Overview: Life through the Lens of the Medicaid Directors

By Matt Salo

State Medicaid programs are large and complex and their directors are faced with implementing changes required by the Affordable Care Act at the same time they continue to work with limited resources, both fiscal and human. Medicaid programs are also leading by example in major transformations of the health care system, including payment reforms, quality oversight, system accountability, and targeted care coordination.

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

Despite the new challenges, the core duties of state Medicaid directors remain the same:

- They work within tight budgets and seek to maximize the value of their dollar;
- They manage a multitude of relationships with different partners and stakeholders in order to leverage a complex system environment to bring services to beneficiaries;
- They are accountable to both state leaders and federal regulators for the activities and outcomes of their programs; and
- They continue to find ways to achieve quality outcomes with limited internal resources.

Directors Must Lead Large and Complex Systems

The job description of a Medicaid director involves a wide range of roles and responsibilities and varies from state to state. Directors continue to have to focus their energies on managing budgets for complex and expensive populations. Across states, 2013 fiscal year budgets ranged from $604 million in Wyoming to more than $55 billion in California, and the program provided services of anywhere from 88,000 in Wyoming to more than 9.1 million beneficiaries in California. Each state, however, grapples with substantial variation in populations covered and services offered, making the program exceedingly complex. The median Medicaid program budget—$5.5 billion—would place it in the rankings of the Fortune 500.

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

Resource Challenges Remain

While the roles and business processes of the Medicaid agency may grow, the functions and duties shouldered by the programs still exist. Programs must continue to meet the obligations and provide the services they have provided in the past. Expectations and responsibilities are layered on top of each other; unlike the private sector, lines of business are never closed. In light of this, internal resource constraints continue to present obstacles to directors as they move to manage their budgets, implement the Affordable Care Act and transform their programs.

The median vacancy rate range for agency employment is roughly 6 to 10 percent, with some states reporting double-digit vacancy rates for authorized positions. Less than half of state Medicaid programs expect to be able to hire new personnel in the 2014 fiscal year, despite programs having to take on major new responsibilities. Compared with the average Fortune 500 CEO, the average Medicaid director’s salary is 3.5 percent of what many of their peers are paid, despite the fact that their budgets rival the revenues of these companies.
These workforce issues loom large for directors’ abilities to effectuate major reforms to programs. Medicaid programs need a workforce that understands a dynamic and changing health care landscape in order to put payment and delivery system reform ideas into practice. Therefore, states are facing the reality of having to either hire a new cohort of staff who can manage these new responsibilities or retrain a sizable portion of their workforce to do so. Few states can realistically anticipate either the budgetary authority or the political feasibility of increasing the size of state government in the current political environment. Retraining the workforce brings its own challenges, as the skill sets needed to implement a basic fee-for-service delivery and payment model can be radically different than the skill sets needed to effectively implement integrated care models and shared savings incentives. Failure to accommodate either of these goals creates significant challenges on the road to reform.

**The Affordable Care Act**

Regardless of the political support for the law, or even the decision whether to expand Medicaid, implementation of the Affordable Care Act has been the number one priority for Medicaid directors because of the significant administrative and technological overhaul they must implement in a relatively short amount of time. The experience of the states has been varied in terms of the capability of their legacy systems—in large part because every state started the process from a different point—and complicated by uneven competencies of information technology systems vendors, the volatile political environment and the necessity of depending on federal guidance that was often delayed or inconsistent.

But regardless of the starting point, every state has had to rebuild their eligibility systems in order to comply with the new income rules adopted in the ACA and rework their application procedures and business processes, as well as design, implement and refine a functional interaction with the exchanges, whether state-based or federally facilitated. In addition, states have focused on modernizing information management processes, reporting systems and data analytics capabilities.

**Health System Transformation**

Across the country, Medicaid agencies are planning and launching initiatives in health system reform. Some of these efforts are targeted to specific service types, disease states or policy gaps.

**Payment Reform**

As an incentive for quality and efficient service delivery or as a disincentive for uncontrolled costs and ineffective care, states are examining a range of payment models that will give a competitive advantage to groups offering better outcomes to Medicaid and its beneficiaries.

Some examples include bundling payments for episodes of care or specific diagnoses and reduced payments for undesirable outcomes such as hospital readmissions or early elective induction of labor. These payments can be specific to provider or beneficiary or based on benchmarks of performance generalized across a population.

**Quality Oversight**

Value-based purchasing is the watchword of modern Medicaid. As such, agencies must have the capacity to assess value and track progress in quality improvement. Monitoring the performance of providers allows Medicaid to identify problem areas and reward quality. Data collection tools, such as all-payer claims databases and quality reporting requirements in managed care contracts, are proliferating. Public release of quality data and analytical tools to support competitive contracting and benchmarking among plans and providers are also a more frequently used tool.

**System Accountability**

Alongside payment reform and quality oversight is the increase in policy solutions that support accountability at every level in the outcomes for beneficiaries, rather than just the delivery of discrete services. Many system accountability measures help realign financial incentives for providers to give better, and less expensive, care. Managed care—including managed long-term care—and other sub-capitated arrangements such as shared savings are a few of the models designed to promote and enhance coordination and holistic care. Rather than working to improve quality in a particular service type or provider, these kinds of arrangements can leverage a broad group of providers in a way that improves outcomes of care generally and creates accountability for individual outcomes. It is feasible to implement accountable care organization models in both fee-for-service and within managed care, and many states recognize the considerable opportunities to drive system improvement through these kinds of risk-sharing arrangements.
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TARGETED CARE COORDINATION

Medicaid agencies across the country recognize the majority of costs are for a relatively small number of individual program beneficiaries. Portions of these costs exist because the complex health and service needs of these individuals are not being met in a coordinated fashion. Medicaid agencies have begun to implement health homes and similar efforts for these populations, including the dually eligible, seriously mentally ill and other beneficiaries with multiple chronic conditions.

Agencies work with health plans and individual providers to identify high-cost beneficiaries or heavy users of inappropriate services, and to effectuate an intervention that ensures better coordination of care and ultimately better outcomes for these individuals. Medicaid agencies have found that effective care coordination often involves different professionals working together to help a beneficiary navigate a range of health and health-related issues.

MULTI-PAYER INITIATIVES

Medicaid is a major player in the health care marketplace, but it is far from the only one. A number of states are working to fit Medicaid into a broader strategy that includes private and other public payers in coherent cross-market value purchasing programs. One such model includes performance-based contracting for similar outcomes across payers. The recently released opportunity for grants from the Center for Medicare and Medicaid Innovations—the State Innovation Models grants—is another option for states seeking multi-payer approaches that include Medicaid as one point of leverage in a multi-payer strategy for system change.

Looking Forward

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

About the Author

Matt Salo was named executive director of the National Association of Medicaid Directors (NAMD) in February 2011. The association, formed in 2011, represents all 56 of the nation’s state and territorial Medicaid Directors, and provides them with a strong unified voice in national discussions as well as a locus for technical assistance and best practices. Salo formerly spent 12 years at the National Governors Association, where he worked on the NGA health care and human services reform agendas. He spent the five years prior to that as a health policy analyst working for the state Medicaid directors as part of the American Public Human Services Association. Salo was a substitute teacher in the public school system in Alexandria, Virginia for two years, and holds a B.A. in Eastern Religious Studies from the University of Virginia.