PERSPECTIVE

University of Massachusetts Medical School
UMASS

The Dynamics of State University Participation in State Medicaid Administration

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Executive Summary

It is not uncommon for state university faculty to participate as part-time consultants in the administration of state Medicaid programs. However, rarely do state universities participate institutionally as public agencies in the administration of state Medicaid programs since the propriety, value and parameters of these engagements are usually not recognized.

Even in states where they flourish, collaborations between state universities and state Medicaid agencies are not well understood and suggest to some people an unlikely confluence of two worlds. The missions of state universities and state Medicaid programs differ, their institutional cultures differ, and their protocols differ. In all states, state universities are considered apart from other state agencies, sometimes to the point of not being thought of as state agencies at all. Yet, the appropriateness and benefits of state universities engaging in Medicaid administration have been well established by state universities and the state Medicaid programs that have worked together. In light of the challenges facing state Medicaid programs and what state universities can do for these programs, state universities contributing to Medicaid administration should be more recognized and more common.

Explanation and examples follow. Rounding out this discussion will be depictions of collaborations in three states: Maryland, Massachusetts and Ohio. Maryland's initiative spotlights analytic, program development and program evaluation services; Massachusetts' features clinical expertise; and, Ohio's dwells on workforce development. In all three states, the state university partner does far more for Medicaid than is covered here, but these examples suggest the breadth of what state universities can do.

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How and Why Universities Should Participate in Medicaid Administration

Federal Medicaid rules sanction the formal participation of state universities in the administration of Medicaid, and this participation is ever more valuable both to state Medicaid programs and to state universities. But to see this, one must read the rules with an eye to how states actually administer Medicaid—which is with the involvement of multiple state agencies—and one must grasp the relevance of state universities to what Medicaid administration now demands.

Under federal regulations, a state must designate a single state agency[1] to administer its Medicaid program. But in every state, this administration is never as singular as this requirement implies.

Medicaid serves poor and near poor mothers, children, seniors and people with profound disabilities. A common denominator for these populations is that each faces special challenges in obtaining and benefiting from health care. In every state, aid in addressing these special concerns comes in part from state health and human services "mission" agencies that disproportionately serve certain Medicaid populations: at risk mothers and children, seniors who are frail, persons who are seriously and persistently mentally ill (SPMI), or persons who are severely developmentally disabled (DD) or who are otherwise severely disabled.

State agencies, such as departments of public health, social services, mental health, youth services, aging, and developmental disabilities services, contribute to the administration of Medicaid in accordance with their expertise and purview, and federal Medicaid dollars are claimed for these contributions. Medicaid's sister health and human services agencies do not sign on to Medicaid to assist Medicaid administration. Their principal interest is funding for their own programs. Under Medicaid, the federal government matches state appropriations dollar for dollar or more for both services and administration. Such leveraging of federal Medicaid dollars for state programs and services became common by the early 1990s and has remained a legitimate mainstay of revenue maximization by states. In every state, Federal Financial Participation (FFP) has become crucial to funding state health and human services agencies. Participation in Medicaid administration came with the package.

When the single state agency is not an umbrella health and human services agency or the collaborating state agency is otherwise outside of the single state agency, federal regulations allow costs to be claimed for another agency's Medicaid administrative work under an interagency service agreement (ISA) with the single state agency[2] that details, in advance, the Medicaid administrative work that the external agency will do. This federal requirement for a written agreement and the latitude that it confers to claim FFP for participation in Medicaid administration pertain to all external state agencies that would contribute their focus and skills to Medicaid administration—including a state's public universities.

[1] 42 CFR 431.10

[2] 45 CFR 95.507(B)(6)

About the University of Massachusetts Medical School

The University of Massachusetts Medical School, one of the fastest-growing academic health sciences centers in the country, has built a reputation as a world-class research institution, consistently producing noteworthy advances in clinical and basic research. The Medical School attracts more than $255 million in research funding annually, 80 percent of which comes from federal funding sources. The mission of the Medical School is to advance the health and well-being of the people of Massachusetts and the world, through pioneering education, research, public service and health care delivery. Commonwealth Medicine, the Medical School's health care consulting and operations division, provides a wide range of care management and consulting services to government agencies and health care organizations. For more information, visit http://commed.umassmed.edu.

In sum, it is common for state agencies other than the state Medicaid agency's Medicaid office to participate in the administration of a state's Medicaid program. There are federal rules that allow and guide this participation. These other agencies participate for the funding involved and to advance their missions, and their participation substantially increases the breadth and complexity of state Medicaid programs and the public resources available to Medicaid. The federal rules for engagement in Medicaid administration apply to state universities as they do to other state agencies, and as we shall see, for state universities, there are also financial advantages and opportunities to advance their mission by assisting in the administration of their state's Medicaid program. That state universities are not primarily in the business of providing health and human services is the paramount reason why the value of the universities participating in Medicaid administration is not obvious to state Medicaid agencies or to the universities, begging the question of what state universities can contribute. The answer is straightforward. State universities can share their principal assets, much as the state health and human agencies that participate in Medicaid administration do.

To a degree and in ways that state Medicaid agencies are not resourced or positioned to match, state universities can bring methodological rigor, subject, analytic and clinical expertise, and training capabilities to bear on tortuous issues of cost, access and quality in Medicaid.

Medicaid can be thought of as boot camp for health policy. Sojourning there is not time wasted for state universities in light of their interests in improving their clinical, translational, health policy or health administration research. Participation also furthers the interest of universities in training health researchers and educators as well as the health care workforce: physicians, clinical psychologists, nurses, pharmacists, social workers, techs, therapists, aides or health care administrators. Issues of cost, access and quality beset all parts of the health care system. But arguably, in light of the populations Medicaid serves, these issues have become tougher for Medicaid than for other insurers, and in that they have, any innovation that works well for Medicaid and its beneficiaries has purchase for other insurers and their beneficiaries.

Medicaid Renaissance

The 1990s saw a Medicaid renaissance in which states actively and at times enthusiastically assumed the initiative for setting the direction of their Medicaid programs. Hitherto, Congress was the driver, backed by the Center for Medicare and Medicaid Services (CMS)[3], the federal agency that oversees Medicaid. Every year or so, Congress would insert Medicaid tweaks and expansions in an omnibus bill. CMS would interpret them, summon its regional staff to its central office in Baltimore for training, and they, in turn, would train state Medicaid staff on what was expected of them. All of this changed in the 1990s. In a number of states, governors stepped up and sent comprehensive plans to

[3] Then called the Health Care Financing Administration (HCFA).

Although most state Medicaid agencies turned to consultants for help, some turned to their state universities, and more should have. Any listing of the competencies involved shows the potential value of state universities as a source of these competencies.

Baltimore on what they wanted to do with their Medicaid programs. When CMS ruled and instructed, states now pushed back, and the federal/state balance for Medicaid administration was forever changed.[4]

The spur to this shift of initiative to the states was the states' burgeoning concerns with cost, access and quality in their Medicaid programs. Far and away, cost was and remains the biggest factor. From a supplement to various cash assistance programs, by the 1990s, Medicaid had become the first or second biggest and fastest growing state expenditure in every state. Governors became obsessed with bending Medicaid's cost curve. But by the 1990s, it was also becoming evident to governors and others that enrollment in Medicaid did not ensure either access to health services or their quality. All too often, Medicaid beneficiaries could not find or get to providers willing to accept Medicaid. All too often, the services Medicaid beneficiaries received did not fully meet their health care needs. Finally, twenty years of experience with Medicaid had shown the fundamental limits to quality of life for people confined to institutional care.

The lure for the states lay in the prospects of managed care, and home and community based care for addressing problems of cost, access and quality. Harkening back to the Health Maintenance Organizations of the 1970s, states saw managed care not only as a means of cost control but also as a means of ensuring that beneficiaries received the care they needed. Similarly, states saw home and community based services both as less expensive than institutional care and as a means of improving quality of life by enabling disabled and frail Medicaid beneficiaries to live and, at times, work in the community.

To pursue either managed care or home and community based services, states had to submit elaborate proposals to CMS since, under standard Medicaid law, states could not limit beneficiaries to services arranged by managed care organizations (MCOs), and most home and community based services were not coverable. Waivers were required for either approach.[5] Developing waiver proposals and negotiating them with CMS required financial, clinical, programmatic and analytic capabilities that were typically in short supply within state Medicaid agencies. Although most state Medicaid agencies turned to consultants for help, some turned to their state universities, and more should have. Any listing of the competencies involved shows the potential value of state universities as a source of these competencies. Over time, CMS eased the elaboration required in waiver submissions, and Congress eliminated in some instances the need for waivers. But by that time it had become evident to states that, to be successful, Medicaid reforms required great skill and care in planning, execution and evaluation.

[4] The recent U. S. Supreme Court decision (NFIB v. Sebelius) on the constitutionality of the Affordable Care Act strengthened this shift by establishing the right of states to refuse to implement a Congressionally mandated expansion of Medicaid eligibility.

[5] Either §1915B or §1115 of the Social Security Act for managed care waivers and §1915C for home- and community-based waivers.

For the universities, and particularly for public academic medical centers, Medicaid is a door through which they can approach the broader issues of health care reform, including the conditions of clinical practice, the organization of health care delivery and workforce needs.

*State universities should be **creators** of knowledge.*

Whichever Direction Health Care Reform Takes

Whether individual states favor or oppose the Affordable Care Act's (ACA) expansion of Medicaid, and almost no matter what comes in the wake of the ACA, states will retain broad responsibilities for Medicaid and the program will be a major influence on everyone's health care.

Should the ACA endure, substantial revisions of state Medicaid programs will likely continue to be sanctioned under the approach that evolved in the 1990s. States will propose plans to CMS, negotiations will ensue, and agreements will be reached. Developing state plans for reform, negotiating the details, executing the plans and evaluating the results will require resources that state universities can help provide.

Should Medicaid be block granted to the states, the call for assistance from state universities will be as great if not greater. States will have flexibility. They will not have to prepare refined plans for CMS's approval or detailed answers to CMS's detailed questions. But CMS's financial contribution to state Medicaid programs will be capped, putting states at greater risk for the costs of ill-advised, ill-prepared or ill-executed plans. State universities may be able to help to get it right.

For the universities, and particularly for public academic medical centers, Medicaid is a door through which they can approach the broader issues of health care reform, including the conditions of clinical practice, the organization of health care delivery and workforce needs. Familiarity with issues and competencies that a university gains in working with its state's Medicaid program are applicable to a host of institutions and stakeholders that are participating or will participate in health care reform: Medicare, private insurers, a full range of providers, health insurance exchanges (HIX), the agencies designing and implementing Health Information Exchanges (HIE), and state chartered commissions established to plan aspects or all of a state's approach to health care reform.

What Should State Universities Contribute?

What can state universities contribute to Medicaid? As stated above, they can bring to bear their principal assets. State universities are in the knowledge business. In serving Medicaid administration, they should be creators of knowledge, repositories of knowledge and conveyors of knowledge.

State universities should be creators of knowledge. In a 2007 monograph, *Improving Medicaid Policy Through State/University Research Partnerships*, Coburn *et al*. made a compelling case that both state Medicaid agencies and universities benefit from working together on program evaluations, analytics and research pertinent to the administration of Medicaid. In these examples, the state Medicaid agencies contributed funding, and access to data and subjects, while the universities contributed expertise, analytic skills and methodological rigor. State Medicaid agencies benefited from findings and insights that provided the

*State universities should be **repositories** of knowledge.*

basis for enhancing these agencies policies and practices, while the universities benefited from funding for their health policy institutes and opportunities to do publishable research.

States can no longer afford to maintain programs that do not work well for their intended purposes, that prove more expensive than they are projected to be, that work at cross purposes with other initiatives, that have unwanted side effects, or that actually do harm. The processes and consequences of every major initiative should be evaluated and the design for evaluation should be anticipated in the design of the initiative. When significant administrative tasks are outsourced to vendors such as MCOs and ASOs,[6] what they do and the results of what they do should also be evaluated.

The populations that Medicaid serves should be surveyed for what they need and for what works most effectively and efficiently in meeting these needs. They should be followed to see how they use services, and what obstacles impede their using them effectively.

This knowledge creation should be done objectively, with the requisite methodologies and rigor, and with proper respect for the rights and sensibilities of subjects. State universities can and should do this work.

State universities should be repositories of knowledge. They have expertise that is needed by state Medicaid agencies and also by other state health and human services agencies that work with Medicaid.

The knowledge requirements of effective state Medicaid administration are large and varied. State Medicaid programs must be operated in accordance with effective administrative practices. Major initiatives must be designed and implemented with a proper understanding of program design and program implementation. Outreach must be informed with the skills of this trade. Medicaid beneficiaries must be approached with an understanding of who they are and what their circumstances are. Systems should be developed with an understanding of informatics. Case management should be done with an understanding of how it is best done. The number of major clinical specialties and the range of questions on medical necessity and best practices that Medicaid receives are best handled by an interdisciplinary team of well-trained clinicians whose knowledge is current. Clinicians with the proper competencies and certifications should determine what is and what is not medically necessary and what is and what is not proper practice. When a class action suit goes against it, a state Medicaid agency typically needs a great deal of expert assistance in formulating and executing the court ordered remedy.

It is not practical to build all the knowledge necessary for Medicaid administration within Medicaid or other health and human services agency staff. Some of this knowledge is highly esoteric, the subjects are too varied, the availability of properly trained professionals is often limited and professionals can be particular in where they are willing to work and under what conditions. They may be willing to work for a university when they would not be willing

[6] Administrative services organizations.

*State universities should be **conveyors** of knowledge.*

to work directly for a state Medicaid agency. The pool of available experts also varies from state capital to state capital. State universities can field much of what state Medicaid agencies need, and do it from virtually next door. These are not experts who will be jetting home to the coast or to the hinterland. University teams may be housed at the university, embedded in the Medicaid or health and human services agency, domiciled out in the community, or some combination of the three.

In any given state, the state university would not be expected to set up shop for all the categories of expertise listed above. Doing so is unfeasible and unwarranted. Some concerns will be more pressing than others. In some areas, Medicaid and health and human services staff will be more than adequate for the tasks at hand. In others, vendors and consultants will make more sense in light of their availability, competence, price and other factors. But when the need is critical and enduring, and other options for addressing this need are nonexistent or unpromising, what a state university has, what it can build and what it can do are worth serious consideration.

State universities should be conveyors of knowledge. Medicaid administration requires training to enhance the knowledge and skills of Medicaid and health and human services staffs, and training of the administrative staffs of providers that work with Medicaid. State universities might do this training.
By addressing broader workforce needs, state universities can assist state Medicaid agencies in meeting their responsibilities for access to and the quality of Medicaid covered services. State Medicaid agencies' responsibilities for access and quality give them an interest in the workforce that provides services to Medicaid beneficiaries. Does this workforce have the needed distribution of professionals and other direct care workers both in terms of numbers and geographic distribution? Do the caregivers have the requisite skills? Are they conversant in the best practices of their fields and promising innovations in care delivery? Do they use health information technology effectively? The answer to each of these questions is sure to be at least a qualified "no."

Even now, every state has shortages of people trained and credentialed in the competencies necessary for providing the full range of covered services needed by its Medicaid beneficiaries. With the Medicaid eligibility expansions envisioned in the ACA, the shortages will become critical in many states, extending even to primary care. Especially for their own states, state universities are in the business of education that addresses the shortcomings in numbers, distribution, knowledge and skills of the workforce, including the health care and human services workforce that serves Medicaid beneficiaries.

Advantages

Working together offers multifold financial advantages to both state universities and their state Medicaid programs. Engagement with Medicaid can position the universities for federal grants, which can be used to support their mutual projects. Two other financial advantages accrue to state universities as public institutions, which private universities do not share.

For state Medicaid agencies, the benefits are straightforward. Increasingly, to administer their programs effectively, these agencies need capacities in data analytics, program evaluation and design, subject expertise and training that they do not have and cannot acquire internally.

Under federal rules, like other state agencies, state universities can put up some or the entire state match for the Medicaid administrative tasks that they perform. This is an advantage when the activity benefits the state university along with Medicaid. Counting in the FFP, which is inclusive of the university's federally approved indirect cost rate, the school benefits from the activity for half or less than half of its cost. The lure of FFP also advantages state universities in their pursuit of private sector funding. Since private foundation grants and *bona fide* donations count as state match, state universities can present the prospect to potential funders that their contributions can, in effect, be doubled. Revenue for a state university can be substantial from one or any combination of these approaches. In that this revenue comes from private sources and is used as state match, state Medicaid agencies benefit from their state universities' services without putting up some or all of the state appropriated dollars that would otherwise be required. Structured correctly, working with their state universities, as opposed to vendors, is almost always a better financial deal for state Medicaid agencies.

Being a state agency confers another advantage on both the universities and their states' Medicaid department. Like with other state agencies, Medicaid programs can usually procure services directly from state universities through the use of an Interagency Service Agreement (ISA), allowing greater flexibility as well as saving administrative time and effort. Such flexibility extends beyond establishing the initial agreement. State Medicaid managers must regularly redirect resources to emergent priorities. Private vendors are obligated to provide services only to the precise terms of a contract, the scope of which is typically multi-year. Even when the parties do their best to anticipate future needs, the unexpected is to be expected.

With a private vendor, state Medicaid agencies must negotiate even the willingness to make changes in a contracted scope of work. With a public partner, however, there are no procurement-related obstacles to moving resources to wherever they are needed. This public-to-public latitude is sometimes challenged by people who do not appreciate that their state's university is a state agency, but even though it has state appointed trustees, a state university is every bit as much a state agency as a state's department of mental health is, and a state department of mental health does not bid to provide mental health services to its state's Medicaid beneficiaries or to do the Medicaid administrative work associated with these services.

Programmatically, the advantages of partnership are mutually beneficial. For state Medicaid agencies, the benefits are straightforward. Increasingly, to administer their programs effectively, these agencies need capacities in data analytics, program evaluation and design, subject expertise and training that they do not have and cannot acquire internally. For state universities, the programmatic advantages are multifold. Access to data and subjects, and the funding opportunities that accompany this access promote research and publication. Scholarly research must be grounded to be trenchant, a condition that the grist of Medicaid supplies. Working with Medicaid hones the expertise of faculty. Working with Medicaid also provides training venues for students.

For collaboration to be successfully established requires time, effort and resiliency both at the university and at the state Medicaid agency. Chances of success are substantially enhanced when high-level administrators at both ends champion the collaboration.

Within the university, the administration of the collaboration is straightforward. The financial management of its work for state Medicaid agencies is common fare. Federal reimbursement under Medicaid is cost based, and arrangements between the Medicaid agency and other state agencies must also be cost based. Since cost accounting, record keeping and apportionment are required for their federal grants, state universities are well acquainted with Medicaid's requirements and well equipped to meet them. State universities, like all other public agencies, regularly execute memorandums of understanding or agreement (MOUs or MOAs) with other public agencies, which are just alternate names for the written agreements that federal rules require of Medicaid administrative collaborations.

Challenges

Since the needs to be met and the advantages to be gained in collaboration by both state universities and state Medicaid agencies are real, and the processes involved in establishing and maintaining collaboration are manageable, it would appear that the only factor barring university/Medicaid collaborations is a want of perceiving the obvious. But the reality is not so simple. George Bernard Shaw said: "England and America are two countries separated by a common language." The same might be said of state universities and state Medicaid agencies. The peculiarities of the university's administrative processes and mannerisms do not quite match the peculiarities of the Medicaid program's administrative processes and mannerisms. There can be differences over the uses of data, intellectual property rights and latitude to publish findings. There can be differences over timing, and the required level of effort. There will be misunderstandings and misperceptions. In the development of collaboration between a state university and its state's Medicaid agency, there are sure to be hiccups along the way.

For collaboration to be successfully established requires time, effort and resiliency both at the university and at the state Medicaid agency. Chances of success are substantially enhanced when high-level administrators at both ends champion the collaboration. Although a global written agreement for work with Medicaid may cover the whole university, successful collaborations should have a home within the university: a department or school that anchors and facilitates the university's work, and serves as interpreter for both the university and the Medicaid agency. Although the university's work should inform Medicaid policies and programmatic decisions, the university's professionals must not make or appear to make policy or politically sensitive programmatic decisions. The value of the university to Medicaid lies in its diligence, integrity, expertise and empirical objectivity. Most of all, the success of these partnerships depends on mutual respect.

For those of us who have worked at establishing these partnerships, it is not surprising that in states that have yet to experience the benefits, the two worlds might be tempted to stick to their respective cubicles. But everywhere that state universities and their states' Medicaid agencies have soldiered through, substantial benefits have ensued for both and for the public they both serve.

Each year, Hilltop and Maryland's Medicaid agency jointly develop a Memorandum of Understanding that details Hilltop's Medicaid administrative work for the coming state fiscal year (SFY), a lengthy list of analyses, evaluations and studies.

Examples

That establishing state university/state Medicaid agency collaboration is well worth the freight is perhaps impossible to convey abstractly. Among state agencies, keeping themselves apart is the default orientation. Ultimately, for both parties, believing in the advantages of collaboration can come only from seeing them directly. Since this presents a 'chicken and egg' problem for states that have not yet made the leap, the best we can do is to provide concrete examples from several states that have benefited and continue to benefit from these collaborations: Maryland, Massachusetts and Ohio. To varying degrees, these state universities provide all three classes of contributions to their state Medicaid agencies. The universities create knowledge, possess knowledge and convey knowledge. But currently each emphasizes and thereby exemplifies one of the three. For Maryland, it is analytics and the creation of knowledge; for Massachusetts, it is the provision of clinical expertise; and for Ohio, it is workforce training.

The University of Maryland Baltimore Campus (UMBC) Hilltop Institute

Partnering with Maryland's Medicaid agency, the Maryland Department of Health and Mental Hygiene, UMBC established The Hilltop Institute in 1994.[7] Its initial function for Medicaid was to provide case management services for high-risk Medicaid beneficiaries with complex care needs and high Medicaid costs. Over time, Hilltop's focus became knowledge creation: research, analysis, and evaluations in support of health policy decisions, primarily for Maryland's Medicaid program. Hilltop also provides policy consultation and technical support. Financial modeling and analysis are a forte of Hilltop, which does cost projections for HealthChoice, Maryland's mandatory Medicaid managed care program, and also, working with an actuarial firm, contributes analyses to development of HealthChoice's capitated rates.[8] Hilltop collaborated with Maryland Medicaid in the development of HealthChoice and continues to support the program with research and policy analysis. Hilltop has worked with Maryland Medicaid to develop pay-for-performance standards. Hilltop warehouses all of Maryland's Medicaid data.

Each year, Hilltop and Maryland's Medicaid agency jointly develop a Memorandum of Understanding that details Hilltop's Medicaid administrative work for the coming state fiscal year (SFY), a lengthy list of analyses, evaluations and studies. Below is an excerpt from Hilltop's 2011 annual report, which briefly describes 17 separate projects under the heading of Medicaid: Program Development and Policy Analysis. This report also includes ***HealthChoice: Program Support, Evaluation, and Financial Analysis***, which lists 13 projects, ***Long-Term Services and Supports: Program Development, Policy Analysis, and Financial Analytics***, which lists 21, ***Data Management and Web-Accessible Databases***, which lists 10, and ***IT Architecture and Platform***, which lists six projects. Maryland's Medicaid paid directly, approximately $2 million a year, for this substantial scope of work. Hilltop does not contribute state match or use private grant money as state match, although it is considering the latter, since the

[7] Initially called the Center for Health Program Development and Management.

[8] At the start of HealthChoice, Hilltop actually set its rates, but that proved controversial, and Hilltop stepped back.

Hilltop modeled the financial impact of ACA upon Maryland through 2020.

institute receives foundation funding. UMBC provides no direct budget support to Hilltop, but UMBC remits to Hilltop a portion of the proceeds of Hilltop's indirect rates.

The majority of Hilltop's revenue, which was $9.4 million in 2011, is received from Maryland Medical Assistance but its book of business extends beyond that. On a smaller scale than for Maryland Medicaid, Hilltop does similar work for New Mexico's Medicaid program. Hilltop serves as a subcontractor to various private research firms and has secured engagements with various foundations including the Robert Wood Johnson Foundation.

Perhaps most significantly, Hilltop provides a comprehensive array of professional supports to organizations that Maryland has established to implement health care reform: the Health Care Reform Coordinating Council (HCRCC), which Maryland's governor established in 2010 to guide Maryland's implementation of the Affordable Care Act, and also Maryland's Health Insurance Exchange. Hilltop modeled the financial impact of ACA upon Maryland through 2020. Hilltop has done a series of background papers and targeted analyses, provided staff support for meetings, and written grant applications. Hilltop continues to be engaged with the Maryland Health Benefit Exchange while the Exchange continues to complete its staffing and develop its implementation plan. Hilltop would not have been prepared for this role without its years of collaboration with Maryland Medicaid.

The following is an excerpt from Hilltop's 2011 report on its activities on behalf of Maryland Medicaid:

Medicaid: Program Development and Policy Analysis

- Prepared the tenth annual report for the Maryland Legislature on the Reimbursement Rates Fairness Act.
- Conducted a number of analyses on physician fees.
- Continued to support the Department in its efforts to expand eligibility for Medicaid to uninsured children and their families and to expand the benefits in the Primary Adult Care (PAC) program by analyzing various characteristics of those enrolled in the programs.
- Analyzed the number of fee-for-service (FFS) claims and managed care organization (MCO) encounters by hospital, and as a percentage of all hospital visits occurring in calendar year (CY) 2009.
- Analyzed the number of individuals who were enrolled in FFS Medicaid each month by coverage group in FYs 2007 through 2011, and analyzed the cost and service utilization for FYs 2008 and 2009 of these enrollees who were diagnosed with certain conditions.
- Analyzed all Medicaid enrollees in FY 2005 through FY 2009 with hepatitis by sex/gender, age group, race/ethnicity, and county of residence, as well as by type of hepatitis and whether they had received a hepatitis A and/or B vaccination.

- Continued to disseminate the findings from a study to evaluate the outreach process of the Kids First Act to determine whether the use of tax forms is effective in identifying and enrolling children who are uninsured but eligible for Medicaid or the Maryland Children's Health Program (MCHP) and published a second issue brief entitled Overcoming Interagency Data-Sharing Barriers: Lessons from the Maryland Kids First Act. Presented these findings before a national audience at the Academy Health Annual Research Meeting.
- Prepared quarterly analytic reports and an annual trends report for the Rare and Expensive Case Management (REM) program.
- Reported on Medicaid and MCHP enrollment and service utilization by pregnant women, infants, and children in CY 2010 to assist the Department in its application for the Maternal and Child Health Block Grant.
- Analyzed services provided to children enrolled in residential treatment centers (RTCs) during CY 2009 to determine the volume of non-mental health, non-RTC services provided to these children by service type, and the costs associated with the FFS claims for these enrollees; and analyzed RTC providers that served children enrolled in Medicaid in CY 2009, the number of services provided by each RTC, the unique number of children served by each RTC, and whether the RTC was located in the state of Maryland.
- Analyzed child Medicaid enrollees aged 0 through 18 years residing in Baltimore City—and then for all Maryland enrollees—who received treatment for asthma during CY 2007 through CY 2010, delineated the data by demographic information, summarized various types of utilization, and provided detailed claims-level information from the institutional, professional, and drug claims files.
- Performed a number of analyses to assist the Department in assessing whether the FY 2010 effort to identify and enroll eligible Baltimore City children in Medicaid had an effect on enrollment.
- Assisted the Department in its response to the 2010 Joint Chairmen's Report (JCR), which requires the Department to study and estimate the impact of various program changes to Medical Assistance and Children's Health Insurance Program (CHIP) and submit a report, by conducting the study and producing the report.
- Assisted the Department in its application to the Centers for Medicare and Medicaid Services (CMS) for the CHIP performance bonus by analyzing enrollment data of children aged 0 through 20 years who were enrolled in either Medicaid or MCHP, as well as the number of children aged 0 through 20 years who were enrolled in Medicaid only, for SFY 2010 and federal fiscal year (FFY) 2010, and SFYs 2007 and 2010 and FFYs 2007 and 2010.
- Conducted an analysis of the cost of habilitative services for individuals aged 19 to 64 years and 19 to 24 years with specific conditions for CY 2006 through CY 2009.
- Performed an analysis of the Medicaid X02 coverage group, which consists of undocumented or ineligible aliens, and their use of health care services in CY 2009.

For more than a decade, OCA has employed the MassHealth Chief Medical Officer and an interdisciplinary clinical team, which have performed all medical management functions for MassHealth.

- Improved the Decision Support System (DSS) by identifying new content areas to add, increasing functionality, adding new reports, and using WebFocus to develop new DSS applications, such as the Managed Reporting Environment (MRE), which is a user- friendly point and click graphical interface that has access to MMIS2 detail data.

The University of Massachusetts Medical School, Division of Commonwealth Medicine, Office of Clinical Affairs (OCA)

Perhaps uniquely among state university/state Medicaid agency collaborations, Massachusetts' started with several operations and their personnel moving from the state Medicaid agency to the University.[9] The initial moves occurred in the 1990s when Massachusetts Medicaid, known as MassHealth, was near the beginning of its large-scale transformation through the development and implementation of waiver initiatives. The motivation was a realization that some of the enhanced professional capabilities required would be better developed and maintained at the university in that the university has more flexibility and facility in recruiting professionals and offers a venue for them that affords separation from politics and the budgetary storms that periodically afflict the Medicaid agency. One of the first operations to move to the university was the Office of Chief Medical Officer, which has since become the Office of Clinical Affairs (OCA).

The office moved because it had become evident that a single physician and her support staff could not have the breath of clinical expertise that Massachusetts saw as necessary for the proper development and execution of the coverage and delivery system reforms that the state envisioned. Both the Massachusetts Executive Office of Health and Human Services (EOHHS)[10] and the University of Massachusetts saw the university's medical school as a more serviceable home for the office, not only because the school could better identify and recruit the necessary talent, but also because as part of the school, the office could draw seamlessly on the full breadth of the medical school's clinical expertise.

For more than a decade, OCA has employed the MassHealth Chief Medical Officer and an interdisciplinary clinical team, which have performed all medical management functions for MassHealth.[11] These functions include utilization review and management services, prior authorization, pharmacy benefit management, data analytics, dental benefit management, quality measurement and reporting, and clinical program development. The professionals and support staff of the OCA are all employees of the University of Massachusetts Medical School, and most have ties to other divisions within the school, but since it is integral to Medicaid administration, their office is embedded within the state's Medicaid agency.

In 2008, in the wake of Massachusetts' health coverage reforms, the state legislature directed the Secretary of EOHHS to initiate a patient centered medical home (PCMH) demonstration program. The program was to include Medicaid, but also all willing government and private payers.

[9] The University of Massachusetts Medical School has since built a number of additional operations from scratch.

[10] Massachusetts' single state Medicaid agency.

[11] Massachusetts' Medicaid program.

In many areas, Massachusetts' only public medical school brings to the task a unique depth of relevant experience and expertise.

The Secretary established a Council that included multiple payers, providers, professional societies, trade groups, advocates and others. This Council designed the initiative, including most critically, a common payment mechanism, the services to be provided by participating practices, and the principles of practice transformation. The majority of the state's private payers have joined the initiative along with MassHealth, as have all of its contracted managed care organizations, and the state employees' health insurance program. Forty-six primary care practices, distributed across the state, were selected as demonstration sites.

EOHHS turned to OCA to develop and execute an implementation plan. In addition to its own professional staff, OCA is relying on multiple academic departments, most prominently, the Department of Family Medicine and Community Health. The majority of practices selected for the PCMH initiative are community health centers, and the Department has long experience with working collaboratively with them. Other departments are also contributing relevant expertise. The Department of Psychiatry has a faculty member with national expertise in the integration of medical and behavioral health services. Other units within Commonwealth Medicine, the division of the school to which OCA belongs, are providing patient communication services, program evaluation, and patient and provider satisfaction surveys, including Consumer Assessment of Health Care Providers and Systems (CAHPS).

While most of the functions described below could be provided by one or more vendors, none would have the long established partnership with MassHealth or share its commitment not only to the state's Medicaid beneficiaries but also to all the residents of Massachusetts. In many areas, Massachusetts' only public medical school brings to the task a unique depth of relevant experience and expertise. It is also uniquely positioned because it is already an embedded partner, aiding in the ongoing administration of the Medicaid program. The University of Massachusetts Medical School is willing to commit some of its own resources to such efforts because there is a strong confluence of interests between the school and its state's Medicaid program in their commitment to the care of Medicaid beneficiaries, and to community health centers and other essential community providers. For some of these efforts (those that directly support the Medicaid beneficiaries), FFP can be claimed. But this is not a threshold question for the school. Rather, the school's involvement is motivated by the mutual interests described above, and by the opportunity to apply the school's knowledge assets toward the health and wellbeing of the people served by both the school and the state's Medicaid agency.

OCA together with its academic partners are performing the following functions:

Practice Coaching — Medical School coaches are visiting the PCMH practices on a rotating schedule to facilitate the formation of practice teams, guide the collection and interpretation of data, disseminate best practices, and help to maintain the adherence of the clinical practices to their transformation goals.

Quality Improvement — The Medical School is providing performance measurement, analysis and improvement strategies to the practices, including

Since the 1980s, The Ohio State University (OSU) has had a working relationship with Ohio's single state Medicaid agency, the Ohio Department of Job and Family Services (ODJFS).

techniques using Plan-Do-Study-Act (PDSA) cycles and workflow re-engineering. Construction and Operation of a Data Reporting System —Medical School experts are guiding the selection of measures, constructing the reporting system, aggregating the data on a monthly basis, and preparing reports for managers of the initiative and as feedback to the practices themselves.

Evaluation —The Medical School is applying its decades of experience in both quantitative and qualitative methods to the formal evaluation of this initiative as it unfolds.

Education and Training — Medical School faculty are preparing webinars and conducting multi-day training sessions for the practices, which are focused on the knowledge and skills required in becoming and operating as PCMHs.

IT Implementation — Medical School IT experts are consulting with the practices on how to best use their EMRs to collect and calculate the measures, to monitor progress, and to support other aspects of transformation.

Executive Leadership — The OCA's Chief Medical Officer for MassHealth serves as the executive leader of the overall initiative. This role has included extensive efforts to persuade various payers to participate, leadership of the governance body of the initiative (the steering committee), retention efforts at moments when participating practices have become discouraged, and mediation between the perspectives of practices and payers.

Project Direction and Management — The Medical School is providing experienced project managers to organize and facilitate the many separate tasks required of this initiative. In addition, the Medical School employs a nurse expert in process improvement to coordinate activities, to tend to all the needed memoranda of understanding and contracts, and to coordinate communication with all stakeholders and sponsors.

Ohio's Medicaid Technical Assistance and Policy Program (MEDTAPP) Healthcare Access Initiative (HCA)

Since the 1980s, The Ohio State University (OSU) has had a working relationship with Ohio's single state Medicaid agency, the Ohio Department of Job and Family Services (ODJFS). The collaboration was both small-scale and intermittent until 2008 when the Ohio Colleges of Medicine Government Resource Center (GRC) was established at OSU by the deans of Ohio's seven medical schools, six of which are public. GRC was established primarily to undertake health policy research for and provide technical assistance and fiscal services to ODJFS, but it serves other state and local agencies and private clients as well. Like Hilltop, GRC has its own staff of researchers, analysts and policy experts, but GRC primarily draws upon the professionals at the state's seven medical schools and thirteen public universities. ODJFS developed Ohio's Medicaid Technical Assistance and Policy Program (MEDTAPP) as the umbrella for the individual projects that the universities undertake at the request of ODJFS. Under the current contractual arrangement with ODJFS, GRC serves as a fiscal and administrative agent, and provides project development, procurement, and management services for MEDTAPP.

To augment existing ODJFS efforts to improve the quality and grow the availability of healthcare providers to serve Ohio Medicaid beneficiaries, particularly in the areas of Child and Adolescent Psychiatry, Geriatric Psychiatry, Pediatrics, Family Practice, Advanced Practice Nursing, and Dentistry, ODJFS launched the MEDTAPP Healthcare Access Initiative (HCA) in 2011.

This initiative provides federal Medicaid administrative match (FFP) to university-based workforce training programs to enable them to produce clinicians trained using innovative healthcare delivery models and committed to serve the Medicaid population. In the initiative's first 18 months, ODJFS will reimburse selected projects for up to $10 million in FFP used to train one thousand practitioners across the state.

Ohio Medicaid (ODJFS) does not provide the nonfederal match to support HCA. The selected applicant universities are responsible for providing match for their initiatives from their own sources, including other state funds, private foundations, faculty in-kind support, and university facility and administration costs.

FFP pays for eligible activities, including:

- "Program direct costs (e.g., salaries, stipends or benefits for Principal Investigators, faculty, residents, fellows, and students in their final years of training);
- Support for teaching, training, and technical assistance activities under this initiative for qualified faculty, residents, fellows, students in their final years of training, and MEDTAPP scholars dedicated to improving access to and quality of care for the Medicaid population;
- Support for curriculum development; and/or
- Planning costs associated with building and/or refining comprehensive health care access partnerships."[12]

The initial process for selecting workforce-training proposals was competitive. In November 2011, the GRC issued a Request for Proposals (RFP) to Ohio's universities. Ohio Medicaid selected fifteen programs at six schools. They are described below:

The University of Akron

- The College of Nursing will enhance family psychiatric nurse practitioner student and faculty training related to serving Ohio's Medicaid beneficiaries. This project will create easily accessible child/adolescent/family curriculum within the current Family Psychiatric Nurse Practitioner track of the College of Nursing graduate program, including intensive exposure to public sector agencies and interdisciplinary training models. Increased student exposure to public and community mental health providers serving the Medicaid population is expected to result in more post-graduation employment in these agencies.

[12] From the HCA RFP.

Efforts will focus on serving Ohio's underserved Medicaid and medically indigent populations, both in the context of training experiences and following completion of training.

Case Western Reserve University

- The School of Dental Medicine will create customized training curriculum, train and place an oral health patient navigator to serve Medicaid families, and place new dentists in settings serving Medicaid populations.
- The Department of Pediatrics will create Case Western Reserve University's Children's Access Now (CaseCAN) to rapidly expand the number of pediatricians and child health professionals serving Ohio's pediatric Medicaid beneficiaries. Trainees will work with multidisciplinary teams, integrating care of disadvantaged children within patient-centered medical homes and medical neighborhoods. All individuals in the program will participate in structured educational programming, experiential learning, and mentored support. The Department of Psychiatry will enhance existing programs with the addition of new faculty and unique curricular elements and clinical placement opportunities to help increase the number of psychiatrists serving Ohio's Medicaid beneficiaries. Efforts will focus on serving Ohio's underserved Medicaid and medically indigent populations, both in the context of training experiences and following completion of training.
- The Department of Family Medicine and the MetroHealth System, with support from the Urban Health Initiative (UHI), will serve as the central hub to coordinate the integration of primary care and behavioral health trainees into the Patient Centered Medical Home (PCMH) model by teaching trainees the fundamental principles of PCMHs, integrating them in to the interdisciplinary team-based approach of practicing health care, and developing their leadership skills to better serve the needs of the underserved Medicaid population. Training programs will foster integration across the continuum of medical education, from medical students to residents to faculty. Placement efforts focus on adding practitioners to serve in Northeastern Ohio's disadvantaged neighborhoods and community clinics.

Kent State University

- The College of Nursing will implement the Psychiatric Mental Health Family Nurse Practitioner education program. This program will prepare nurses to provide advanced and integrated physical and mental health care and treatment to individuals, families, and/or groups with complex psychiatric mental health problems. Curriculum content will emphasize the needs of the medically underserved across the lifespan and improvement of mental health outcomes for the Medicaid population.

The Ohio State University

- An interdisciplinary curriculum development, coordination, outreach, and oversight team will create interdisciplinary educational programs for graduate and undergraduate students focused on serving Medicaid and other low income populations. The two new programs will target graduate and undergraduate students in health- related disciplines and returning students currently employed in health care settings.

- The Departments of Psychiatry, College of Nursing, College of Social Work, and other partners will implement a new paradigm for educating professionals to provide behavioral health services to the underserved, including a lecture/forum series targeted at early engagement of undergraduate health professional, medical, nursing, and social work students; integration of psychiatric and physical health care; and development of an online Mental Health Services in Primary Care Settings Certificate Program.
- The College of Dentistry will provide dentistry fellows with specialty training and placements related to serving disadvantaged children and special populations. The College of Dentistry's MEDTAPP project will provide innovative training opportunities for future dental professionals related to nutrition and social determinants of health to assist them in dealing with the non-biologic factors related to dental disease and care compliance.
- The Moms2B Program will create non-traditional, community-based practice placement and precepting opportunities in impoverished neighborhoods for family, pediatric, psychiatric, and midwifery advanced practice nursing students, as well as medical, social work, medical dietetics, and nutrition students.
- The College of Nursing will establish a training center integrating primary and behavioral health care. Advanced Practice Nursing students, including Adult Nurse Practitioners, Family Nurse Practitioners, and Pediatric Nurse Practitioners, Psychiatric Mental Health Nurse Practitioners, Women's Health Nurse Practitioners and Nurse Midwifery students will be assigned clinical placements, where they will work with faculty preceptors and members of a health care team in delivering comprehensive, transdisciplinary integrated primary care. Undergraduate RN students and graduate advanced practice nursing students will facilitate health coaching for patients, especially those with chronic disorders.
- Ohio State University leadership will also focus on enhancing health care practitioner training partnerships with high volume Medicaid sites. Specifically MEDTAPP funding will support the creation of opportunities for many practice placement and learning experiences with Medicaid patients. Participants will include medical students and residents as well as nursing and social work students.

University of Toledo

- The Department of Psychiatry will enhance training and retention of health care providers to better serve Ohio's Medicaid population using new models of interprofessional care delivery. The Interprofessional Immersive Simulation Center TM (IISC) will focus on experiential learning through clinical simulation exercises specifically written for recovery-oriented, person-centered health care. Team members involved in this effort include psychologists; psychiatrists; advanced practice nurses; physicians in family medicine, medicine and pediatrics; physician assistants; other health care providers; medical students, residents, fellows, and graduate students.

Wright State University

- The Division of Child and Adolescent Psychiatry will expand residency and fellowship programs to accommodate additional practitioners trained and committed to serve Ohio's Medicaid beneficiaries. As part of this expansion, experts will enhance training and placement opportunities in community-based sites, thereby encouraging commitments to serve Ohio's Medicaid beneficiaries.
- The Departments of Psychiatry, Geriatrics, Community Health, and Family Medicine will implement a community-based collaborative medical education approach to provide a competent and caring workforce for an aging Ohio. This program will focus on serving Medicaid beneficiaries with physical and behavioral health disorders, including dementia and severe mental disorders. This approach will target all levels of medical education, from students through fellows.

Conclusion

Five years ago, no one would have thought the basic training of clinicians, e.g. advanced practice nurses, to be of sufficient centrality to state Medicaid administration to justify spending Medicaid administrative dollars to help support it. Yet clearly, if state Medicaid programs significantly expand Medicaid enrollment, and there are not enough clinicians to serve current Medicaid beneficiaries, state Medicaid administration has a problem that it cannot ignore.

In contemplating what they can and should do to assist their states' administration of Medicaid, state universities should think beyond the stereotypes of what Medicaid was and appreciate what it has become, and even more, what it is becoming and can become. State Medicaid administrators should be thinking in a similar vein in contemplating the value of working with their state universities.

The paradigm for State University/State Medicaid agencies working together has been well tested. It is decidedly achievable. Its value is demonstrable, and increasingly important in light of Medicaid's burgeoning perplexities, and the growing impact of Medicaid on all health care coverage and delivery.