CHAPTER 4

Building Capacity to Administer Medicaid and CHIP

Medicaid and the State Children's Health Insurance Program (CHIP) are major purchasers of health care services. Together they accounted for over $470 billion in state and federal expenditures in fiscal year (FY) 2013, or 15 percent of national health care spending (MACPAC 2014). These programs cover a substantial number of people—more than 70 million in Medicaid and 8 million in CHIP in FY 2013. This number is growing as states implement the expansion of coverage to adults at or below 138 percent of the federal poverty level and as outreach efforts associated with Medicaid, CHIP, and the exchanges result in additional eligible persons being referred and coming forward to enroll in coverage (MACPAC 2014). The demands on state Medicaid agencies are extensive and diverse and continue to grow as these programs increase in size and scope and seek to increase value and accountability through more sophisticated purchasing strategies (NASBO 2014). However, Medicaid experts have noted that administrative capacity constraints already hinder states' ability to meet program requirements; to implement proactive strategies to improve quality, outcomes, and value; and to integrate Medicaid and CHIP into broader delivery system and financing reforms (Griffin et al. 2014).

Medicaid and CHIP are jointly administered by the states and the Centers for Medicare & Medicaid Services (CMS). While CMS is responsible for program administration at the federal level, state agencies have the flexibility to establish many policies—within federal guidelines—and to manage their own programs on a day-to-day basis. State responsibilities include determining eligibility, enrolling providers, setting payment rates, developing coverage policies, adjudicating claims, overseeing contractors, managing information systems, monitoring access to and quality of services, addressing casework, and ensuring program integrity. Federal statute (§1902(a) of the Social Security Act (the Act)) requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. (See Box 4-1 for more information on requirements relating to administration of CHIP.) In many states, the single state agency

contracts with other public or private entities, including other state or local government agencies, to perform various program functions that may encompass extensive policy and operational aspects of program administration.

Consistent with MACPAC's statutory charge to review the factors affecting expenditures for the efficient provision of items and services by Medicaid (§1900(b)(2) of the Act), the Commission is focusing attention in this report on state administrative capacity. This chapter describes the administrative requirements for state Medicaid programs, obstacles states and the federal government face in administering Medicaid effectively, and models and strategies that have been implemented to strengthen administrative capacity. The Commission recognizes that sufficient administrative support and adequate capacity are needed for the state responsibilities related to effective and efficient operation of the Medicaid program, yet there are few clear performance standards or metrics to assess state capacity, identify gaps in performance, prioritize investments, and identify appropriate responses. The chapter concludes by noting the Commission's ongoing concern about Medicaid administrative capacity and by highlighting potential areas for future work.

Medicaid Administrative Responsibilities

State roles and responsibilities

As governmental health insurance programs, state Medicaid programs must manage all of the operational functions of a large health insurer as well as a host of additional responsibilities

BOX 4-1. CHIP Has Specific Administrative Requirements

The State Children's Health Insurance Program (CHIP) pays for the health insurance coverage of targeted low-income children whose family income is above the state's Medicaid eligibility levels in 1997, when CHIP was created. States operate their CHIP programs as a CHIP-funded expansion of Medicaid, a CHIP program separate from Medicaid, or a combination of both approaches. Like Medicaid, states administer their programs within federal rules and receive federal matching funds for program expenditures. However, while states receive an enhanced federal matching rate for CHIP, funding for each state is capped by an annual allotment, and the amount of the CHIP allotment that a state can spend on certain non-benefit activities is limited to 10 percent of total CHIP expenditures. These non-benefit activities can include outreach conducted to identify and enroll eligible children in CHIP, program administration costs, health services initiatives, and other child health assistance. These expenditures are matched at the enhanced CHIP matching rate (unlike Medicaid, which provides 50 percent match for most administrative expenditures) and are counted against both the 10 percent limit and the allotment.

CHIP programs that are operated as CHIP-funded expansions of Medicaid are subject to the same administrative requirements as Medicaid. Many states operate CHIP programs as stand-alone programs but in practice use the same staff and systems that support Medicaid such that the two programs are administratively integrated. Some states operate fully separate CHIP programs. These fully separate programs are typically smaller in size and are subject to fewer and different federal administrative requirements. For these reasons, the administrative capacity issues unique to stand-alone CHIP programs are generally excluded from this chapter, which focuses on the requirements that apply to Medicaid and by extension to CHIP programs that are CHIP-funded Medicaid expansions or separate CHIP programs that states choose to administer by Medicaid staff and systems.

relating to public health, social insurance, and public financing. For example, while state Medicaid agencies must manage traditional insurer responsibilities such as eligibility, provider enrollment, claims adjudication, and financial management, they must also manage coverage of long-term services and supports, provide access to non-traditional support services such as non-emergency transportation and language translation, attend to the program's role in supporting the health care safety net and health information exchange, accept appeals and grievances and conduct fair hearings, and coordinate enrollment with health insurance exchanges and separate CHIP programs. The demands on state Medicaid agencies are extensive and diverse and have grown substantially over the nearly 50-year history of the program (Box 4-2).

BOX 4-2. Medicaid Programs Manage a Large and Diverse Set of Responsibilities

Manage and oversee delegation agreements: Develop, manage, and oversee delegation agreements with state agencies and local governments, as appropriate.

Define covered populations, benefits, and provider qualifications: Implement coverage of mandatory eligibility groups and services, determine which optional eligibility groups and services will be covered, determine how to enroll and pay providers of mandatory services, and decide what optional provider types may enroll and receive payment.

Define and make payments: Establish payment rates consistent with efficiency, economy, and quality of care and sufficient to enlist multiple types of providers; adjudicate claims and process payments.

Design, operate, and oversee delivery systems: Develop, implement, and oversee delivery systems (e.g., fee for service, managed care, alternative approaches).

Determine eligibility: Accept and process eligibility applications consistent with state and federal requirements for timeliness and accuracy.

Implement enrollee protections and safeguards: Provide systems and support to ensure that Medicaid enrollees receive protections and rights granted by federal law; manage appeals and fair hearings processes.

Manage utilization: Control utilization of Medicaid services, safeguard against unnecessary and inappropriate use, and provide specific controls for institutional services and outpatient drug use.

Claim federal financial participation: Collect and document expenditures according to appropriate federal matching rates; submit budget and expenditure reports to the Centers for Medicare & Medicaid Services.

Collect and monitor program data: Collect and report information necessary for program administration and accountability; maintain statistical, fiscal, and other records.

Measure and manage quality and performance: Assess the quality of Medicaid services and the performance of providers and vendors and take prompt and appropriate action when concerns are noted.

Defend state practices and reports: Respond to an array of federal auditing inquiries (e.g., Office of Inspector General, Recovery Audit Contractors, Payment Error Rate Measurement).

Ensure program integrity: Identify and address instances of fraud, abuse, and mismanagement and ensure that federal and state funds are spent appropriately; initiate state investigations and participate in federal reviews and audits.

Source: Griffin et al. 2013.

Federal statute and regulations not only spell out minimum requirements and expectations for state program administration, but also give states flexibility as long as these requirements are met. As a result of this flexibility, there is significant variation in how states organize, staff, and operate their Medicaid programs. Additional administrative demands (and variation) stem from state efforts to go beyond basic program expectations and leverage Medicaid's purchasing power to contain cost growth, drive value, and improve population health (Box 4-3).

Federal roles and responsibilities

Medicaid and CHIP are jointly administered by the states and the federal government. States have primary responsibility for day-to-day program operations, including the activities described above, while the federal government develops regulations and guidance to implement federal laws, reviews and approves state plan amendments and waiver requests, oversees state program implementation and operations, and processes state claims for federal reimbursement of program expenditures. Responsibility for executing these federal functions is generally divided between the CMS central office, which is responsible for setting overall Medicaid policy, and 10 CMS regional offices, each of which is responsible for program and financial oversight of a group of states. Additional oversight responsibilities are shared among other federal organizations, including the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and the U.S. Government Accountability Office (GAO).

BOX 4-3. Medicaid Programs Continually Assume New Responsibilities

Streamline eligibility policies and processes: Automate eligibility processes; interface with a federal data services hub; coordinate with exchanges.

Maximize efficiency across Medicaid, exchanges, and CHIP: Coordinate Medicaid and State Children's Health Insurance Program (CHIP) eligibility with coverage through the exchange via a no-wrong-door eligibility and enrollment process; minimize the effects of churn among programs.

Implement delivery system and payment reforms: Become more active purchasers to obtain better value; develop incentives to promote coordination and collaboration across providers and the use of evidence-based practices; develop strategies for aligning provider payment with quality and improved outcomes.

Rebalance long-term services and supports: Expand access to community-based care options and manage transitions between settings.

Support Medicaid and interagency collaboration: Improve coordination between Medicaid and state public health, insurance oversight, income support, housing, educational, employment, transportation, and justice systems to support common goals.

Improve performance management, quality measurement, and data management: Develop data reporting and analytic capacity to incorporate quality and performance management into program operations and strengthen program accountability.

Provide transparency and public accountability: Collect information and present it in a format accessible to a variety of audiences; provide timely information and data to support policymakers.

Source: Griffin et al. 2013.

Within CMS, primary federal responsibility for ensuring the efficient and effective administration of Medicaid and CHIP rests with the Center for Medicaid and CHIP Services (CMCS). As directed by the Secretary of HHS (the Secretary), CMCS staff interpret and help operationalize statutory requirements through the development of federal regulations and subregulatory guidance (e.g., state Medicaid director letters and responses to frequently asked questions). CMCS staff provide states with direct technical assistance, negotiate the terms and conditions of waivers of state plan requirements, and respond to requests for information from a wide variety of stakeholders including the Congress, providers, and enrollees. CMCS is also responsible for monitoring the quality and performance of Medicaid and CHIP. Other offices within CMS that maintain some responsibility for Medicaid and CHIP policy development and program oversight include the Center for Medicare and Medicaid Innovation, the Center for Program Integrity (CPI), and the Federal Coordinated Health Care Office.

CMS also has 10 regional offices, each with an associate regional administrator responsible for Medicaid and CHIP program oversight and organized as the Consortium for Medicaid and Children's Health Operations. Regional office staff serve as the front line for CMS in monitoring the implementation of federal policies, interacting directly with state Medicaid agencies through oversight of the state plan amendment process, Medicaid managed care contracting and rate setting, information systems design, and states' claims for federal financial participation. Regional office staff also help to convey policy information from the central office to state officials and advise the central office based on their direct interactions with the states.

Obstacles Facing States and the Federal Government

Meeting these broad statutory, regulatory, and efficiency demands requires funding, staff, data, technology, and systems to support operations and innovation, and leadership to provide ongoing oversight. At MACPAC's January 2014 meeting, state Medicaid directors and policy experts described how administrative capacity constraints can limit states' ability to meet program requirements such as eligibility determination timeliness and claims payment accuracy and can hinder their ability to be more proactive in activities such as oversight, quality, outreach, and analytics (Griffin et al. 2014). They also noted that while Medicaid has undergone significant changes and that the pace of change continues to quicken, little attention has been paid to the effort needed to take advantage of opportunities to evolve and expand. Moreover, state Medicaid program administrative costs (shared by states and the federal government) have remained relatively constant at about 5 percent of total Medicaid spending.[1] State Medicaid directors speaking at the January meeting identified a variety of barriers to developing and maintaining Medicaid administrative capacity, as described in the following sections.

Financial constraints

State disincentive for administrative spending. From a budget perspective, one of the biggest challenges for states is how to finance the growing demand for health care services while still making needed investments in other areas such as education and transportation (NASBO 2014). Nearly all states are required to balance their budgets, so greater spending on Medicaid requires either less spending on other activities or additional revenue; similarly, greater spending on Medicaid administrative activities is often offset by less spending on Medicaid services. The zero-sum

nature of state budget decisions creates a powerful incentive for state agencies to limit spending on program administration.

Federal disincentive for administrative spending. In addition, the structure of the federal match for program administration exerts added downward pressure on Medicaid administrative resources, particularly in states where the federal medical assistance percentage (FMAP) for health care services is much greater than the matching rate for administration (50 percent for most activities).[2] At a 50 percent matching rate, every dollar a state spends on Medicaid administration is matched by a dollar of federal money, but in the 37 states that receive greater than 50 percent match for services, every dollar a state spends on services is matched by more than a dollar of federal money. In Utah and South Carolina, for example, which have matching rates over 70 percent, every dollar spent on medical care is matched by over 2 dollars in federal money (HHS 2014).

Most states can maximize the federal funding they can draw down to support Medicaid (and thereby maximize the total budget available for Medicaid) by prioritizing spending on services, not administration. During times of economic stress, states can maximize federal support by cutting spending on administrative expenses (which result in a dollar of federal funding lost for every state dollar cut) instead of services (which in most states results in more than a dollar of federal funding lost for every state dollar cut).

Increasing system demands and complexity

More delivery system and payment options. Over the decades, the Congress has significantly expanded the populations and services states can cover and the delivery and payment systems they use. New options provided to states in recent years include the flexibility to provide an alternative benchmark benefit package, implement Express Lane Eligibility for children, enroll low-income pregnant women in CHIP, cover family planning services as a stand-alone benefit, provide health homes for enrollees with chronic conditions, and form pediatric accountable care organizations (MACPAC 2013a). The Congress has also mandated new program requirements, such as the requirement to increase payments for certain primary care services to the Medicare payment rate for 2013 and 2014. While new options and mandates provide attractive opportunities for states, the administrative requirements for participation in both mandatory and optional activities are added to already competing priorities and capacity constraints.

Tracking and reporting. For state staff, such opportunities almost always mean additional responsibilities, which are often absorbed into existing workloads, according to state Medicaid directors (Griffin et al. 2014). In addition, they often mean that states must devote additional resources to recordkeeping, financial reporting, and audit support to comply with federal spending rules. This is particularly true when optional programs include enhanced federal matching funds. All expenditures associated with programs with a special federal matching rate must be tracked and reported separately so that the appropriate amount of federal funding can be drawn down and so that federal auditors can ensure that enhanced funds are provided only for spending on services and activities entitled to the higher matching rate (Table 4-1). As a case in point, to supplement the rule and state plan template that states must follow to implement the temporary Medicaid primary care physician payment increase, CMS has had to issue eight sets of Q&As to guide states in appropriately tracking and documenting requests for additional federal matching funds (CMS 2014a).

State Medicaid directors told MACPAC that these administrative requirements factor into the

TABLE 4-1. Examples of Programs with Different Federal Matching Rates

Program	Enhanced Matching Rate	Citation
Primary care payment rate increase up to the Medicare payment rate for primary care services furnished by a physician with a primary specialty designation of family, general internal, or pediatric medicine	100 percent for expenditures attributable to the amount by which Medicare exceeds the Medicaid payment rates in effect on July 1, 2009, available in calendar year (CY) 2013 and CY 2014	P.L. 111-148, as amended; §1902(a)(13)(C) of the Act
Health homes and associated services to certain individuals with chronic conditions	90 percent, available for the first eight quarters that the health home option is in effect in the state	P.L. 111-148, as amended; §1945(c)(1) of the Act
Community First Choice initiative to provide home and community-based attendant services and supports for certain individuals at or below 150 percent of the federal poverty level, or a higher income level applicable to those who would otherwise require an institutional level of care	Six percentage point increase in the federal medical assistance percentage (FMAP), available as long as an approved state plan amendment is in effect	P.L. 111-148, as amended; §1915(k)(2) of the Act
Competitive Balancing Incentive Payment Program for states in which less than 25 percent or 50 percent of Medicaid expenditures for long-term services and supports (LTSS) are non-institutional and that implement a plan to increase the percent of expenditures that are for non-institutional LTSS	Two or five percentage point increase in FMAP for non-institutional LTSS depending on baseline, available from fiscal year (FY) 2011 through FY 2015	P.L. 111-148, as amended
Money Follows the Person (MFP) Rebalancing Demonstration to provide grants to states to transition individuals from institutional to community-based LTSS	MFP-enhanced FMAP equal to the state's regular FMAP increased by a number of percentage points equal to 50 percent of the number of percentage points by which the regular FMAP is less than 100 percent, not to exceed 90 percent FMAP, available (through competitive grants) beginning in FY 2007	P.L. 109-171, as amended by P.L. 111-148
Electronic medical records incentives for provider adoption of electronic health records and state administrative expenses related to such incentive payments	100 percent federal financial participation for payments to eligible providers and 90 percent for state administrative expenses, available to providers for a six-year period beginning no earlier than 2011 and no later than 2016	P.L. 111-5; §1903(a)(3)(F) of the Act

Source: MACPAC analysis.

decisionmaking process for new programs. In a presentation to the Commission, the Medicaid director for the state of Maryland described seven temporary or optional program changes in his state with enhanced federal matching rates: the Medicaid expansion for low-income adults, the temporary increase in payment for primary care services provided by primary care physicians, the Community First Choice initiative, a health home initiative, the Competitive Balancing Incentive Payment Program, the Money Follows the Person initiative, and certain eligibility worker activities associated with implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (Milligan 2014). The state chose to implement many of these programs in part because of the availability of enhanced federal matching rates even though this created considerable demands on the agency to appropriately track and allocate costs and then support responses to multiple federal audits.

Complex compliance requirements. The compliance requirements can be particularly complex when administrative staff support multiple programs or activities that have different matching rates, or when programs overlap or have similar structures. States must be able to track and document staff time and costs at the activity or task level so that they can be applied to the correct program. For example, a state can receive 75 percent federal match for certain eligibility activities, but not for outreach prior to enrollment or for post-eligibility activities such as managed care choice counseling. To appropriately claim federal match, states must allocate the cost of individual workers among these various activities.

The Congress has also expanded the demands on state agencies; for example, the ACA requires states to develop new eligibility policies and systems to improve the accuracy and timeliness of eligibility determinations, and it also requires states to submit additional data to support program integrity, program oversight, and administration. Some of these new federal requirements include provisions to support their implementation. For example, states may receive 90 percent federal match for the design, development, and implementation of new eligibility policies and systems through 2015 and are exempted from federal audits of eligibility systems for three years (CMS 2013a, CMS 2012a). Other new provisions create demands on top of existing requirements. For example, in response to ACA provisions regarding Medicaid data, CMS has published requirements for states to submit a Transformed Medicaid Statistical Information System dataset (T-MSIS) that includes hundreds of additional data elements (CMS 2013b). CMS is providing technical assistance to states but has not exempted states from complying with existing data reporting requirements during the T-MSIS implementation period.

The federal government also designates administrative, coding, and system requirements for insurers and requires Medicaid agencies to comply with these standards. For example, in 2009, HHS published a final rule adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding (HHS 2009). The final rule noted that the transition from the current ICD code set to the new code set was anticipated to cost the Medicaid program over $300 million, which would be shared between the federal government and states. States commented that the implementation of ICD-10 created short- and long-term costs and put stress on safety net payer systems that were already under duress (HHS 2012). The transition to ICD-10 is one of several national administrative data requirements that state Medicaid programs are currently in the process of implementing; others

include new provider enrollment requirements, implementation of a standard unique health plan identifier, and additions to the national provider identifier requirements.

Changing role of state Medicaid staff

Need for greater technical expertise. Historically, many state Medicaid staff have been responsible for insurance functions such as claims examination, identification of third-party liability, and audits of provider cost reports. Today, some of these activities are becoming automated or replaced by more analytical processes that require fewer or more targeted personnel, including staff with more sophisticated knowledge and skills than were previously required. For example, some states have implemented prepayment predictive models that can identify those claims most likely to be in error through statistical analysis, reducing the need for manual review of low-risk claims. At the same time, as these systems become more sophisticated, state Medicaid staff may require new skills to take on additional responsibility for contract oversight, data analytics, information technology systems development, and implementation of delivery system reform efforts.

The Medicaid Information Technology Architecture (MITA) initiative, a multiyear federal effort designed to improve the administration of the Medicaid program by integrating business and information technology across the Medicaid enterprise, identified human resources as a key element of system change (CMS 2006a). As the supporting information systems are modernized and integrated, Medicaid agency roles can change from performing operations that require a large administrative staff to those that require executive management and smaller professional teams who have the expertise and experience to understand and use timely and actionable data.

Staff attrition. State Medicaid agencies need high-level analytic, financial, and clinical expertise to implement and oversee these modernized systems, yet they struggle to attract and retain staff with the necessary qualifications. There is tremendous labor market competition for people with this expertise, so states often find that while they are able to attract high-quality staff interested in public service and the opportunity to work on issues such as health reform, many will leave state government for more lucrative private-sector opportunities. In 2013 and 2014, nearly a third of states experienced vacancy rates of greater than 10 percent for funded positions (NAMD 2014). Medicaid agencies are also subject to statewide hiring freezes and furloughs, and, like many government agencies at the state and federal levels, experience brain drain as seasoned program leaders retire from public service. While Medicaid leadership positions are not political appointments in all states, both leaders and staff frequently turn over when there is a change in administration. The median tenure for state Medicaid directors is just three years (NAMD 2014). High turnover at both leadership and staff levels compromises the ability to sustain focus and achieve larger program goals.

Inflexible civil service rules. State civil service rules that apply to many public employees can also create challenges when job classifications are not calibrated to reflect the level of responsibility in a Medicaid agency or the higher level of private market competition for these types of expertise. For example, the defined roles and responsibilities (and pay scale) for a contract manager position may be sufficient to support the contract oversight needs of some state agencies but not Medicaid, where individual vendor contracts can exceed $1 billion per year. Furthermore, collective bargaining agreements may require Medicaid agencies to negotiate before reconfiguring job descriptions or caseloads. This can make it difficult for states to reassign staff quickly when programs demand change; for example, a

state may be unable to task eligibility workers with additional outreach and choice counseling activities even if automation has replaced many of the eligibility verification checks and calculations that were previously their responsibility.

Need for training. State Medicaid directors who spoke to the Commission stated a need for leadership development for senior leaders and for additional training for managers and staff to improve both performance and retention (Griffin et al. 2014). This training is needed to support the modernization of the Medicaid program, as new initiatives often share the common goal of moving away from paper-based, compliance-focused processes to person-centered and automated processes. This change is occurring across all aspects of the Medicaid program, from eligibility streamlining to proactive program integrity to long-term care system rebalancing. Changes that rely on staff to apply more analysis, judgment, and autonomy also require more highly skilled staff and, thus, more training. Where new initiatives seek to integrate multiple programs and processes, staff from legacy programs may need basic training in Medicaid program requirements.

In some cases, the federal government has been able to provide training resources to support states. For example, to help improve the effectiveness of state efforts to update fraud, waste, and abuse reduction practices, CMS partnered with the U.S. Department of Justice (DOJ) to form the Medicaid Integrity Institute (MII), which provides training to hundreds of state staff each year (MII 2014). For most new initiatives, states must develop additional capacity internally.

Federal capacity constraints. Administrative capacity at the federal level is also challenged by a combination of budget constraints, staff attrition, and the changing nature of health care program oversight. For example, while states increasingly use capitated managed care programs to deliver and pay for Medicaid services, with payments subject to actuarial soundness rules, CMS does not have actuaries in the regional offices who are responsible for the initial review of capitation rates (GAO 2010).

Lack of administrative performance standards and measures

Few performance metrics. Medicaid's lean administrative costs are often cited as one of its virtues, but little is known about the appropriate level of investment in program administration and where this would do the most good. States must individually develop the capacity to effectively administer the Medicaid program—and to respond to changing demands and opportunities to innovate—without clear performance standards or metrics to judge the effectiveness of specific investments. Without evidence to support greater investment in administrative resources, states may struggle to identify and correct performance gaps or to justify spending on new initiatives (Griffin et al. 2014).

The performance of some Medicaid administrative activities can be measured and this information used to justify additional investments. Program integrity is an example of an area where results can be quantified and the information used to support greater spending, as states and CMS can measure the increase in the amount of overpayments identified and collected through enhanced program integrity activities and calculate a return on investment for these efforts. For example, during a five-year period, the federal government spent $7.2 million on the MII, and states reported more than $31 million in overpayments, cost avoidance, and budget reductions resulting from this training (Box 4-4) (CMS 2013c). This return on investment in the MII has been recognized by states, the Congress, and the GAO and used to support its continued funding.

Short-term outlook for investment. Lack of outcome data for other administrative functions may result in less emphasis being placed on these activities or bias investment toward activities with short-term, quantifiable returns. In the case of the MII, $31 million is significant compared to the amount spent on training, but small compared to over $400 billion in annual Medicaid benefit spending (MACPAC 2014). A lack of comparable return on investment information on activities with indefinite returns (e.g., implementing stronger up-front management controls, more efficient payment mechanisms, and strategies to promote evidence-based care) may lead to underinvestment in these activities, even though they could also strengthen the integrity and effectiveness of the Medicaid program.

Lack of accreditation standards. Accreditation is used in other health care activities to gain consensus around standards of quality and improvement, recognize high performers, and demonstrate accountability. Health plans can obtain accreditation through the National Committee for Quality Assurance, which has developed performance standards in several areas of health plan operations (e.g., quality management and improvement, utilization management, member rights) and a process for assessing and reporting plan performance against these standards (NCQA 2014). State and local public health departments can be accredited through the Public Health Accreditation Board, a non-profit organization that has developed standards and measures that reflect domains relevant to public health agencies, such

BOX 4-4. The Medicaid Integrity Institute: A Model to Develop State Capacity

The Medicaid Integrity Institute (MII) is one of several initiatives developed as a result of the Deficit Reduction Act of 2005 (P.L. 109-171), which established the federal Medicaid Integrity Program, appropriated funding for Medicaid program integrity activities, and directed the Secretary of the U.S. Department of Health and Human Services to provide education and training for state program integrity staff (§1936 of the Act).

The MII was created in 2007 as a partnership between the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Justice (DOJ), which shares responsibility for investigating health care fraud and operates a professional training facility. The MII provides no-cost training to state staff, focusing primarily on employees from Medicaid program integrity units. Between fiscal year (FY) 2008 and FY 2012, CMS spent $7.2 million to operate the MII. Over that five-year period, more than 3,300 state staff attended 82 courses on topics such as fraud investigation, data mining and analysis, and case development. States self-reported more than $31 million in identified overpayments, recovered overpayments, disallowances, avoided costs, and budget reductions resulting from participation in the MII, for an estimated return on investment of as much as 431 percent.

The MII has been widely cited as a model for state capacity development. The U.S. Government Accountability Office reported that the modest spending on the MII enhanced states' capabilities in program integrity. The National Association of Medicaid Directors also reported that the MII enabled state staff to more successfully identify fraud, waste, and abuse and make more efficient use of state and federal Medicaid funds. CMS and DOJ have announced plans to expand the MII by offering more classes, developing a credentialing program, and extending the reach of the MII to more participants through distance learning. The MII is expected to maintain its primary focus on fee-for-service fraud detection.

Sources: MII 2014, CMS 2013c, GAO 2012, NAMD 2012.

as community assessment, public education, and workforce development (PHAB 2014). However, no such entities exist for Medicaid programs, although some states have expressed interest in performance standards and accreditation programs, perhaps tied to enhanced funding that could be used to justify additional investments in state capacity (Griffin et al. 2014).

Misalignment of priorities and responsibilities

Conflicting responsibilities. Both federal and state Medicaid administrators face the sometimes conflicting responsibilities of quickly implementing required program modifications, providing access to necessary services, and assuring program integrity. At the state level, for example, program managers are often concerned with maintaining or increasing provider participation and therefore may prefer policy decisions that lessen administrative burden on providers and assure prompt payment. Program integrity managers, on the other hand, may prefer increased front-end assurance of proper payment, even at the risk of some delay as a result of verification.

Similar conflicts play out at the federal level. CMCS has primary responsibility for Medicaid policy and program development and a vested interest in disseminating policy guidance as quickly as possible to help states implement new requirements and keep funds flowing to the providers that are serving enrollees. At the same time, however, CMCS staff are also responsible for issuing regulations that are consistent with statutory requirements, reviewing states' payment policies to assure compliance with federal rules, and reviewing states' claims for matching funds. The deliberation required by these activities can be at odds with efforts to speed implementation and maintain state flexibility. Further, a number of other federal offices and agencies—including the CPI and the Office of Financial Management (OFM) within CMS, the HHS OIG, and the GAO—are responsible for examining the use of public funds and protecting the integrity of public programs. From the state perspective, the priorities of these various federal agencies can sometimes appear misaligned.

Administrative conflicts are likely to arise during times of significant and rapid program change, as has been the case recently with implementation activity related to the ACA. Among the most significant of these changes are the new requirements for states to determine Medicaid eligibility using automated systems and new income counting rules. CMCS invested millions of dollars to support state-level systems changes and published extensive policy guidance for states but deferred issuing detailed regulations on issues relating to program integrity (MACPAC 2014). The OFM, which manages the Payment Error Rate Measurement (PERM) program, elected to forgo measurement of Medicaid eligibility error rates for three years beginning in FY 2014 to give CMS and states time to develop and test new approaches to measure the accuracy of eligibility determinations (CMS 2013a). The OIG, however, has published a plan to begin conducting eligibility reviews in FY 2014 in order to determine the extent to which states improperly enrolled individuals in Medicaid programs and to estimate national enrollment error rates (OIG 2013).

Models and Strategies to Strengthen Administrative Capacity

CMS, states, and private organizations have developed a variety of strategies to strengthen Medicaid administrative capacity. These include methods to increase the effectiveness of existing resources, mechanisms to supplement state

resources, and ways to share costs with other states or other state agencies.

Increasing the effectiveness of existing resources

As noted above, state Medicaid programs—like many public programs—struggle with a mismatch between the skills of program staff and the evolving needs of the program, as well as labor market competition for staff that possess in-demand skills. Programs to help develop agency leaders and managers and improve both performance and retention have had limited reach but some success in helping to fill skill and leadership gaps in Medicaid agencies. CMS has also developed multiple strategies to promote cross-state information sharing and provide technical assistance.

- **Medicaid Integrity Institute (MII),** developed and funded by CMS in collaboration with DOJ, provides ongoing training for state Medicaid program integrity staff, with the goal of raising national program integrity performance standards and professionalism (MII 2014) (Box 4-4). Since 2007, the MII has provided professional education to more than 3,300 Medicaid employees (CMS 2013c).
- **State Operations and Technical Assistance Initiative and Medicaid State Technical Assistance Teams** were developed by CMS to provide federal technical assistance to states on day-to-day operations and new initiatives, promote communication and information sharing with states, facilitate ACA implementation efforts, and support states in developing strategies to improve the efficiency of Medicaid programs in response to state budget challenges (CMS 2011).
- **Medicaid and CHIP Learning Collaboratives** were developed by CMS to facilitate policy and operational discussions among state and federal staff to address common challenges and pursue innovations in areas such as coverage, data analytics, value-based purchasing, and interfaces with the federally facilitated exchange. The collaboratives use virtual meetings to share ideas and documents, including technical assistance tools, state resources, and background materials (CMS 2014b).
- **Medicaid Leadership Institute (MLI),** a private initiative funded by The Robert Wood Johnson Foundation and directed by the Center for Health Care Strategies, was a 12-month fellowship program for state Medicaid directors that was designed to increase their substantive knowledge, strategic thinking, problem solving, technical, and leadership skills. Thirty Medicaid directors participated in the MLI program between 2010 and 2014, when funding expired (MLI 2014).
- **California Department of Health Care Services (DHCS) Academy** is a state-specific initiative funded by the California HealthCare Foundation to provide training for managers in DHCS. The curriculum focuses on core aspects of an effective, accountable program, including the basics of managing Medicaid, access to coverage and care, and delivery system innovation. Eight cohorts of 30 to 35 competitively selected staff will participate over four years.

Sharing resources among states

Traditionally, states developed Medicaid policies, operational procedures, and systems independently, even when responding to the same federal requirement or implementing a program model used by another state. Regular federal funding for information systems and policy development was previously available to each state, such that the federal government could reimburse multiple states

for the development of similar infrastructure. The development of individualized systems and programs limited each state's ability to easily use policies and processes developed by other states.

Partnerships among states. To support efficiency and cost-effectiveness, states have begun to develop ways to partner with each other to share information, resources, and technology assets. Some states have formed organizations to foster collaboration. For example, the six New England states and the University of Massachusetts Medical School formed the New England States Consortium Systems Organization (NESCSO), a non-profit corporation that identifies collaborative opportunities (e.g., staff training), manages multistate projects (e.g., research on evidence-based procurement practices), and provides technical assistance to member states on policy and systems (NESCSO 2014). NESCSO is also developing a regional data warehouse with Medicaid Management Information System (MMIS) claims data to provide member states the ability to conduct timely comparative analyses using a shared data source (NESCSO 2014).

A small number of states have closely partnered to share information technology systems. Hawaii, which has one of the smallest Medicaid programs, has contracted with the Arizona Medicaid program to provide MMIS hardware and software for nearly 15 years. Michigan and Illinois recently announced a partnership that allows Illinois to access Michigan's MMIS as a shared service, rather than implement a stand-alone system. The partnership will allow Illinois to acquire a modernized MMIS more quickly and cost-effectively than if it procured its own system, and it is expected to reduce Michigan's cost to operate and maintain the system by 20 percent (IGNN 2013).

Federal support for sharing systems. CMS has encouraged states to leverage other states' business processes and systems where possible and explicitly makes enhanced federal funding for eligibility system development projects contingent (among other requirements) on the development of systems that promote sharing, leveraging, and reuse of Medicaid technologies within and among states (CMS 2012b). CMS also maintains the Collaborative Application Lifecycle Tool, a secure website where states can obtain other states' system development documents, including business process models, templates for concepts of operations and other planning and development artifacts, business and technical requirements, requests for proposals, statements of work, and system design documents (CMS 2014c).

Leveraging other state assets

At least 15 states have contracted with state universities to provide policy and analytical support to the Medicaid program (Coburn et al. 2007). Six states, including Maryland, Massachusetts, and Ohio, have developed full-time partnerships between the Medicaid agencies and research institutes associated with their state university that provide various types of support, including data warehousing and analysis, policy research, program evaluation, workforce development, and provider training (Scott 2012). University-based institutes provide a link between policy experts and students, which may stimulate interest in Medicaid program administration as a career path. The direct involvement of university staff in Medicaid operations may also inform curriculum innovations that help future agency staff and leaders develop the skills needed by the Medicaid program.

These partnerships experience challenges, including tensions around the objectivity and independence of the university research center when working for Medicaid on a politically controversial or sensitive issue (Coburn et al. 2007). However, both Medicaid agencies and universities report that they benefit from a long-term relationship that can support the

identification of relevant research for the Medicaid program, as well as opportunities to leverage federal Medicaid funding (through contracts between the state Medicaid agency and the university) and private research funding (secured by university staff) to support Medicaid research initiatives.

Procuring external support

Under federal law, states can contract with external entities for most administrative functions, with the exception of enrollee outreach and enrollment (42 CFR 431.10, §1902(a)(5) of the Act). States can fill needs for highly technical expertise, short-term capacity demands, and ongoing staff support through consulting contracts or extensions to program support contracts. States commonly procure information technology support; 29 percent of programs have outsourced MMIS operations to outside vendors (NAMD 2014). Other areas for which states often procure support include program integrity, data analysis, managed care enrollment support, cost containment, call-center operations, program evaluation, and policy analysis.

It can be more costly (on a per hour basis) for states to hire external contractors to perform a task than to assign it to state staff, but in some cases it can be the more cost-effective approach. For example, federal rules require that managed care payment rates must be certified by an actuary (42 CFR 438.6), but between the high salaries commanded by actuaries (typically greater than public salaries) and intermittent demand for this expertise, most states find it more efficient to contract with an actuary, when needed. On the other hand, many states contract with long-term staff extenders to provide needed capacity when the agency is prevented (due to hiring freezes or labor rules) from directly employing or assigning the necessary staff. This approach can be more costly overall, as states generally pay contractors higher hourly rates than state employees and must reimburse travel and other expenses.

States that rely on contracting support for key program functions should have strong procurement and oversight capabilities and a variety of elements in place, including a well-constructed contract, multiple incentives (or disincentives) related to compliance, and clearly defined performance metrics. Effective oversight of these contracts also requires staff with adequate technical and management expertise to provide oversight and the authority to hold contractors accountable. However, a comprehensive review of Missouri's Medicaid operations found that oversight of contracted activities appeared limited as a result of staffing levels, skill sets, and a historical lack of institutional emphasis, and was further complicated by the fact that several Medicaid contractors were direct competitors and therefore required proactive state facilitation to ensure cooperation (The Lewin Group 2010). Recommendations for improvement included incorporating performance metrics such as key dates and activities into each contract and assigning a contract manager to each contractor to ensure adherence to contract terms (The Lewin Group 2010).

Streamlining information collection and support dissemination

In recent years, CMS has launched several initiatives designed to improve both the collection and dissemination of operational information for the Medicaid and CHIP programs, including:

- **Transformed Medicaid Statistical Information System (T-MSIS),** a data source that builds on existing person-level and claims-level MSIS data submitted by states to improve timeliness, reliability, and completeness;

- **Quality reporting systems,** systems to capture state-reported quality data based on measures developed by CMS as required by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and the ACA;
- **Business process performance indicators,** a new set of core indicators for Medicaid and CHIP developed by CMS that will focus initially on individual (applicant and enrollee) experience with eligibility and enrollment and provider experience with enrollment and claims payment; and
- **MacPro,** a web-based system designed by CMS to replace paper-based state plan, waiver, and other programmatic documents with a structured electronic data format, which will provide more consistent and comprehensive information on state activities for use by CMS, states, and analysts.

As noted in MACPAC's June 2013 report to the Congress, modernizing the systems that collect programmatic information on Medicaid and CHIP would help strengthen the administrative capacity of states and the federal government in several ways (MACPAC 2013b). CMS could strengthen its program oversight by providing consistent and comprehensive information on state activities, and states could more easily learn about the policy choices made by others as they consider their own program changes. Better data would help CMS reduce reporting burdens by directly calculating certain measures reported elsewhere by states and could also help CMS and states understand the effectiveness of different strategies. However, implementation of these initiatives, which requires both information system and business process changes, is a multiyear endeavor, and none has been fully implemented as of early 2014.

Federal funding for specific activities

The federal government provides additional funding to support specific administrative activities through two mechanisms: increased matching funds and dedicated funds. These additional funds may allow states to, for example, invest in delivery system reforms that create the potential for long-term savings, even if they incur immediate operational costs. At MACPAC's April 2014 meeting, Medicaid policy experts speaking about the Medicaid health homes initiative emphasized to the Commission that offering enhanced match is a good way to encourage states to implement new program options that they would not be able to otherwise consider given state resource constraints (Moses et al. 2014).

Enhanced matching funds. States can receive a 75 percent federal match for certain administrative activities, including several that require clinical or information systems expertise (e.g., work done by skilled professional medical personnel, survey and certification of nursing facilities, operation of an approved MMIS for claims and information processing, certain eligibility worker activities, performance of medical and utilization review activities or external independent review of managed care activities, and operation of a state Medicaid fraud control unit). States can receive a 90 percent federal match during the design and implementation phases of certain activities, including new information systems and new fraud control units and a 75 percent match to operate these systems. States are allowed 100 percent match for the implementation and operation of immigration status verification systems.

Dedicated funds. The Congress has periodically provided funding to assist with the design, implementation, and initial operation of a variety of administrative activities intended to improve the efficiency and effectiveness of state

Medicaid programs. For example, the Deficit Reduction Act of 2005 established the Medicaid Transformation Grants program to encourage states to adopt innovative methods to improve their effectiveness and efficiency in providing medical assistance under Medicaid. Funding of $150 million was appropriated for federal FY 2007 and FY 2008 (CMS 2006b). The ACA included funding to support the Adult Medicaid Quality Grant Program, a two-year program designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid through grants of up to $1 million per year over a two-year project period (CMS 2014d).

Next Steps for MACPAC

State Medicaid programs are required to "provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan" (§1902(a)(4) of the Act). There is a general consensus that, given the scale of responsibilities of the Medicaid program—which includes the provision of health coverage to over 70 million individuals as well as the management of over $450 billion in public money—state and federal policymakers should seek value and high performance as well as efficiency. However, there are few clear standards to assess efficiency, value, or performance in state and federal Medicaid program administration. There is also little strong evidence on best practices in Medicaid program management and decision making, particularly compared to other large-scale public programs such as education.

MACPAC's future work in this area will focus on learning more to inform two key questions: (1) how should administrative performance be measured and (2) what strategies are most effective in helping states develop adequate capacity? We will focus on areas where Medicaid policy experts have identified critical needs: data analytics, staff development, and payment and delivery system reform.

Activities that will inform these questions may include a survey of the range of organizational models used by state Medicaid programs; a review of the performance metrics used by states, federal agencies, and private sector payers; and collection of the methods states use to assess the return on capacity-building investments. MACPAC will learn more about the strategies to strengthen Medicaid administrative capacity described in this chapter and how promising approaches can be better shared among states and with federal administrators and policymakers. We will also learn more about administrative standards, benchmarks, and methods used in other fields—such as information technology, employer-sponsored insurance, and public education—and look for opportunities to adapt to Medicaid those approaches that have worked well elsewhere.

Moving forward, the Commission will continue to focus on how to improve and modernize Medicaid at the state and federal levels, including reviewing administrative capacity, performance measures, and efforts to ensure accountability.

Endnotes

[1] MACPAC analysis of CMS-64 Financial Management Report net expenditure data. Excludes administrative activities that are exclusively federal (e.g., program oversight by CMS staff).

[2] The federal match for Medicaid administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal match. Those with a 75 percent federal match include compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency; pre-admission screening and resident review for individuals with mental illness or intellectual disability who are admitted to a nursing facility; survey and certification of nursing facilities; translation or interpretation services in connection with the enrollment of, retention of, and use of services by children of families for whom English is not the primary language; operation of an approved Medicaid Management Information System for claims and information processing; performance of medical and utilization review activities or external independent review of managed care activities; and operation of a state Medicaid fraud control unit.

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