FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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STAYING ON TOP OF HEALTH REFORM: AN EARLY LOOK AT WORKFORCE CHALLENGES IN FIVE STATES

EXECUTIVE SUMMARY

In the summer of 2010, states were intensely engaged in the first stages of work associated with the federal health care reform law, the Patient Protection and Affordable Care Act (ACA). ACA includes a major coverage expansion through Medicaid and new Health Insurance Exchanges, and much of ACA will be implemented by the states. While states were turning to ACA, they were still facing severe fiscal pressures related to the recession which have resulted in major cutbacks in programs and state workforce. To better understand the dynamics of the workforce challenges that factor in to the implementation of health reform, the Kaiser Commission on Medicaid and the Uninsured (KCMU) contracted with the Center for State and Local Government Excellence (SLGE) to examine the situation in five states (Connecticut, Michigan, Massachusetts, North Carolina and Washington) that represent a range of geographic and political experiences. Key findings from the study show:

Many states moved quickly to set up the broad planning structures needed to implement health reform, relying on collaboration and inter-department communication as well as outreach to key stakeholders. States passed legislation and governors established task forces, advisory groups, and health care cabinets (generally by executive order) to provide leadership and accountability for implementation of health care reform. In nearly all states, agency heads responsible for insurance, public and community health, and Medicaid are all playing lead roles. In our study states, Connecticut, Michigan, and Washington were among the dozen states that established health care cabinets by executive order within weeks of enactment of the ACA. Massachusetts, North Carolina and Washington reported that they have advisory groups that are dealing with different aspects of health care reform and are designed to bring more people into the process of planning for health reform implementation.

The state political environment and expected leadership transitions create uncertainties and are already factoring into state strategies on health reform implementation. With 37 states holding gubernatorial elections in 2010, many political appointees who are spearheading state efforts to implement ACA may leave state government in 2011. State legislatures could also experience significant turnover. Two of the states, Connecticut and Michigan face gubernatorial transitions and are moving at a faster pace to complete strategic plans for health reform implementation prior to elections. In Washington, the goal is to complete decisions related to the insurance aspects of health care reform before the governor's and insurance commissioner's terms end in January 2013. Washington officials are also planning to complete all the policy decisions related to the Health Insurance Exchange during the 2011–2012 legislative policy session.

States are concerned that there is not adequate staff capacity to carry out the volume of work within the fixed time frames under ACA. Many states have not completed a comprehensive workforce needs assessment, but all are concerned about their aging workforce, limitations of state hiring processes and salary schedules as well as the effects of the recession on the state workforce, particularly with the amount of work required to implement health reform. In general, states reported that despite possessing a high level of expertise to implement many aspects of ACA, there are too few staff to carry

out the broad requirements of health care reform within the established times frames. In some areas where states do not have considerable expertise, such as development and implementation of eligibility systems and Health Insurance Exchanges, they expect to tap consultants to supplement existing staff capacity. However, there is some concern that there will be competition for experts to assist states because all states are working under the same timelines. States are also using non-partisan institutes or other non-governmental agencies to supplement the state workforce. For example, The North Carolina Institute of Medicine is staffing the state's health care reform advisory committee and serving as a central information resource for the state.

Timely guidance and financial support from the federal government will help states successfully implement health reform. Even though many of the major coverage provisions in ACA go into effect in 2014, state officials say they need federal guidance as early as possible to be ready by then. States are waiting for federal guidance as well as templates or prototypes that can be used to shape approaches to specific aspects of the ACA like enrollment systems or designing Exchanges. Clear guidance, as well as opportunities for federal-state information sharing will help states move forward and prevent duplication of efforts. In a recent HHS conference call, several state staff stressed the importance of a "true partnership" between the federal and state governments, asking that information be shared freely, quickly, and broadly to maximize shared learning. States reported that federal funds will provide help, but they are challenged to find staff and contractors who can help write grant applications to access these funds. Most states have applied for $1 million grants given to states by HHS for planning activities related to setting up the Exchanges.

Key staffing challenges for health reform implementation are around designing insurance Exchanges, handling expanded enrollment for Medicaid and state Exchanges and updating eligibility systems. Most states are just beginning to think about their approach to a Health Insurance Exchange and one senior official called establishment of the Exchanges "the biggest workforce challenge of health care reform." In most states, administrative capacity for Medicaid is already very lean, and the Medicaid expansion and new requirements are expected to stretch that capacity even more so. Inevitably, a larger program will require additional staff. States also will need to evaluate their current eligibility systems for Medicaid and determine whether these systems can handle the new Medicaid expansion, effectively coordinate with the Exchange, and be updated to move toward on-line enrollment with sophisticated data matching capabilities. In many cases, health reform will necessitate new eligibility systems, which means that states need to start planning now because new systems take time as well as financial and staff resources to implement.

Looking forward, federal health care reform offers a chance to restructure Medicaid eligibility determinations and improve program operations. States are already rethinking their Medicaid structure and operations as they begin planning for program expansion under the ACA. For example, in its next legislative session, Washington plans to consider a proposal to move its Medicaid Administration out of the Department of Social and Health Services and merge it with its Health Care Authority. Michigan is considering moving eligibility determinations out of the Department of Human Services and into the Department of Community Health, which administers the Medicaid program, to help simplify the eligibility determination process and to facilitate integration with the insurance Exchange. Some state officials believe the focus on improving and expanding Medicaid and broadening access to health insurance as part of the Exchanges will improve overall health care in their states. North Carolina hopes to leverage an expanded Medicaid program to elevate the standard of care across the state. While states are in the early planning stages of thinking about health reform, January 1, 2014, looms as a challenging deadline. To be ready, states must engage in critical planning and preparation now.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. States are expected to play key roles in implementing both Medicaid and private insurance coverage changes. To make coverage more affordable, the law creates a new continuum of coverage pathways and provides assistance to individuals with family incomes up to 400 percent of the federal poverty level (FPL) by expanding Medicaid to a national floor of 133 percent FPL and providing subsidies to individuals between 133 percent and 400 percent FPL to purchase coverage through new Health Insurance Exchanges. The Medicaid expansion and Exchange coverage will go into full effect beginning in 2014; these provisions will provide coverage to an additional 16 million through Medicaid and another 16 million through the Exchanges by 2019 when the law is fully implemented.

States are largely responsible for implementing the Medicaid expansion and for establishing state-based Health Insurance Exchanges. For nearly all states, setting up a Health Insurance Exchange will be a new responsibility for which they have no previous experience. In addition, states will be responsible for transitioning to a new definition of income for Medicaid; providing for coordination in enrollment across Medicaid, CHIP, and Exchange coverage; developing eligibility and enrollment systems that are consumer-friendly and technology-enabled; developing adequate provider networks to serve Medicaid; and enforcing new insurance market regulations.

Economic and political uncertainties abound as states strive to make major changes in health care systems to meet the tight deadlines required by the ACA. While some states have begun to see modest improvements in tax revenues, most do not expect state revenues to return to pre-recession levels for at least two years. Federal financial support through the American Recovery and Reinvestment Act (ARRA) has helped state governments weather the economic storm. ARRA provided an estimated $87 billion in federal fiscal relief in the form of an enhanced Medicaid match rate for October 2008 through December 2010. This relief was extended through June 2011, although at lower levels than those originally included in ARRA. However, this relief is expected to expire as states enter state fiscal year 2012. As the economy recovers, states will need to address significant fiscal responsibilities that have been on the back burner, including unfunded pension liabilities, a backlog of needed infrastructure investments, as well as the new requirements included in ACA.

In addition to economic constraints, many states are facing major political changes. Thirty-seven states have gubernatorial elections in November 2010. Electoral changes mean that the leadership framework for health care reform implementation will change dramatically throughout the country. State legislatures and the U.S. Congress could also experience significant turnover. Forty-six states will hold legislative elections in 2010 with more than 6,000 state seats (83 percent of all legislative seats) up for election. Some aspects of federal health care reform will require state legislative action.

Since states are responsible for implementing many aspects of health reform, the Kaiser Commission on Medicaid and the Uninsured (KCMU) contracted with the Center for State and Local Government Excellence (SLGE) to better understand the dynamics of the workforce challenges that factor in to the implementation of health reform by examining the situation in five states that represent a range of geographic, political, and gubernatorial transition experiences.

RESEARCH METHODOLOGY

The five states selected for this study have political and geographic diversity and a range of experiences. Governors include both Democrats and Republicans, with some states experiencing political transitions while others will retain an incumbent. Telephone interviews with state officials from Connecticut, Massachusetts, Michigan, North Carolina, and Washington were conducted between July 12 and September 1, 2010. Individuals interviewed included public and community health agency heads, insurance commissioners, Medicaid administrators, finance directors, leaders of health care reform cabinets, and health policy experts. The interviews explored state plans for managing health care reform implementation and probed the types and extent of workforce challenges anticipated in light of expanding health care responsibilities, as well as state budget issues related to the recession. The interviews with Massachusetts officials focused on what lessons might be learned from that state's experience with implementation of its state law, including how it set up a state Exchange for consumers to shop for health insurance.

In addition, this report includes state responses to an on-line workforce survey of the members of the International Public Management Association for Human Resources (IPMA-HR) and the National Association of State Personnel Executives (NASPE). The survey was conducted by the Center for State and Local Government Excellence (SLGE) in November and December 2009 and focused on workforce changes, unfilled positions, the timing of retirements, and changes to retirement plans and benefits. Additional comments from state members of IPMA-HR and NASPE members were gathered in July and August 2010.

FINDINGS

The in-depth interviews with officials in the five target states probed action strategies, progress to date, and major challenges they are facing. Although the five states are at different stages, they are all driven by the same ACA requirements and deadlines. Some key findings are highlighted below.

1. Many states moved quickly to set up the broad planning structures needed to implement health reform, relying on collaboration and inter-department communication as well as outreach to key stakeholders.

Because of the scope and complexity of the ACA, many governors and state legislatures moved quickly to set up the infrastructure for carrying out the new law. Their actions included passing legislation related to implementing the federal law and establishing task forces, advisory groups, and health care cabinets, generally by executive order, to oversee program planning. As of mid-August, eight states had created legislative committees to study the federal law and monitor progress, and 19 had established health care cabinets or advisory groups made up of senior state employees. Some states are relying on existing structures such as the Delaware Health Care Commission, established in 1990, and the Oregon Health Care Authority, established in 2009, to focus on the federal health reform law.[1]

These entities have similar charges, including providing leadership and accountability for implementation of health care reform; analyzing the federal law and its implications in the state; developing strategic work plans; coordinating across state agencies; monitoring federal grant opportunities and regulations; providing transparent access to information; assessing workforce capacity and training needs, both within the state government and in the health care and insurance industries; and recommending executive and legislative action to implement the ACA. While the makeup of the entities varies depending on where specific functions affected by health care reform are housed, agency heads responsible for insurance, public and community health, and Medicaid are

all playing lead roles. Some states have separate advisory boards to focus on specific issues in health reform and to bring non-government stakeholders into the implementation process.

In our study states, Connecticut, Michigan, and Washington were among the dozen states that established health care cabinets by executive order within weeks of enactment of the ACA. Massachusetts, North Carolina, and Washington reported that they have advisory groups that are dealing with different aspects of health care reform and are designed to bring more people into the process of planning for health reform implementation. Some more detail on the structure set up around health reform in the study states follows:

Connecticut. The work of Connecticut's Health Care Reform Advisory Board, which was created in July 2009 in anticipation of federal legislation, laid the groundwork for the Health Care Reform Cabinet by analyzing the bill immediately upon passage and making recommendations on how to tailor it to Connecticut programs and needs. The Connecticut Health Care Reform Cabinet is made up of the commissioners/top deputies from the departments of Economic and Community Development, Developmental Services, Public Health, Mental Health and Addictive Services, Revenue Services, Social Services (where Medicaid is housed), Insurance, Information Technology, and Children and Families. It has three workgroups that are focusing on what state leaders consider the most pressing issues — communication and outreach, funding opportunities, and creating the Health Insurance Exchange. More specifically, through the Executive Order, The Health Care Reform Cabinet was tasked with:

- Providing transparent access to information;
- Assessing insurance market reforms needed to prepare Connecticut for final implementation of national health reform in 2014;
- Developing a plan to pursue federal funds for a temporary high-risk health insurance pool;
- Creating a Health Insurance Exchange that will: create a website where small business owners and individuals can find a comparison of insurance policies including costs incurred and benefits provided; provide a point of access for all eligible residents and businesses to choose their insurance; and be structured to promote the highest quality and most cost-effective health care providers and insurers.
- Pursuing federal funding and/or foundation funding opportunities to assist in developing the Exchange and implementing any other aspects of health care reform.[2]

On behalf of the Cabinet, the Department of Public Health is required to launch and regularly update a website that will provide Connecticut residents with information about national health care reform, the phases of implementation and how changes may benefit them.

Massachusetts. Massachusetts adopted state health care reform in April 2006, so officials are using both the infrastructure already in place to implement the state law and an interagency work group to assess the ACA. A key component in implementing health reform in Massachusetts is the Connector, an independent state authority created by Chapter 58 of the Acts of 2006 to implement key elements of health reform. The Connector is governed by the Board of the Commonwealth Health Insurance Connector Authority (the Board), and chaired by the Secretary for Administration and Finance. The Board is composed of ten members with diverse backgrounds and areas of expertise, which allows for a broad range of perspectives to be represented. The Board approves all major policy, regulatory and programmatic decisions, and generally meets on a monthly basis in a public forum.[3]

The Connector manages the CommCare and CommChoice programs and serves as an intermediary that assists individuals in acquiring health coverage.[4] In addition, the Connector is charged under Chapter 58 with developing several policy and regulatory components of reform including the establishment of the benefits packages and premium contribution schedules for the CommCare

program; development of regulations defining what constitutes Minimum Creditable Coverage (MCC); and construction of an Affordability Schedule. The Connector works with many state agencies including the Division of Insurance (DOI) and MassHealth (Medicaid). The Connector contracts with MassHealth to conduct eligibility screening and much of the enrollment process for CommCare applicants.

Michigan. The Michigan Health Insurance Reform Coordinating Council created by Executive Order is charged with:

- Conducting a comprehensive evaluation of health reform laws to identify decision points or state action items necessary to comply with the law or to further enhance access to health care, reduce costs, and improve quality;
- Identifying and recommending mechanisms to assure a coordinated and efficient state implementation;
- Engaging stakeholders to develop implementation recommendations;
- Facilitating collaboration with federal agencies regarding the establishment of new rules, regulations, or mechanisms for implementation;
- Developing recommendations for implementation of a Health Insurance Exchange;
- Analyzing the impact of health reform on state departments and agencies, including budgetary impacts;
- Identifying federal grants, pilot programs, and other non-state funding sources to assist with implementation;
- Recommending executive action or legislation to effectively and efficiently implement health reform.[5]

In accordance with the requirements in the Executive Order, Michigan state officials have engaged key stakeholder groups, including unions, employee groups, trade associations, and insurance providers. Some think tanks in the state with an interest in health care reform have provided connections with important external groups. Michigan has also applied for a federal grant to fund an expanded health insurance ombudsman position in the Office of Financial and Insurance Regulation to enhance consumer outreach efforts.

North Carolina. After the passage of ACA, North Carolina created the Health Reform Overall Advisory Committee made up of a range of stakeholders. It convened for the first time on August 5, 2010. Stakeholders representing groups involved in or affected by health care reform were invited to join the statewide Health Reform Overall Advisory Committee and its eight workgroups. The North Carolina Institute of Medicine (NCIOM), a quasi-state agency that serves as a non-political source of analysis, advice, and intergovernmental conversations on health policy issues, is managing the process and tasked with focusing on science and outcomes rather than politics. NCIOM is also managing the statewide health reform website. More than 200 people are involved in the process, including state officials, members of the legislature, health care professionals, academics, insurance providers, not-for-profit leaders, local public health officials, and representatives of community-based organizations. The elected
insurance commissioner and Secretary of the Department of Health and Human Services co-chair the Committee. Both the full advisory committee and the eight workgroups are meeting monthly through August 2011 to review the federal law, identify funding opportunities, assess existing health care resources and data needs, and help the state prepare for changes in the way health care is delivered. In addition to the broad advisory group, the state departments of Health and Human Services and Insurance have internal teams to coordinate staff action and respond to immediate deadlines and requirements.

Washington. In Washington, the Governor's Health Care Cabinet, created by Executive Order, is made up of top-level agency staff. The Health Care Cabinet was scheduled to submit a plan to the Governor by August 1, 2010, identifying:

- Short- and long-range opportunities, issues, and gaps created by the enactment of national health reform;
- Structures and processes needed by state agencies to orchestrate reform implementation, including those to appropriately assist the private health care sector in its implementation efforts;
- Workforce capacity and training needs in the public and private sectors; and
- Specific action steps, timelines, and assignment of lead responsibility.

The work plan must contain recommendations from the Administrator of the Health Care Authority and Secretary of the Department of Social and Health Services, in coordination with the Office of Financial Management and Executive Policy Office, identifying specific actions and timelines to implement uniform policies and to consolidate duties, functions, and powers related to state agencies' health care purchasing under the Health Care Authority.[6]

Federal funding opportunities and recommendations for changes to state law necessary to implement ACA must be submitted in the July 2011 legislative session. The state also has a Joint Legislative Select Committee on Health Reform Implementation that is reviewing the law and examining it from a legislative perspective. This committee has three advisory groups — workforce, Exchange and insurance reforms, and low-income coverage — that are bringing stakeholders into the process. The state's elected insurance commissioner is a member of the governor's Cabinet and meets monthly with the Joint Select Committee.

2. The state political environment and expected leadership transitions create uncertainties and are already factoring into state strategies on health reform implementation.

States will face changes in leadership in many states after elections in November. With 37 states holding gubernatorial elections in 2010, including 25 in which the incumbent is retiring, term-limited, or was defeated in a primary, the leadership framework for health care reform will change dramatically throughout the country. Gubernatorial transitions mean many political appointees who are spearheading health care reform may leave state government in 2011. While career employees are heavily involved in many aspects of health care reform — particularly in Medicaid, where the administrator is often a career employee — overall leadership, policy direction, and interagency coordination come from political appointees.

State legislatures could also experience significant turnover. Forty-six states will hold legislative elections in 2010 with more than 6,000 seats (83 percent of all legislative seats) up for election. Some aspects of federal health care reform will require state legislative action, like setting up an insurance Exchange. In addition, a dozen states also have elected insurance commissioners whose terms will expire between now and 2014.

Further complicating the political environment are legislative and legal actions challenging some aspects of federal health care reform. Legislators in at least 40 states have proposed legislation to limit, alter, or oppose selected state or federal actions including single payer provisions and mandates requiring the purchase of insurance. Attorneys general in 20 states have filed or announced plans to pursue lawsuits opposing provisions of the ACA.[7]

Political transitions are shaping health care reform timing and strategies. In general, political appointees dominate the leadership positions in the entities charged with health reform implementation, although career staff are heavily involved for expertise and to ensure continuity through political transitions. Two of the states in this study (Connecticut and Michigan) will see a change in governor in January 2011.

Connecticut is working to develop a health care reform policy framework before a new governor takes office in January 2011. Top priorities for the Connecticut Health Care Cabinet are to ensure the deep involvement of career service employees to provide continuity when the administration changes, and to engage external stakeholders to build awareness of and commitment to the overall strategy. While the Health Care Reform Cabinet is made up entirely of senior state employees appointed by the governor, the Advisory Board includes both state employees and key industry stakeholders appointed by leaders of the legislature. In July 2010, Governor Rell named Deputy Public Health Commissioner Cristine Vogel to serve as Special Advisor for Health Care Reform to oversee integration of federal health reform initiatives in the state and carry out strategies developed by the Health Care Reform Cabinet, which she chairs. Ms. Vogel relinquished her Deputy Public Health Commissioner duties to focus full-time on health care reform before Governor Rell leaves office.

In Michigan, the Health Care Insurance Reform Coordinating Council is developing a strategic plan and working to secure as much federal funding as quickly as possible before Governor Granholm leaves office. The Council expects to deliver a strategic plan to Governor Granholm by the end of October that will lay out the questions and choices the state faces and provide recommendations for action. Governor Granholm appointed Michigan Department of Community Health Director Janet Olszewski, a long-time public health director, to lead the effort and maximize short-term results. The Michigan Public Health Institute (MPHI), a not-for-profit state organization established by the legislature in 1990 to bolster the state's public health infrastructure, supports the council's work, particularly in writing grant applications.

In Washington, the 2012 election is influencing the implementation schedule. The goal is to complete decisions related to the insurance aspects of health care reform before the governor's and insurance commissioner's terms end in January 2013, regardless of their reelection plans. Officials are also planning to complete all the policy decisions related to the Health Insurance Exchange during the 2011–2012 legislative policy session.

In the midst of implementing state reform efforts, Massachusetts navigated a political transition, but both governors were committed to reform. Republican Governor Mitt Romney chose not to seek a third term and left office nine months after signing the state's health care reform law. Democratic Governor Deval Patrick was inaugurated January 4, 2007. Both governors were strongly committed to health care reform, which helped facilitate the transition. State officials reported that a "can do" leadership culture set the tone for carrying out health care reform under tight deadlines, even with a change in political leadership.

The Commonwealth Health Connector — the nation's first state-run Health Insurance Exchange and a cornerstone of the Massachusetts reform — became available to residents below the poverty level on October 1, 2006, and, for those between 100 percent and 300 percent of the poverty line on January 1, 2007 — three days before Governor Patrick was inaugurated. State officials say a diverse Board of Directors established to guide the design and oversee continued operation of the Health Connector helped meet the tight deadlines and sustain progress. The Board includes the Massachusetts Secretary of Administration and Finance, Commissioner of the Division of Insurance, and Medicaid Director along with experts in public health, commercial insurance, health care cost containment, and labor relations.

3. States are concerned that there is not adequate staff capacity to carry out the volume of work within the fixed time frames, and states will need to hire contractors for some key health reform responsibilities.

The aging workforce, salary schedules and hiring practices can affect capacity to implement health reform. Although many states have not undertaken a workforce analysis to specifically assess their needs to implement health reform, it seems clear that many are concerned that there is not adequate capacity to handle the workload. The age and salary levels for state workers compared to the private sector are expected to be key factors in state workforce capacity over the next several years. Overall, a looming talent challenge is emerging as one-third of the state government workforce is eligible to retire in the next five years. Human resource managers say they are having difficulty finding qualified candidates for positions that require substantial expertise and experience given the competitive job market for these positions. The biggest recruitment challenges are in higher level positions and those requiring specialized expertise or licenses, such as information technology professionals, nurses, physicians, health instructors, social service case workers, financial analysts, procurement/acquisition specialists, agency directors, and other senior managers.[8] Traditional civil service hiring practices take time and leave little room for salary and benefits negotiation.

A Washington state personnel survey found that entry and lower level jobs in the state pay 10 percent more than comparable jobs in the private sector. Higher-level positions, the survey found, are paid as much as 20 percent less. Another state interviewed for this project found that 32 percent of health services employees are eligible to retire in the next five years, and that salaries for senior positions are not competitive with the private sector. A related analysis recently found that on average, total compensation is 6.8 percent lower for state employees than for comparable private sector employees.[9]

The recession has exacerbated pressure on state workforce capacity. In response to an on-line national workforce survey,[10] when asked about the workforce changes governments have adopted as a result of the economic downturn, almost 90 percent of state respondents indicated that their governments had implemented hiring freezes; 65 percent had instituted pay freezes; and nearly half (46 percent) had furloughed employees. Other changes included layoffs (39 percent), early retirement incentives (28 percent), and pay cuts (13 percent). On the other hand, almost half (46 percent) of the state respondents indicated that retirement-eligible employees were postponing retirement, which could be linked to retirement-eligible employees working longer to boost their retirement income, particularly if they suffered investment losses from the downturn. A recent report shows that states, localities, and school districts have cut 231,000 jobs since 2008.[11] With on-going publicity about state budget challenges, state employment no longer enjoys a reputation for job security. State officials fear that ongoing publicity about state budget challenges may make state employment a less attractive option even if funding for new or frozen positions becomes available.

These workforce issues have left agencies responsible for implementing federal health reform chronically short-staffed. The commissioners, managers, and directors who are leading their states' health care reform efforts repeatedly cited a lack of time to focus on the complexities of the ACA, meet deadlines for short-term program implementation, and complete grant applications as their biggest challenges. One official said her department has been in "total scramble mode" since March 23. For example, a recent early retirement incentive in Connecticut led to a 10 percent workforce reduction in the Medical Care Administration, including the loss of four experienced senior managers in one day. Washington reported that nearly one-third of the Department of Social and Health Services is eligible to retire in the next five years. In Michigan, about 20 percent of current employees in the Medical Service Administration are eligible to retire now, with another 15 to 20 percent eligible in the next five years. Massachusetts estimates that each of the agencies involved in health reform could use one to two

full-time employees to implement the ACA. States also noted that they needed help to apply for and administer grant and demonstration projects.

Many states will seek outside contractors to implement new requirements for the Exchanges and IT systems, but states in the study indicated that there was a strong preference for hiring full-time staff in public health and Medicaid administrations to build the sustained workforce capacity needed to fulfill ongoing state responsibilities related to health reform. This preference applies to administrative, policy, and management positions because of long-term capacity needs and the desire to sustain high-level expertise in career service positions.

States reported that there is considerable expertise among the current workforce, even though they are limited in numbers. Despite workforce challenges, state leaders in this study were confident that their workforce has the knowledge, expertise, and commitment to implement many of the key provisions in health care reform. Agency and division directors reported having highly skilled staff who are thinking creatively, taking risks, asking challenging questions, and handling increased workloads. However, despite the high level of expertise, there are too few staff to carry out the broad requirements of health care reform within the established time frames.

States expect to tap consultants for technology systems and insurance expertise and worry that there may be competition for experts who can help design health Exchanges. States plan to rely on consultants and contractors to supplement existing staff capacity, particularly to build and possibly operate large and complex information systems and to provide policy guidance, business advice and program design for the Health Insurance Exchanges. The potential for nationwide competition for contracted expertise in specific areas may slow progress. Because all states are working on the same timelines to develop similar programs, contractors with special expertise — particularly for design of Health Insurance Exchanges and complex information management systems — could be in short supply. Information technology expertise to design and run new information systems is a particular concern for some state officials, who say it is difficult to retain highly skilled IT professionals in-house because of better private sector salaries, making the need for consultants more urgent. Insurance departments are likely to use consultants and contractors, since this is already a common practice to meet short-term needs for special expertise. Massachusetts contracted out for actuarial services to create plan designs and to meet tight deadlines in establishing the Health Connector, the state's Health Insurance Exchange.

States scramble to find staff and consultants with grant writing expertise. States are heavily reliant on federal grants to provide resources to move forward with health reform; however, accessing federal grant funds is creating another workforce challenge. States need to find staff or consultants with grant writing expertise to apply for available funds on tight deadlines.

In our study states, non-partisan institutes are a valuable source of staff and expertise. Access to either state-supported or other non-partisan research institutes can provide supplemental expertise and staff support, particularly for research and grant writing. The North Carolina Institute of Medicine is staffing the state's health care reform advisory committee and serving as a central information resource for the state. The University of Massachusetts Medical School has provided project management support and Massachusetts has also relied on medical schools and foundations for analytical support. The Michigan Public Health Institute is providing a range of staff support services including grant writing. Even organizations without a direct connection to state government have provided valuable expertise and capacity.

4. Timely guidance and financial support from the federal government will help states successfully implement health reform.

Timely regulatory guidance is essential to successful implementation of health reform at the state level. Federal leadership that provides timely information, prompt action on funding opportunities, flexibility in evaluating state responses, technical assistance, and regulatory guidance is essential to successful state health care reform. States are balancing ACA deadlines with the need for federal information, guidance, and support to facilitate informed decisions. For health care reform to succeed, said one official, the federal government needs to treat states as partners rather than stakeholders. Even though many of the major coverage provisions in ACA go into effect in 2014, state officials say they need federal guidance as early as possible to create the technology and procurement infrastructure that is required to have new systems up and running in a coordinated way by 2014. States are awaiting federally-developed templates and prototypes that can be used to shape approaches to specific aspects of the ACA. In particular, templates that provide frameworks for required electronic enrollment platforms for Medicaid and the Health Insurance Exchanges would help states streamline their planning, reduce burdens on staff, and prevent duplication of efforts across many states.

Federal-state information sharing will speed up learning curves. While states will approach health care reform differently depending on their existing structures and programs, the opportunity to share information and compare policy directions provides a valuable resource for fast-track learning. HHS forums and conference calls where state officials responsible for health care reform can receive updates on federal regulations and Exchange information with their state counterparts have proven valuable. In a recent HHS conference call, several state staff stressed the importance of a "true partnership" between the federal and state governments, asking that information be shared freely, quickly, and broadly to maximize shared learning. States raised important issues about the Exchanges at two forums held by the National Governors' Association in September 2010 in Vermont and Washington. Such forums accelerate learning and strengthen the federal-state dialogue.

Federal grant funds are a critical source of funding for states under ACA, but states are hard-pressed to keep up with deadlines to access these funds. For many cash-strapped states, federal grants are the only source of short-term funds to meet ACA requirements, particularly for hiring staff and consultants to bolster workforce capacity. Major immediate tasks of the health care cabinets and implementation councils include monitoring funding opportunities and deadlines; ensuring that applications are submitted on time and addressing any questions that arise in the review process. Some states say they have struggled to keep up with grant applications because of limited available staff, despite the urgency of getting every available federal dollar to support implementation. The North Carolina Institute of Medicine created and regularly updates a spreadsheet with details about all available federal funds. The Michigan Public Health Institute is preparing grant applications on behalf of state agencies to continue the state's success in securing federal funding.

On July 29, 2010, the Department of Health and Human Services announced the availability of $1 million in planning grants per state to help states begin work to establish Exchanges. States could use the funds for a variety of activities including to: assess current information technology (IT) systems and determine needs; plan for consumer call centers to answer questions from their residents; and develop partnerships with community organizations to gain public input into the Exchange planning process. Grant applications were due on September 1, 2010. Most states applied for one of these planning grants.

5. Key staffing challenges for health reform implementation are around designing insurance Exchanges, handling expanded enrollment for Medicaid and state Exchanges and updating eligibility systems.

Creating the new Health Insurance Exchange poses major challenges and many questions. States are just beginning to think about their approach to the overall Health Insurance Exchange as well as its link to Medicaid eligibility and administration. One senior official called designing the Health Insurance Exchange "the biggest workforce challenge of health care reform." Both Connecticut and North Carolina have workgroups dedicated to analyzing the Exchange requirements and working on the overall plan and design. Questions about the Health Insurance Exchanges have dominated recent HHS forums, reflecting both the importance of this component of the ACA and the challenges states are facing in the beginning stages of program design.

Prior to January 1, 2013, states must notify HHS if they intend to establish and operate a state-based Exchange, according to federal standards. In addition, HHS will make a determination if the state is making sufficient progress towards having the state-run Exchange operational by January 1, 2014. If the state chooses not to establish an Exchange or is not making sufficient progress, HHS will plan for a federally established/operated Exchange in the state. Territories have the option to establish an Exchange and a limited amount of funding is allocated for this purpose. Massachusetts was able to launch components of its Health Insurance Exchange in less than a year, in part, because all policy guidance and regulations were established within the state.

Specific issues related to creating insurance Exchanges that officials interviewed for this report mentioned include:

- Managing the complex information technology needs, including integrating data with other state databases, particularly Medicaid, and creating single point-of-entry on-line enrollment systems;
- Designing new eligibility and enrollment processes that interface with Medicaid eligibility determinations and enrollment;
- Finding staff with the diverse skills needed to run the Exchange, including business and marketing;
- Creating business plans for self-supporting operation of the unsubsidized portions of the Exchanges; and
- Competing for access to a limited number of consultants with the necessary expertise to design Exchange programs.

Medicaid expansion will stretch staff capacity. Generally, states have lean administrative resources to operate Medicaid, despite its complexity. Over time, Medicaid enrollment and program responsibilities have expanded at a much faster rate than funding for administrative functions. Like other areas of state government, Medicaid administrative capacity has been affected by the recession, with agencies losing staff and resources at a time when demand for the program and enrollment have been increasing. For example, Michigan reported that the number of Medicaid enrollees has grown by nearly 73 percent during the past nine years and claims volume has increased by 50 percent during the past four years, while funding for administration of the program has remained relatively flat. North Carolina also points to a modest staff for administration of Medicaid with 426 staff to manage a $10.6 billion-a-year program that currently serves 1.7 million people over the course of a year.

Major changes to Medicaid eligibility under the ACA present both challenges and opportunities for states. Building the infrastructure needed to administer vastly expanded Medicaid programs will stretch both staff capacity and expertise, particularly in creating more sophisticated information systems to expedite eligibility determinations and enrollments. Generally, additional staff will most

likely be required to meet new program responsibilities as well as larger caseloads. State officials interviewed for this report believe streamlining and automation of eligibility determinations and enrollment processes will both improve Medicaid operations and possibly lead to efficiencies for staff over the long run as system operations become more familiar and efficient.

Federal health care reform offers a chance to restructure Medicaid eligibility determinations and improve program operations. States are already rethinking their Medicaid structure and operations as they begin planning for program expansion under the ACA. In addition, some state officials believe the focus on improving and expanding Medicaid and broadening access to health insurance as part of the Exchanges will improve overall health care in their states — provided sufficient funding is available to meet new needs. Examples of restructuring underway in the states interviewed for this report include:

- Washington is planning to move its Medicaid Administration out of the Department of Social and Health Services and merge it with its Health Care Authority. The reorganization, which will be proposed in the legislative session that begins January 2011, is similar to structures already in place in Kansas and Oklahoma and in the process of being established in Oregon.
- Michigan is considering moving eligibility determinations out of the Department of Human Services and into the Department of Community Health, which administers the Medicaid program. The goal is to simplify the eligibility determination process and consolidate program administration, particularly to facilitate integration with the Health Insurance Exchange.
- North Carolina hopes to leverage an expanded Medicaid program to elevate the standard of care across the state. As Medicaid grows and commands more dollars, state officials say, it will have the economic and clinical power to have a positive impact on the practice of medicine in the state.
- In Massachusetts, officials are assessing how the federal law supports changes the state sought to make prior to passing its state law. For example, Massachusetts initially worked primarily on access to care and is now seeking to make more progress on payment reform and cost containment in addition to focusing on access. There are Medicaid and Medicare grants and incentives that support these state goals. One Massachusetts official suggested that states give equal attention to access and cost as they implement the new federal law.

Creating new eligibility and enrollment systems takes time and costs money. Many states have antiquated Medicaid eligibility systems that have not been updated and will not be able to accommodate the Medicaid expansion or requirements to coordinate enrollment with the Exchange. Many states will need new eligibility systems, others will need significant modifications to current systems to meet the new ACA requirements, and there are a number of states where upgrades to and creation of new automated enrollment systems were underway prior to the passage of ACA.

States in this study generally seemed further along in enrollment system upgrades. In North Carolina, for example, the new NC Fast system is intended to ensure that eligibility determinations are more consistently accurate and that vital information is integrated with other state databases. Michigan inaugurated a new Medicaid Management Information System in 2009 that was an upgrade to a 1970s-era system. Massachusetts has created an on-line enrollment system with a single point of entry for both Medicaid and the Health Connector. The integrated system has helped the state enroll more children in an insurance program, since all adults must apply for coverage. Massachusetts is working on refining its technology systems to better track changes in enrollment status and further reduce paperwork.

While states are in the early planning stages of system design, January 1, 2014, looms as a challenging deadline. Designing a system to tie into an old one or building a completely new one is both time consuming and expensive. In order to meet the deadline for having an expanded Medicaid program up and running with a new way of determining eligibility by January 1, 2014, one official said the state should be working on the design and testing of every aspect of those systems right now. Instead, some officials say they are waiting for more guidance from HHS while they initiate their planning processes.

CONCLUSION

In the summer of 2010, states were beginning to assess the impact and new requirements related to implementing the health reform law while still facing severe budget pressures stemming from the recession. The capacity of the state workforce is key in moving forward with implementation. Analysis in five states (Connecticut, Michigan, Massachusetts, North Carolina and Washington) shows that while states are moving quickly to set up the infrastructure to implement reform, many states will face a number of challenges. First, expected changes in leadership in many states after the November 2010 elections could disrupt or interfere with planning efforts already underway as new staff take responsibility for health reform efforts. In addition, due to an aging state workforce, state salary structures and hiring practices as well as the toll from the recession, states are concerned that there is not adequate administrative capacity to carry out the volume of work within the fixed time frames under ACA. While there is considerable expertise to implement many provisions of the new law, states will also need resources to hire outside contractors for some key provisions including moving forward with the design for Health Insurance Exchanges and new enrollment systems. To meet the tight timeframes under ACA, states need to start this planning now; however, many are still waiting for additional federal guidance. Despite big challenges, some states view federal health care reform as an opportunity to restructure Medicaid eligibility determinations and improve program operations which could yield long-term benefits.

This report was prepared by Elizabeth Kellar, Christine Becker, Joshua Franzel, Amy Mayers, and Danielle Miller Wagner of the Center for State and Local Government Excellence and Robin Rudowitz and Barbara Lyons from the Kaiser Commission on Medicaid and the Uninsured. The authors thank the state officials who shared their time and expertise to make this report possible.

[1] Based on data compiled by the National Governors Association (www.nga.org) and the National Conference of State Legislatures (www.ncsl.org).
[2] Ibid.
[3] Report to the Massachusetts Legislature Implementation of the Health Care Reform Law, Chapter 58 2006–2008.
[4] CommCare is a subsidized insurance program available to Massachusetts adults earning up to 300% of the Federal Poverty Level (FPL) who do not have access to ESI or other subsidized insurance and who meet certain eligibility guidelines. CommChoice is a commercial (non-subsidized) insurance program currently available to individuals and (in the near future) to small employers.
[5] Based on data compiled by the National Governors Association (www.nga.org) and the National Conference of State Legislatures (www.ncsl.org).
[6] Ibid.
[7] *State Actions to Implement Federal Health Reform,* National Conference of State Legislatures, September 1, 2010, www.ncsl.org.
[8] Ibid.
[9] Bender, Keith A. and Heywood, John S., "Out of Balance? Comparing Public and Private Sector Compensation Over 20 Years," Center for State and Local Government Excellence and National Institute on Retirement Security, April 2010.
[10] "The Great Recession and the State and Local Government Workforce," Center for State and Local Government Excellence, January 2010.
[11] Leachman, M., Williams, E. and Johnson, N., "Failing to Extend Fiscal Relief to States will Create New Budget Gaps, Forcing Cuts and Job Loss in at Least 34 States." Center on Budget and Policy Priorities, August 2010.

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