MEDICAID EVIDENCE-BASED DECISIONS PROJECT

The Role of Clinicians Within Medicaid Agencies

As the single largest health insurer in most states, Medicaid programs hold a diverse set of administrative responsibilities that require clinical expertise, such as defining covered services, managing health care utilization and quality standards, overseeing delivery systems, and creating payment structures. But while all Medicaid agencies employ clinical staff, there is little public research describing how different states leverage clinical capacity to administer their programs.

This brief uses interviews with clinical staff from 6 state Medicaid agencies and other experts in Medicaid operations to provide insight into how states use their clinical staff. It examines different clinical leadership roles and disciplines, the range of responsibilities and strategic portfolios held by clinical staff, and how clinical expertise can drive value for the agency. The brief concludes with considerations for how other states might optimize, extend, and grow clinical capacity and leadership in their own programs.

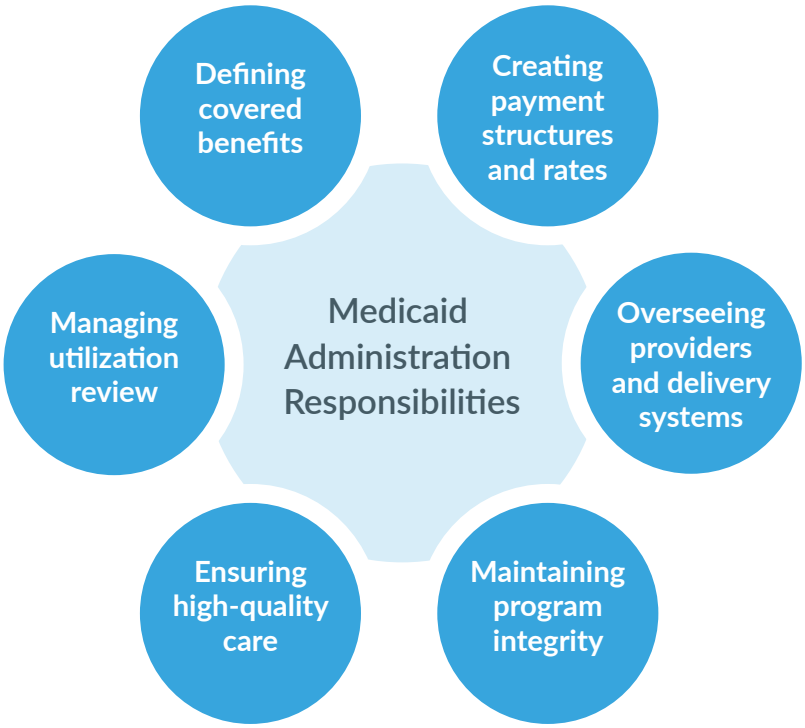
This brief is based on a report, *The Role of Clinicians Within Medicaid Agencies*, completed for the Medicaid Evidence-based Decisions Project (MED). MED is a collaboration of state Medicaid agencies giving state policymakers the resources they need to make the best evidence-based decisions for improving health outcomes. MED reports and other tools provide valuable evidence about effective treatments and information about harmful or unnecessary services. If you are with a state Medicaid agency and you are interested in a copy of the full report, please contact med@ohsu.edu.

BACKGROUND

Administering Medicaid

Medicaid is the nation's single largest health insurance program, covering more than 1 in 5 Americans.[1] The program is unique among health insurers in its breadth of benefits and its coverage of some of the most medically complex individuals with the highest care needs.[1]

To administer Medicaid, state agencies are charged with a complex set of responsibilities that include defining covered services, creating payment structures, overseeing enrolled providers and different delivery systems (e.g., managed care), managing utilization review, ensuring high-quality care, and maintaining program integrity.[1-3] These responsibilities are evolving as programs navigate record-high Medicaid enrollment,[4] rising health care costs,[4] expensive emerging medical technologies,[5,6] the expansion of covered services,[7] and the continued movement toward managed care, with more than 70% of Medicaid beneficiaries now covered by privately administered plans.[8-11]



Clinical Expertise

The Centers for Medicare & Medicaid Services (CMS) has long recognized the value of clinical expertise in administering Medicaid programs with an enhanced federal match rate for adminis-

Research Approach

This brief uses research from relevant policy and academic literature sources alongside 9 key informant interviews with state Medicaid program officials and CMS clinical leadership. It aims to describe how different states use and leverage their clinicians; the range of clinical disciplines, roles, and responsibilities held by these staff members; and key considerations that state Medicaid programs can use to help guide their own clinical strategy and the future development or extension of clinical expertise within their agencies.

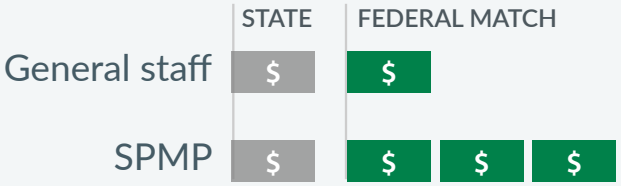
The 6 state programs interviewed for this report vary in program structure (e.g., states who are primarily fee-for-service (FFS) and states with primarily managed care delivery systems), geography, enrollment size, Medicaid expansion status, and political leadership. To maintain state confidentiality, we do not attribute commentary or specific program characteristics to individual states.

trative duties performed by clinicians (see Skilled Professional Medical Personnel Enhanced Match box below).[12-14] However, clinical expertise has come into sharper focus in recent years.[3,15] A 2021 article on the increasingly important role of chief medical officers (CMOs) within private health insurance plans stated that "clinical leadership is a differentiating factor for success" as value-based payment models expand and providers and insurers take on more responsibility for care quality and coordination.[16]

Skilled Professional Medical Personnel Enhanced Match

Since 1978, CMS has provided an enhanced federal match rate (federal financial participation [FFP]) of 75% for certain Medicaid administrative services performed by clinically trained staff such as physicians, nurses, or pharmacists and their directly supporting staff (see Figure 1).[12-14,17] These staff members are categorized as "skilled professional medical personnel" (SPMP).

FIGURE 1
Federal Financial Participation (FFP) for Medicaid administrative services



The *Code of Federal Regulations* (CFR) defines SPMP as follows:

> Physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency.[12]

To receive the enhanced rate, SPMP activities must directly relate to the administration of the state's Medicaid program, and the SPMP position must "have duties and responsibilities that require those professional medical knowledge and skills."[13]

States may also have Medicaid Administrative Claiming (MAC) programs under which the state can draw down enhanced SPMP federal matching funds for clinically relevant services, programs, and policy development performed by local health departments and certain other public entities that support Medicaid administration.[18,19]

The enhanced SPMP rate allows states to receive a significantly higher share of federal funding for employed clinical positions that meet the SPMP definition, which can improve affordability of these positions.[20] One state interviewed reported past difficulties in claiming enhanced matching funds for Medicaid behavioral health clinicians—specifically licensed mental health counselors, marriage and family therapists, and social workers—due to the heavy focus on "medical" practice within the CFR definition for SPMP. However, CMS recently addressed this issue with guidance that allows states to claim the SPMP rate for a wider range of behavioral health clinicians.[21]

States must also account for the time and resources needed to maintain adequate documentation to support claiming the enhanced federal match for SPMP services, including clinician qualifications, justification for how the task necessitates clinical expertise, and time tracking.[19,22] There are many examples of past federal audits that recouped federal SPMP funds from states due to improper claiming.[23]

KEY FINDINGS

Clinical Organizational Structure

Organizational Roles and Disciplines

Clinicians within the Medicaid agencies interviewed for this brief are organized into a spectrum of staffing models. These range from a concentrated clinical office that contains most clinical and pharmacy staff and is overseen by the CMO to a much wider distribution with clinicians spread across several divisions. Among the interviewed states, those with primarily managed care delivery systems generally reported having a concentrated, clinical-specific office, and those with primarily FFS or primary care case management (PCCM) delivery systems generally reported using less concentrated clinical staffing structures.

As summarized in Table 1, the interviewed Medicaid programs reported a wide range of clinical leadership roles and disciplines on staff. For more detailed information about how interviewed state Medicaid agencies structure their clinical offices, including arrangements with external contractors and universities and number of staff in each specialty, please request a copy of the full MED report.

TABLE 1
Clinical leadership roles and disciplines on staff

Clinical Staff	Types of Leadership Positions	Specialty Examples
Physicians and nonphysician clinicians	» Medical director or CMO » Medicaid director » Head of ACO oversight office	» Pediatrician » Psychiatrist » Family medicine » Addiction medicine » Optometry » Audiology
Pharmacists	» Chief pharmacy officer » Pharmacy program manager	» Pharmacist
Dentists	» Chief dental director » Dental director » Program director	» Dentist » Dental hygienist
Nursing	» Chief nursing officer » Agency director	» Nurse practitioner » Registered nurse » Licensed practical nurse
Behavioral health	» Medical director » Behavioral health office director » Policy and benefit division director » Special advisor	» Psychiatrist » Addiction medicine physician » Psychologist » Licensed clinical social worker » Counselor or therapist » ABA provider

Abbreviations. ABA: applied behavior analysis; ACO: accountable care organization; CMO: chief medical officer.

External Contracting and University Relationships

While most clinical staff in the interviewed agencies are directly hired state employees, Medicaid programs also bring in clinical expertise through different contractual relationships (see Figure 2). These options may be of particular interest for smaller states and agencies. Federal regulations allow states to claim FFP, at least up to the baseline rate of 50%, for administrative work conducted by contracted personnel in other public agencies (including state universities) if services are specified in written agreements.[14,24-26]

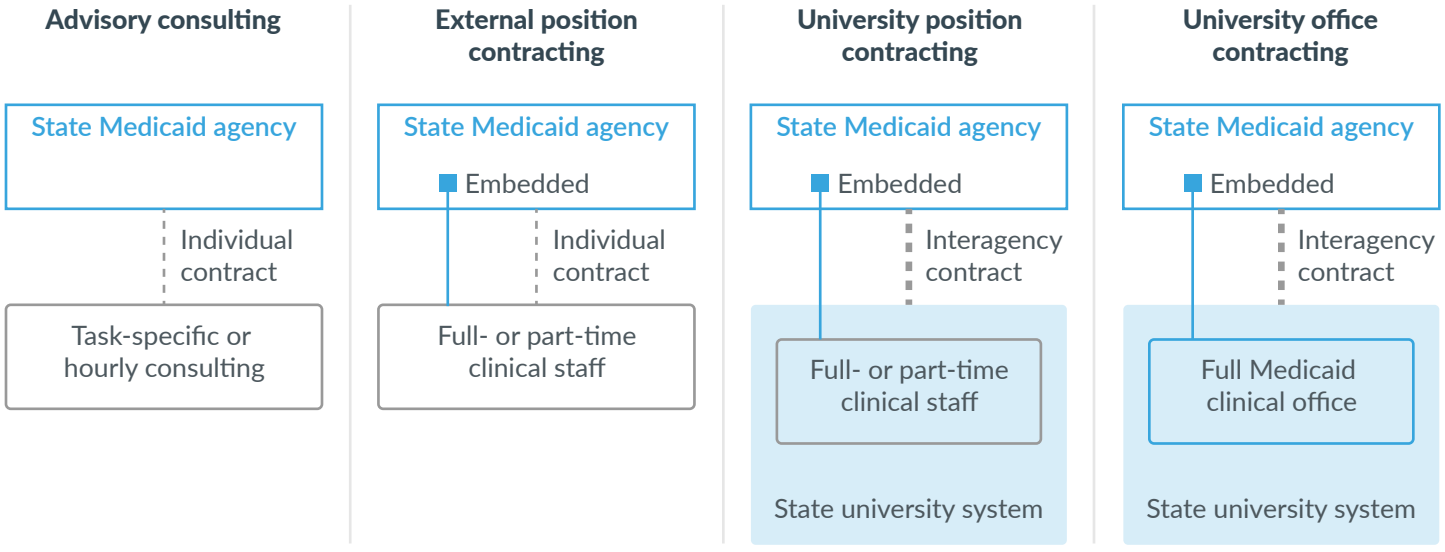
- **Advisory consulting.** Multiple interviewed agencies contract with specialty clinical consulting vendors, provider systems, or individual experts for certain tasks—typically on an as-needed basis. Examples include member appeal reviews, specialty prior authorizations (PAs), orthodontic evaluations, pediatric consults, and ongoing consultation contracts with providers who have specialty expertise.
- **External position contracts.** States use direct contracts with individuals to fill roles, often in particular specialties, such as dental directors, full-time pharmacist positions, and part-time pediatrician consultants.
- **State university contracts.** Multiple interviewed Medicaid programs bring in both part- and full-time clinical staff through state university or medical systems, often via interagency agreements.[24-26] The university arrangement may provide simplified contracting, faster hiring, faculty opportunities, and higher or more flexible compensation ranges. It can also provide the agency with closer access to the university's clinical and research infrastructure, even including a formal state-university partnership research program.[27] University-contracted positions among interviewed states ranged from pharmacy roles focused on drug utilization review (DUR) to a full Medicaid clinical office that sits within a department of the state medical school.

Clinical Staff Duties

State staff interviews and additional research revealed many different types of Medicaid administrative duties where clinicians draw on their clinical background and expertise to provide a "clinical eye" to strategic Medicaid operations. In addition to clinical knowledge, these insights include perspective that accounts for the realities of patient experience, provider service delivery, and broader health system and financial operations.

FIGURE 2

External contracting and university relationship options



Clinical staff duties were grouped into the following areas:

Utilization Review and Service Authorization

Clinicians including medical directors, pharmacists, and nurses consistently engage in service review and approval. Tasks may include direct service review, provider peer-to-peer requests, and resolving escalated PA and medical necessity determination cases with utilization management (UM) or benefit administration vendors. Medical directors typically issue final authorization decisions, and agencies may need to intermittently engage specialty expertise for certain cases.

Examples

- A nursing review or pharmacy team oversees the UM vendor to escalate PA or medical necessity determinations that need higher clinical review or may arise from unclear federal and state regulations.
- Pharmacy and medical clinical leadership conduct PA reviews for high-cost pharmaceuticals and review claims for out-of-state care episodes.

Member Issues

Beyond service review and authorization, Medicaid clinicians are involved in additional member-related tasks including resolving specific care delivery cases, handling member complaints, addressing specific managed care organization (MCO) or provider issues, performing occasional care coordination tasks (e.g., children with medical complexity), and making clinical evaluations for long-term care program placement.

Examples

- Medical directors help resolve complex discharge cases for members in both FFS and MCO plans.
- Clinical leadership and staff handle individual issues or questions around specific providers or MCOs.

Benefit Development, Implementation, and Updates

Falling heavily on clinical leadership, this work can include review of clinical research, external consultation, regulatory and implementation considerations, budget impact analysis, and clinical criteria development. It frequently involves collaboration with other staff (e.g., policy, finance, operations). Benefit updates often originate from utilization reviews that reveal gaps or ambiguities in state rules or criteria.

Examples

- State clinical leadership defines medical necessity for the Early and Periodic Screening, Diagnostic, and Treatment benefit.
- Following a legislative request on the coverage of a new medical device, a Medicaid agency conducts a clinical efficacy review and simultaneous utilization and budget impact analysis led by the clinical analytics team.
- Pharmacy teams conduct evidence review and clinical deliberation to guide the coverage and placement of new drugs on the state's preferred drug list in conjunction with a Pharmacy and Therapeutics Committee; they also lead formulary management and utilization criteria decisions through a DUR program and external board.

Provider Engagement, Program Management, and Program Integrity

Medical directors are often a "face" of the Medicaid program and consistently meet with providers to maintain relationships and address specific concerns. Engagement is critical in states with smaller Medicaid networks. Clinicians also participate in or help lead statewide provider quality improvement collaboratives,[28] and some lead programs that engage and support providers (e.g., Nurse-Family Partnership). Different types of clinicians may also be involved in program integrity reviews.

Examples

- Clinical leadership solicits input from the provider community on priority quality measures for a state's MCO contracts.[29]
- A Medicaid program leader with clinical experience uses provider workgroups to build an ICD-10 code crosswalk to more accurately reflect child mental health disorders for billing purposes.
- Nursing audit reviewers and occasionally medical directors conduct chart reviews to monitor fraud, waste, and abuse; they occasionally assist criminal fraud units within the state attorney general's office.

Clinical Transformation Initiatives

Larger strategic initiatives are one of the most engaging parts of clinical leadership portfolios. Example initiatives include quality improvement, value-based payment, creative research projects, benefit expansion (e.g., dental care, community health workers, social determinants of health), and primary care delivery transformation.[30] These projects typically involve agency-wide collaboration, and several Medicaid programs reported using a clinical team lead (e.g., medical director) side by side with a financial or operational lead to ensure that clinical considerations are captured in both the service design and

Aligning Clinical and Operational Lanes for Strategic Initiatives

Interviews with Medicaid program staff consistently highlighted the value of more closely aligning clinical and operational or financial expertise during the ideation and implementation of larger projects and transformation initiatives.

One state described its general process for these larger strategic projects in the following steps:

Idea generation at multidisciplinary team level with 1 or 2 primary leads → **Implementation** with a large operational team, an executive sponsor, and both a clinical and operational lead → Moving **long-term operations and maintenance** for the completed benefit across multiple teams and frontline staff

For example, a Medicaid program recently undertook a strategic initiative to broaden the state's coverage benefit and provider network for medications for opioid use disorder. This process included both a clinical leader (medical director) and operational leader (behavioral health services operations lead) to help improve the breadth and quality of the participating treatment provider network while working with the pharmacy program to remove PA requirements for the medication within the network. After implementation, the benefit moved back into an operations and maintenance phase, living primarily under the pharmacy team.

In another state example, a Medicaid medical director has been closely integrated with the agency's managed care health plan oversight office in the development of a primary care sub-capitation payment model. Clinical involvement was heavy during the strategic design phase, and as the project has matured, the medical director still reengages for design considerations but disengages when the conversation becomes strictly financial and the relative value of their participation declines.

the delivery or payment structure (see Aligning Clinical and Operational Lanes for Strategic Initiatives box on previous page).

Examples

» Clinical and operational teams implement a new benefit around social determinants of health that includes provider screening protocols, a new technology system, and workforce development.
» A medical director leads a team in receiving a multimillion-dollar federal grant for a randomized controlled trial to study the use of skilled nursing facility care in a home-based setting (home-first or acute hospital-to-home model).

Vendor Contracting and Oversight

Clinicians play many different roles in the selection and oversight of vendor contracts (e.g., MCOs). Many feel their past operational clinician experience provides value in this area, and one state reported the importance of involving the "clinical eye" earlier in the contracting process. Medicaid clinicians also help directly oversee these vendors, which often have their own clinical staff. Medicaid programs may need to employ similar expertise and have agency clinical staff directly interact with vendor clinical staff to overrule or resolve contract and member issues.

Examples

» A team including clinicians (e.g., nurse reviewers) conducts quality reviews to ensure MCOs or PCCMs are meeting contract requirements.
» A CMO and quality team helps select performance measures for value-based purchasing contracts and a directed payment program for MCOs.
» Clinical leaders use past provider experience to evaluate requests for proposals (RFPs) or advise on real-world feasibility or enforcement of contract provisions (e.g., too many quality metrics would be unrealistic for providers to manage).

Interagency Consultation

Medicaid clinical staff routinely provide consultation to other state agencies or divisions, including public health and emergency preparedness, behavioral health, corrections, aging and long-term services, developmental disabilities, and children and family services. This can include a formal allocation of medical director time to another division, as well as informal consultation for divisions that serve the same clients.

Examples

» Medicaid nursing staff who work with children with medical complexity provide clinical guidance to the state's developmental disability agency.
» Medicaid clinical staff lead a state's COVID-19 testing strategy for the health department and advise on COVID-19 immunization reimbursement policy.

Agency Strategic Affairs and Leadership

In all interviewed states, clinical leadership is part of an executive team or reports to the agency director. Informants felt this is important for ensuring appropriate clinical representation. In one state, the clinical office's broad portfolio (oversight of most benefits and contracts) has led to increased involvement in larger strategy and budget discussions. Another clinical leader felt that agency leadership has prioritized leading with the "clinical voice" and involving clinical staff earlier in planning. Clinical staff regularly interact with the legislative process, including the education of elected officials and executive staff and bill analysis that leverages their health system experience.[31]

Examples

» Clinical staff provides input and engagement to develop equity and primary care payment elements of the state waiver.
» A pharmacy team manages legislative directives, including a drug price transparency program and a drug affordability board.

Committees and Workgroups

Clinical staff reported consistent participation with external advisory boards related to Medicaid administration, such as the Medicaid Medical Care Advisory Committee, state interagency groups and committees, and national advisory groups that help shape federal policies or guidelines. Pharmacy staff help operate Pharmacy and Therapeutics Committees and DUR boards that advise on state preferred drug lists and utilization criteria.

Example

» Clinical staff from different disciplines participate in focused interagency groups and committees (e.g., immunization committees run by the department of health or maternal mortality review).

» State medical leadership participates and provides input in working groups for the National Committee for Quality Assurance to inform clinical guidelines and standards.

Attracting, Retaining, and Maximizing Clinical Leadership and Expertise

State Medicaid programs have a limited number of clinicians to deploy within the agency and must also navigate well-documented compensation differences with the private sector to fill open positions.[32,33] Key informant interviews shared a range of strategies, experiences, and principles for enhancing the impact of existing staff clinical expertise, extending those capabilities by bringing in additional clinical resources and recruiting and retaining clinical staff members.

Enhancing Clinical Expertise

- **Providing administrative support and resource infrastructure to clinical leadership**, even in a part-time capacity, to lower administrative burden and give leaders project management support on key workstreams. This can be done through new investment (e.g., hiring project managers and improving data analysis infrastructure) or reallocation of existing staff.
- **Assigning both a clinical and operational or financial lead to guide larger clinical transformation projects**, which can help ensure that clinical considerations are better captured throughout the strategic planning and implementation process.
- **Fostering a clinical hub within the agency and integrating a "clinical view" agency wide.** Agency staff pointed to the value of creating a cohesive "clinical voice" and a structured, collaborative clinical hub to weave policy and programmatic initiatives together across disciplines and specialties.
- **Leveraging specialty clinical backgrounds of staff to drive particular lanes of work.** State clinicians reported many different areas of training, and states have opportunities to match relevant backgrounds (e.g., pediatric, maternal, or behavioral health) with certain topics or special initiatives.
- **Providing clinical staff with access to formal Medicaid leadership development programs**, such as the Milbank Memorial Fund Fellows and Emerging Leaders programs and the Center for Health Care Strategies Medicaid Pathways Program.[34-36]

Extending Clinical Expertise

- **Using part-time positions or contracts to gain access to different specialties.** As described in **External Contracting and University Relationships** on page 5, this can include part-time positions within the agency as well as specific tasks like pediatric medication consults.
- **Leveraging additional university relationships.** Beyond contracted positions, states can engage university systems through informal information exchange with specialty provider experts (e.g., discussion with hepatology units on hepatitis C antiviral initiation criteria). They may also pursue formal data research collaborations like the State-University Partnership Learning Network managed by AcademyHealth[3,27,37,38] or other targeted relationships

to conduct specific evaluations[39] or engage university system providers.[40]

- **Collaborating with other state agencies, quality collaboratives, and MCOs.** Program staff can engage clinical leaders at other state agencies and collaborate to target priority chronic conditions,[41] implement new treatment benefits,[42] or develop new quality metrics for Medicaid contracts.[43] Statewide quality collaboratives around topics like children's health can bring Medicaid clinical leadership together with providers, subject matter experts, and other agencies, while some states also leverage relationships with clinical leaders at MCOs to better align clinical quality metrics and priorities.[28,44]

Recruiting and Retaining Clinical Expertise

- **Leveraging the Medicaid mission.** Key informants emphasized the Medicaid mission of helping vulnerable people and the chance to drive population- and system-level change as key reasons for joining Medicaid.
- **Knowing where to find clinical leaders.** A new generation of clinicians is moving through policy fellowships (e.g., the National Clinician Scholars Program[45]) and could be fruitful targets for leadership positions. Some Medicaid agencies have internship programs for medical and pharmacy students. Medicaid programs can also benefit from experienced clinicians and other health care professionals (e.g., those

The Role of Ongoing Clinical Practice

Many key informants felt there is significant value in continuing some level of clinical practice while serving in a Medicaid agency, though several also highlighted time commitment challenges. Clinicians who still practiced part-time reported the ability to stay connected to patients and identify real-time issues occurring within health systems. Several clinicians felt that it improved policymaking and could help relationships and credibility when engaging providers during their agency work.[46] Creating a pathway to continue practicing could also be an important recruitment factor for younger clinicians, because stopping altogether may mean the end of a clinical practice career.

A number of interviewed medical director physicians did continue some level of practice, but the ability to do so varied by state. In some states, clinicians are able to practice through a review of potential conflicts of interest and annual financial disclosures and with precautions taken to avoid particular provider systems. One interviewed state recently worked to create a pathway that allows for licensed clinicians to continue practicing for a limited number of hours during the work week and on weekends following approval by a clinical practice review committee. In Louisiana, certain clinical leadership positions (including the Medicaid medical director) are exempt from state financial conflict-of-interest regulations for the purposes of practicing medicine.[47]

In contrast, another interviewed Medicaid program reported difficulty in obtaining permission due to state concerns about financial conflicts of interest. Key informants reported similar concerns in other states that made it difficult to practice or required clinicians to do pro bono work. Medicaid staff also highlighted that clinical staff members are required to keep up clinical certifications and licensing but may not receive the requisite time or financial support to do so. Regardless of whether they practice, Medicaid clinicians are still responsible for staying up to date with rapidly changing clinical knowledge and may need to actively consult a network of practicing clinicians around particular topics.

working at health care technology or insurance companies) transitioning to Medicaid administrative roles and bringing significant operational and regulatory experience.

- **Increasing clinical leadership engagement.** Informants suggested the retention of clinical leaders could be improved by providing adequate programmatic support and a balanced portfolio that includes longer-term strategic projects to create clearer career trajectories and accomplishments. Shorter-term program tasks like medical determinations will always be a significant responsibility, but they do not have to monopolize leadership portfolios. Higher-visibility projects may also aid recruitment efforts when candidates speak to current staff.
- **Providing a pathway to continue clinical practice.** Key informants noted the ability to continue clinical practice may improve agency recruitment efforts and help policymaking (see The Role of Ongoing Clinical Practice box on previous page).

STATE CONSIDERATIONS AND OPPORTUNITIES

With increasing national focus on delivery system reform and new payment models, health insurers are prioritizing clinical leadership and the ability to integrate and leverage clinical expertise and perspective across their organizations and business lines.[16]

As states assess how they might optimize or improve their own clinical capacity, staffing structures, and impact, they can consider the following options.

Explore Ways to Receive the Enhanced SPMP Federal Match

The enhanced 75% federal match rate for most clinician administrative roles, including behavioral health clinicians, gives state Medicaid agencies the opportunity to draw down more federal funding for those positions and partially address the public-private compensation gap. However, states will also need to account for the time and resources needed to maintain adequate documentation to support claiming the enhanced match.

Consider Options to Leverage External Relationships

Depending on state size and resources, Medicaid agencies may have very different needs relating to clinical capacity and may want to consider the following external opportunities to build and supplement clinical expertise:

- **Establishing relationships with state university systems.** This may include interagency agreements for full-time positions supporting the agency that allow Medicaid programs to leverage university infrastructure, access more flexible hiring and compensation levels, and draw down FFP. Agencies can also build university data research partnerships, formally and informally leverage university provider specialty expertise to advise on clinical policy, and create internship pipelines through medical and pharmacy schools.
- **Soliciting additional specialty expertise through contracted consulting.** These include individual contracts, arrangements with specialty provider systems, and medical expertise advisory companies.
- **Leveraging health system advisory groups** such as statewide quality improvement initiatives or MCO clinical advisory bodies to bring together public, private, and academic clinical expertise around particular topic areas.

Pursue Strategies to Improve Clinical Staff Recruitment, Retention, and Impact

State Medicaid agencies must be creative to hire, retain, and leverage clinicians within their budgets. To help recruitment, state staff suggested providing clinicians with a pathway to continue

part-time clinical practice. To both attract and retain clinical staff, as well as maximize their value to the agency, states can provide a more balanced work portfolio with larger strategic leadership opportunities, reallocate administrative support and project management resources to support these efforts, and invest in clinical support infrastructure (e.g., program management or data analytics).

Foster a Clinical Nexus or Hub Within the Agency

While Medicaid agencies may have significant organizational differences, Medicaid staff commented that there is "tremendous value in having a sense of clinical team"—regardless of the exact structure—and in enabling collaboration and exchange across different clinical specialties and disciplines. The strategic initiatives detailed in this brief highlight the ability to create a more centralized clinical voice and weave different policies and programs together toward larger aims. State officials may consider how their own structures could be optimized to hone a larger clinical leadership voice and direction across the agency.

Integrate and Apply an Agencywide Clinical Lens

State key informants consistently highlighted the importance of integrating a clinical view or voice across all parts of the Medicaid program to incorporate knowledge of real-world health systems and provider experience. To provide this clinical lens, states may consider emphasizing the following principles:

- **Intentionally building clinical and operational tracks** to guide larger strategic initiatives.
- **Prioritizing a closer integration of clinical and financial lanes** to better anticipate the clinical implications and consequences of payment structures and budget decisions.
- **Adding clinical background and perspective** into more operational projects and conversations across the agency.

CONCLUSION

Through our research and key informant interviews, we found that Medicaid clinical staff members are tasked not only with core administrative functions around health care service utilization review and program integrity but also managed care and payment design, value-based purchasing, evolving and expanding covered benefits, and broader clinical transformation initiatives. These responsibilities cut across many different areas of the health care system. State Medicaid agencies rely on relevant clinical backgrounds through internal hires, collaborations, and external relationships to provide the appropriate level of clinical expertise and leadership to these initiatives. Future research of interest to states may include deeper inquiry into particular agency roles, clinical disciplines, or the evolving clinical strategy and related considerations that states employ in the design and negotiation of managed care plans and emerging payment models.

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