency.[16]

State Medicaid agencies have a critical role in responding to the opioid epidemic. Individuals living in poverty and/or rural communities, as well as individuals who have co-occurring mental illnesses and/or have a history of SUD, are prescribed painkillers at higher rates and are at greater risk of prescription painkiller overdose.[17] This year's Operations Survey showed that as leaders of their agencies, Medicaid Directors are working to combat the opioid crisis by:

- Limiting the number of opioids that can be prescribed;

- Requiring patient education on the risks of opioids;

- Using PDMPs to track prescriptions that are being filled;

- Mandating use of electronic prescriptions;

- Authorizing prescriptions of overdose reversing drugs, such as naloxone;

- Expanding opioid use treatment, including through Section 1115 waivers; and

- Connecting members with appropriate primary care, mental health, and pain management specialists.

- Integrating physical and behavioral health services, encompassing changes at the agency level, changes to managed care contracts, and changes at the point of care;

- Better leveraging Prescription Drug Monitoring Programs (PDMPs) to support appropriate prescribing;

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* **Note:** While in many cases behavioral health reform entails (or is linked to) broader delivery system and payment reform, NAMD decided to categorize it as a separate priority for the purposes of this report given the specific parameters and challenges surrounding Medicaid's work in addressing mental health and substance use disorders.

- Investing in community-based services for mental health treatment;
- Coordinating with partners in the criminal justice system;
- Targeting investments for individuals with high acuity needs; and
- Expanding SUD treatment capacity through SUD Institutions of Mental Disease (IMD) 1115 demonstration waivers.

Section 1115 Demonstration Waivers

In March 2017, CMS sent a letter to state Governors[18] signaling "a new era for the federal and state Medicaid partnership," in which Medicaid agencies have "more freedom to design programs that meet the spectrum of diverse needs" of populations under their care. The letter signaled a commitment to "breaking down the barriers to support state initiatives" aimed at health improvement, highlighting Section 1115 waivers as a mechanism for advancing state-pioneered and flexibly administered innovation. Unlike state plan authority, which generally mandates that any program changes be applied to all covered populations, Section 1115 waivers enable states to apply changes to a geographical, income-based, or condition-specific subset of their populations and experiment with varied benefit designs to better test new approaches.

As Section 1115 waivers have become an increasingly central component of regulatory policy, they continue to drive more of Medicaid operations not only as vehicles for testing out innovations, but also as intensive, "all hands on deck" projects requiring significant planning, time, and resources. Indeed, eight Directors in this year's survey named planning, implementation, or evaluation of their Section 1115 waivers as one of their top three strategic priorities for the coming year.

Even if not always considered a top strategic priority, more than 80 percent of Directors surveyed (38) indicated that they planned to seek further flexibility from a Section 1115 waiver in FY 2018. Across states, the most common flexibilities being pursued related to IMDs for SUD services, IMDs for mental health services, community engagement efforts (including work requirements), changes in Medicaid drug coverage, APMs for federally qualified health centers (FQHCs), and new cost-sharing arrangements for childless adults **(Figure 9)**. It is important to note that many of these waiver flexibilities, including the IMD waivers for SUD and mental health and the waivers implementing APMs for FQHCs, could be employed by Directors as tools for advancing their strategic priorities.

Program Integrity

As Medicaid Directors advance their agencies' strategic priorities, they remain committed to addressing fraud, waste, and abuse through effective program oversight. In FY 2017, Medicaid Directors continued to pursue robust strategies to ensure the integrity of their programs,

Figure 9: Flexibilities Being Pursued by States Via Section 1115 Waivers
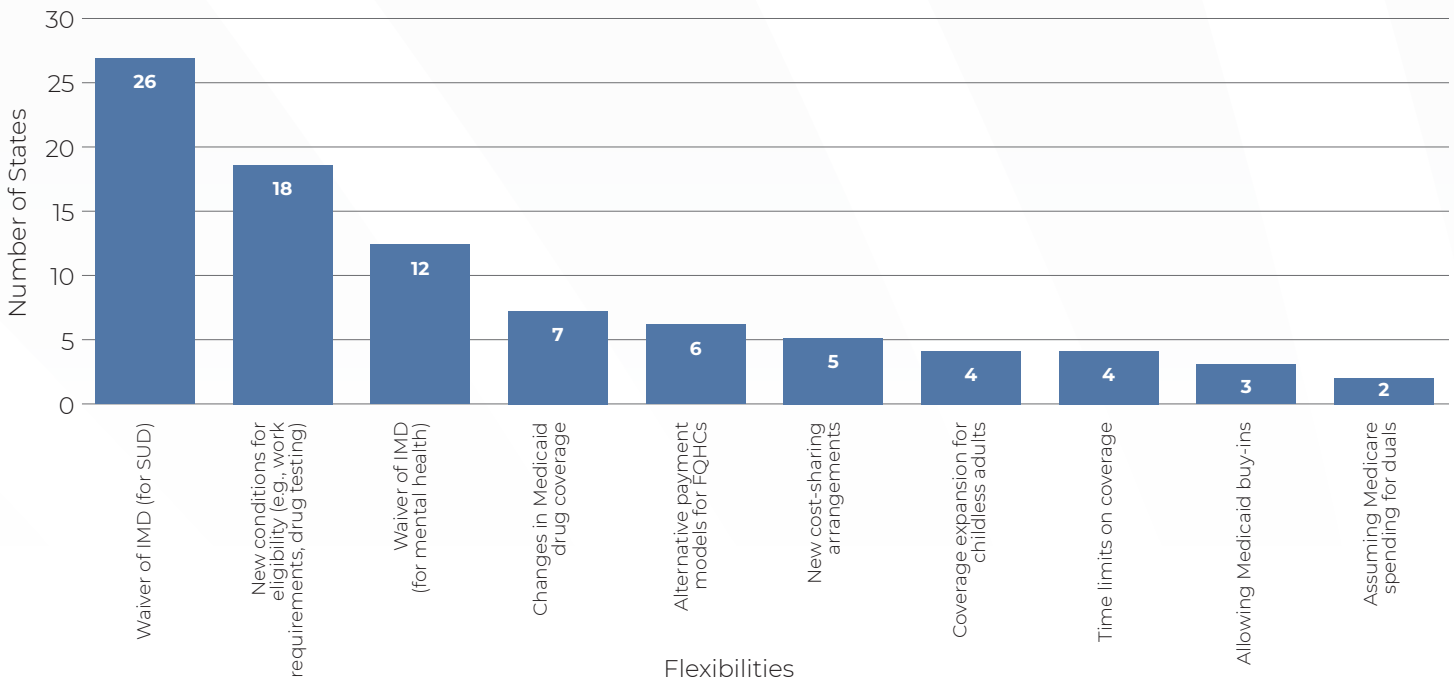
Figure 10: Most Effective Program Integrity Strategies Reported by Directors in FY 2017

Strategy	Number of Directors
Enhanced collaboration with managed care organizations (MCOs)	27
Data mining	26
Enhanced collaboration with Medicaid Fraud Control Units	22
Provider training and education	17
Triaging the internal process of responding to program integrity cases	15
Systematic fraud and abuse audits	14
More internal meetings dedicated to program integrity	13
Enhanced collaboration with federal/Medicare contractors	12
Modifications to MCO contracts	11
Taking advantage of CMS resources (e.g., CPI training)	11
Onsite provider visits	11
Hiring staff with program integrity expertise	11
Enhanced collaboration with State Attorney General Office	10
Enhanced collaboration with data analytics vendors	8
Onsite MCO visits	7
Optimized provider screening	7
Corrective action plans	6
Enhanced collaboration with State Medicaid Inspector General	6
Modification of payment structure to incentivize better monitoring	4
Provider risk scores	3
Enhanced collaboration with benefit managers	3
Enhanced collaboration with law enforcement	3
Computerization of health records and/or enrollment	2
Routine surveys	2
Enhanced collaboration with health insurance exchanges	2
Establishment of a new office dedicated to program integrity	2
Enhanced collaboration with other purchasers/payers (e.g., private sector)	1

Strategies (y-axis) · Number of Directors (x-axis)

including data mining, provider training and education, systematic audits, onsite visits, modifications to payment structures, and hiring staff with program integrity expertise. In this year's survey, several Directors additionally cited collaboration with extra-agency entities, such as managed care organizations (MCOs) (27 states), Medicaid Fraud Control Units (22 states), federal/Medicare contractors (12 states), the State Attorney General's Office (ten states), and data analytics vendors (eight states) **(Figure 10)**, as an effective program integrity tactic used in FY 2017.

In this year's survey, Directors also had the opportunity to discuss predictive modeling as a relatively nascent, but promising, program integrity strategy. By harnessing their own data or partnering with third party entities, Medicaid agencies continue to build their capacity to pinpoint fraudulent activity through surveillance reviews and targeted queries, with the ultimate aim of prospectively identifying fraud, waste, and abuse through state-specific algorithms and trend analyses.

Looking ahead to the coming year, Directors indicated plans to continue prioritizing program integrity in their agencies. In addition to enhancing provider education, making better use of data, increasing coordination with external entities, and optimizing areas of oversight, several Directors cited plans to invest in additional program integrity staff. Notably, Directors reported a desire to strengthen internal program integrity capacity for complex populations, including individuals requiring LTSS and individuals with behavioral health issues.

As in past years, NAMD's FY 2017 Operations Survey revealed that while primary responsibility for Medicaid operations remained in-house, Medicaid Directors continued to coordinate with external entities for support in operating their agencies' population-specific programs, as well as Medicaid functions (defined as the operational mechanisms or processes to ensure that care is delivered in transparent, measurable, accountable, and integrative ways).

Operational Jurisdiction of Medicaid Programs

Responsible for the care of 20 percent of Americans, Medicaid must wear many "hats," administering programs for individuals with a diverse array of health needs. As in past years, Medicaid agencies continued to partner with sister state agencies to run the day-to-day operations of these population-specific programs, leveraging cross-agency expertise to improve care for beneficiaries with complex health needs, such as children with special health needs, individuals with mental health or substance use issues, and/or individuals living with physical, developmental, or intellectual disabilities. This year's survey showed that in FY 2017:

■ The day-to-day operations of programs for individuals with intellectual and/or developmental disabilities (ID/DD) were run or co-run by sister state agencies or departments in 30 states;

■ The day-to-day operations of mental health programs were run or co-run by sister state agencies or departments in 26 states;

■ The day-to-day operations of SUD programs were run or co-run by sister state agencies or departments in 26 states; and

■ The day-to-day operations of LTSS were run or co-run by sister state agencies or departments in 20 states **(Figure 11)**.*

Figure 11-A: Number of States in Which Medicaid Programs Are Solely Run by the Medicaid Agency
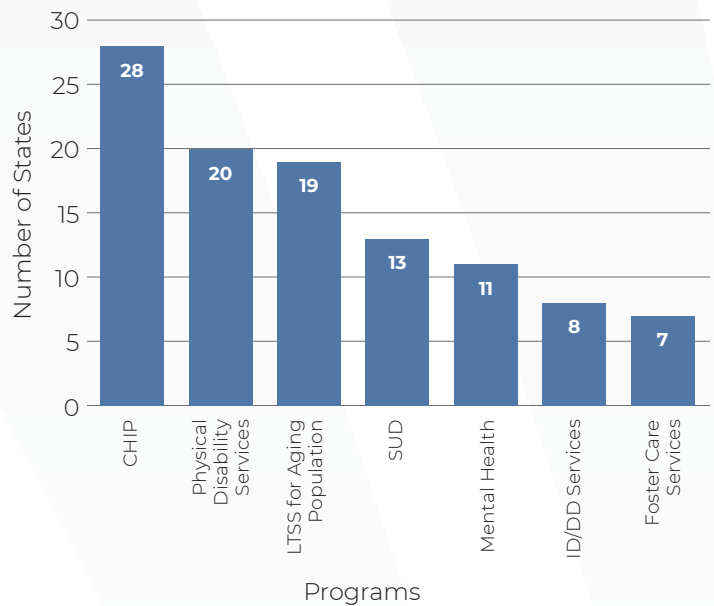
Figure 11-B: Number of States in Which Medicaid Programs Are Solely Run by a Sister State Agency or Department

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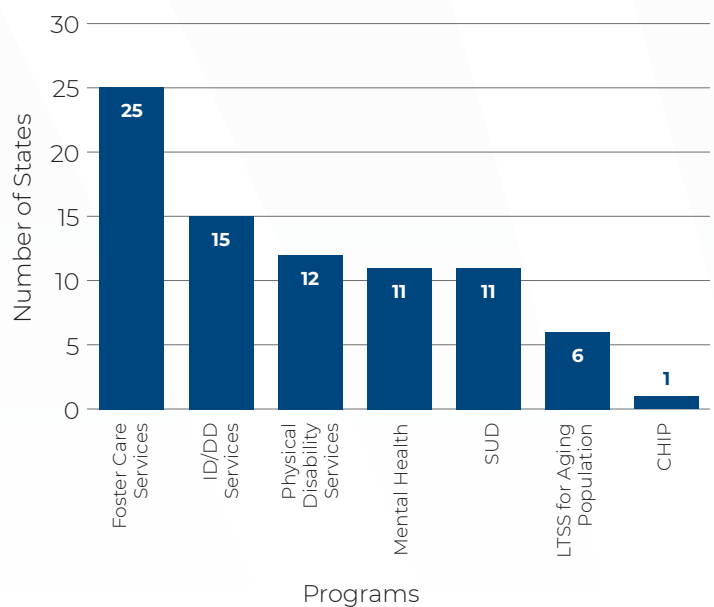
* **Note on methodology:** These numbers include states in which a sister state agency fully ran the day-to-day operations of programs; a sister state agency co-ran the day-to-day operations of programs with the Medicaid agency; or a sister state agency co-ran the day-to-day operations of programs with a contractor (in rarer cases, they also include states in which the sister state agency, the Medicaid agency, and a contractor worked together).

Figure 11–C: Number of States in Which Medicaid Programs Are Co-Run by Multiple Entities

Legend:
- Medicaid Agency + Sister State Agency
- Sister State Agency + Contractor
- Medicaid Agency + Contractor
- Other Combination

ID/DD Services: Medicaid Agency + Sister State Agency 11, Medicaid Agency + Contractor 3, Sister State Agency + Contractor 1, Other Combination 5

LTSS for Aging Population: Medicaid Agency + Sister State Agency 11, Medicaid Agency + Contractor 2, Other Combination 6

Mental Health: Medicaid Agency + Sister State Agency 10, Medicaid Agency + Contractor 4, Other Combination 8

SUD: Medicaid Agency + Sister State Agency 9, Medicaid Agency + Contractor 1, Sister State Agency + Contractor 1, Other Combination 8

Foster Care Services: Medicaid Agency + Sister State Agency 6, Medicaid Agency + Contractor 1, Other Combination 5

CHIP: Medicaid Agency + Sister State Agency 3, Medicaid Agency + Contractor 4, Other Combination 2

Physical Disability Services: Medicaid Agency + Sister State Agency 3, Medicaid Agency + Contractor 4, Other Combination 3

Y-axis: Number of States
X-axis: Programs

These cross-agency partnerships enable Medicaid agencies to address the extensive and complex needs of the Medicaid population more holistically and effectively. With such partnerships, though, comes a distinct set of challenges, as Medicaid Directors must achieve consensus in the face of varying—and occasionally competing—priorities, demands, cultures, and work styles. Oftentimes, such relationships require strong leadership skills, ranging from relationship-building to conflict resolution.

Operational Jurisdiction of Medicaid Functions

As chief executives of a more than half-a-trillion-dollar program with numerous pathways for improving the

SIDEBAR 5: THE SOCIAL DETERMINANTS OF HEALTH

As health care leaders, Medicaid Directors know that health hinges upon more than just medical factors. Data indeed show that up to 40 percent of health outcomes are determined by nonclinical factors such as income, education, and employment.[19] Consistent with these data, nearly 80 percent of physicians believe that in order to achieve better health outcomes, patients' social needs must be as thoroughly and consciously addressed as their medical needs.[20]

As they strive to address the challenges facing the Medicaid program in more inclusive and integrated ways with an eye towards the social determinants of health, Medicaid Directors continue to coordinate with other agencies and departments. In FY 2017, 38 Medicaid agencies coordinated with state Departments of Education and/or schools; 38 Medicaid agencies coordinated with Departments of Corrections; and 27 Medicaid agencies coordinated with Departments of Housing **(Figure 5.1)**.

Figure 5.1: Cross-Agency Coordination

Education/public schools: 38
Corrections: 38
Housing: 27
Community affairs: 13
Veterans affairs: 11
Public safety: 8
LGBT affairs: 4

Y-axis: Number of States
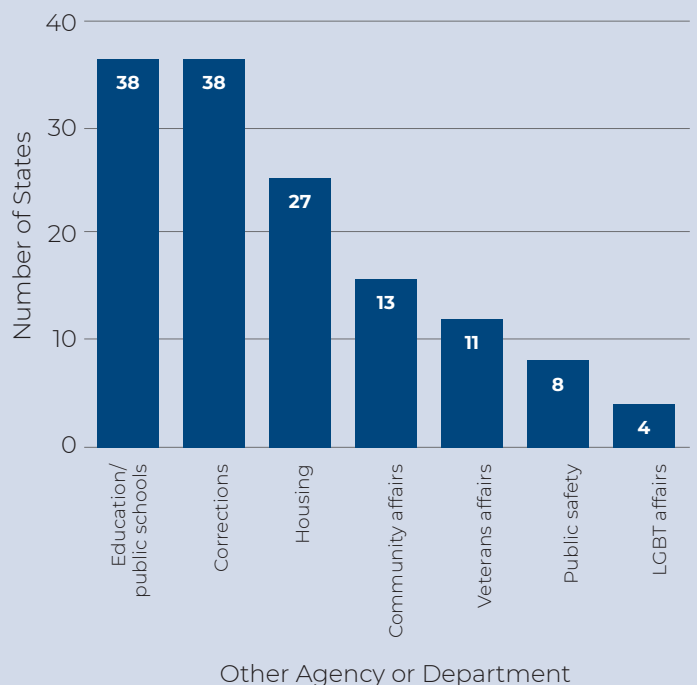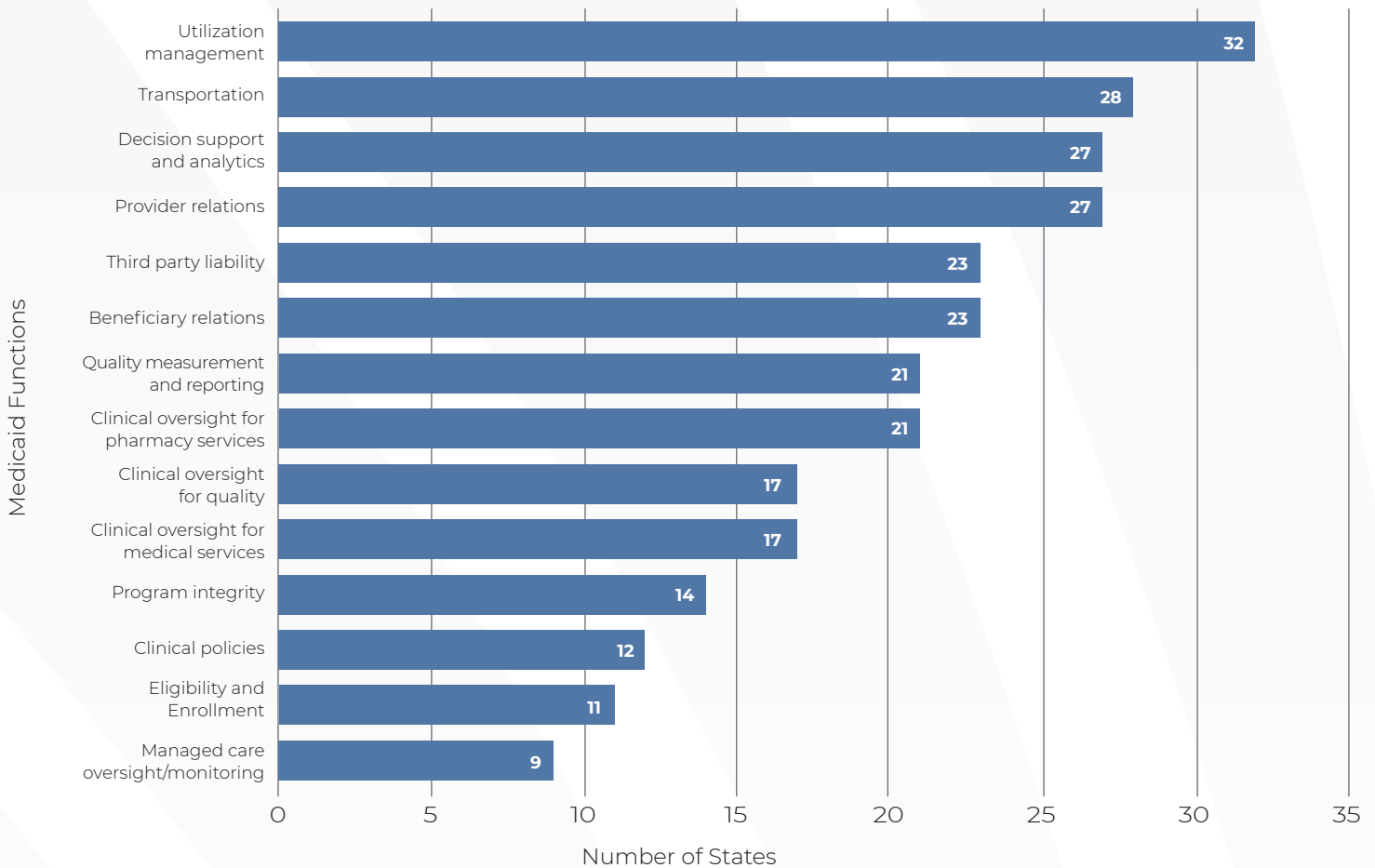X-axis: Other Agency or Department

Figure 12: Medicaid Functions Operated or Co-Operated by Contractors

delivery, quality, and value of care, Medicaid Directors are responsible for ensuring that their agencies function smoothly. As in past years, Directors continued to look outside of state government for support in managing Medicaid's functions in FY 2017. Thirty-nine (39) Directors indicated that the day-to-day operations for at least one key Medicaid function in their agencies were run or co-run by a contractor. The functions for whose daily operations were most frequently run or co-run by contractors across all states included utilization management (32 states), transportation (28 states), provider relations (27 states), and decision support and analytics (27 states). Relatively few Medicaid agencies, by contrast, partnered with contractors to coordinate the day-to-day operations of eligibility and enrollment (11 states) and clinical policies (12 states); even fewer partnered with third parties to assist with managed care oversight (9 states) **(Figure 12)**.*

As Medicaid has leveraged contractors' expertise, it has evolved into a strong public-private partnership.

While beneficial, the partnership can sometimes create challenges, requiring Directors to build new relationships and manage large-scale, multi-part contracts, often requiring new resources at the staff level. As they coordinate with managed care plans to deliver care, for example, Medicaid Directors must work to develop their teams so they can provide meaningful and effective oversight of the MCOs. In some states, Directors have organized their internal staff to mirror the staff structures of MCOs, allowing for comparable expertise to develop and encourage relationships between Medicaid staff and their managed care counterparts. Directors have also tracked changes in Medicaid staff morale during the transition to managed care from fee-for-service, repositioning staff into roles that allow them to harness their strengths while highlighting the population-level impact that staff can have on beneficiaries by implementing managed care.

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* **Note on methodology:** These numbers include states in which the contractor fully ran the day-to-day operations of functions; the contractor co-ran the day-to-day operations of functions with the Medicaid agency; or the contractor co-ran the day-to-day operations of functions with a sister state agency (in rarer cases, they also include states in which the sister state agency, the Medicaid agency, and a contractor worked together).

Looking to the Year Ahead

In 2018, a common refrain echoed in the health policy world has been: "The states are where the action is." Increasingly, Medicaid exemplifies this axiom, with Medicaid Directors at the helm. Managing the nation's largest public health insurance program, Medicaid Directors have one of the most action-packed roles in state government. As shown by this report, FY 2017 raised the visibility of Directors, ushering in a new wave of intensified public attention and political pressure. Balancing new demands and expectations amid uncertainty, Directors built new relationships and handled resource diversions—all while maintaining investments in value-based care, data and systems, behavioral health care, long-term services and supports, and program integrity. As they worked to track performance and realign incentives, they strove to drive patient-centered care, keeping Medicaid beneficiaries at the heart of reform. As part of this effort, Directors continued to invest in relationships with contractors and sister state agencies to deliver care more holistically, leveraging multidisciplinary insight to better address the social determinants of health.

With 36 state gubernatorial elections occurring in November 2018, the upcoming months are expected to be politically dynamic, with likely implications for Medicaid operations and leadership. Considering the high number of Directors who are politically appointed, the heightened political nature of the Director position, and Director tenure, investments in the professional development of Directors and their teams remain imperative. NAMD looks forward to supporting its members as they navigate the remainder of 2018 and beyond, providing the full range of leadership, programmatic, and policy support needed for their success.

Methodology

Each year, Medicaid Directors and their staffs work with NAMD to develop an understanding of the operational aspects of the Medicaid program at the state level, offering information about their operations, leadership challenges, and priorities going forward.

Between January and April of 2018, 45 Directors completed either the PDF or online version of NAMD's Operations Survey evaluating Medicaid agency operations in FY 2017. Divided into six sections, the survey contained 49 questions, many of which were multi-part and/or required qualitative description. NAMD added several questions on Medicaid leadership and development to this year's survey, addressing the leadership strengths and competencies of Directors as well as tools and strategies Directors employ to build their teams.

Question-specific notes on methodology include:

- **Medicaid Director experience:** In calculating the number of Medicaid Directors who served as their agencies' Deputy Director before becoming Medicaid Director, NAMD included positions we deemed to be the functional equivalent of the Deputy Director, including Deputy Administrator, Associate Medicaid Director, and Chief Deputy Director.

- **Director tenure:** NAMD's calculation of median Medicaid Director tenure reflected tenure data at the time of the survey's collection (April 2018). Median tenure excluded Directors who did not submit a survey as well as Directors who were interim/acting as of April 2018.

- **States in which sister state agencies operate/co-operate Medicaid programs:** The data NAMD reported regarding the number of states in which the sister state agency operated/co-operated Medicaid programs in FY 2017 included states in which a sister state agency fully ran the day-to-day operations of programs; a sister state agency co-ran the day-to-day operations of programs with the Medicaid agency; or a sister state agency co-ran the day-to-day operations of programs with a contractor. In rarer cases, they also included states in which the sister state agency, the Medicaid agency, and a contractor worked together.

- **States in which contractors operate/co-operate Medicaid functions:** The data NAMD reported regarding the number of states in which a contractor operated/co-operated Medicaid functions included states in which the contractor fully ran the day-to-day operations of functions; the contractor co-ran the day-to-day operations of functions with the Medicaid agency; or the contractor co-ran the day-to-day operations of functions with a sister state agency. In rarer cases, they also included states in which the sister state agency, the Medicaid agency, and a contractor worked together.

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