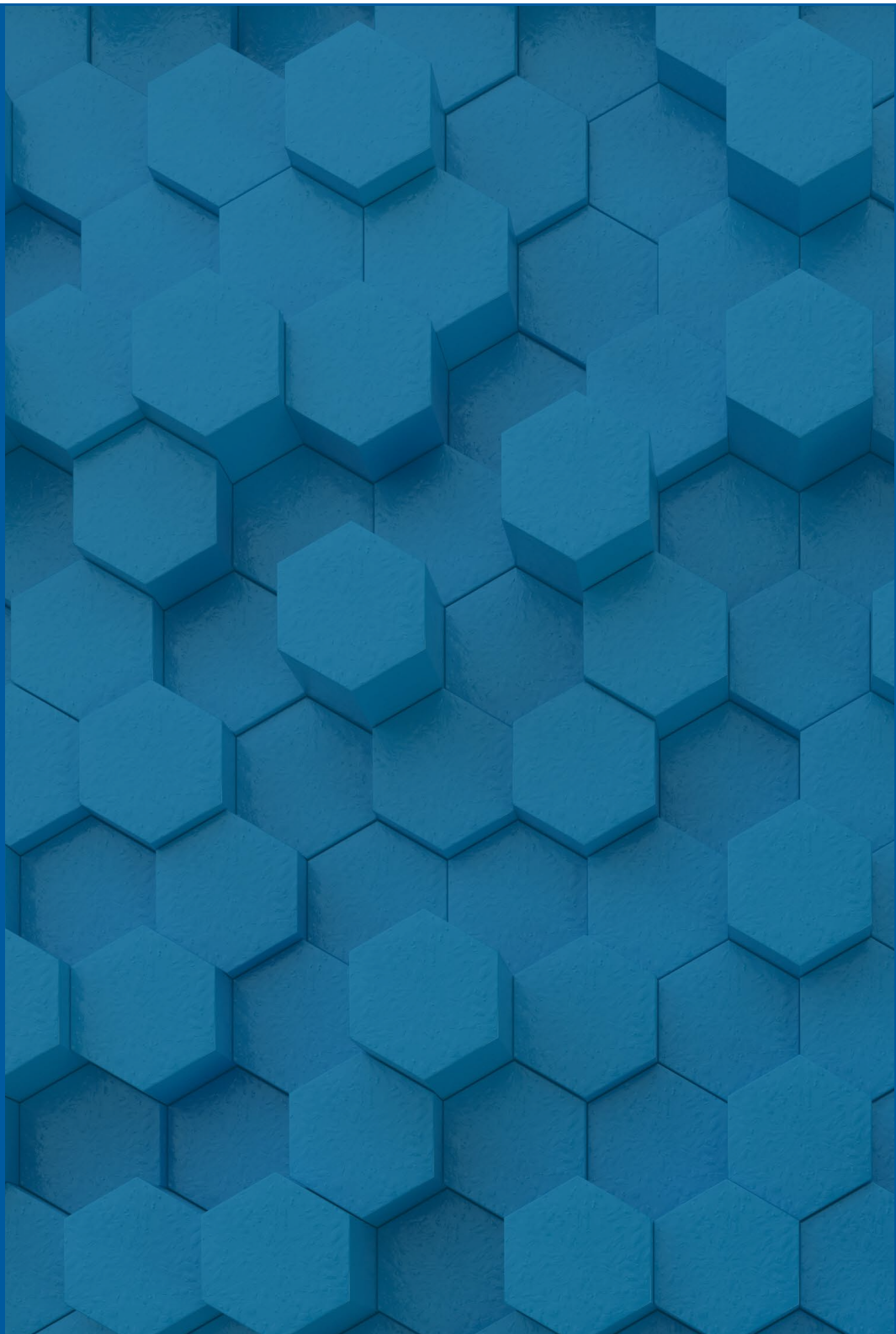
Strategies to Help State Medicaid Agencies Maximize Their Impact and Advance Population Health



REPORT

DECEMBER 2020

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Milbank Memorial Fund

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Abstract

State Medicaid agencies (SMAs) face an ever-evolving landscape characterized by increasing demands. To fulfill their traditional role as a source of health coverage and their newer role as a driver of population health, SMAs must manage two important sets of competing needs: 1) balancing collaboration, regulation, and purchasing; and 2) balancing daily operations with care delivery reforms. To help SMAs balance these needs, this report offers a strategic approach that includes:

- developing and managing key agency functions like benefits administration, compliance, and provider engagement,
- leveraging these functions to improve population health, and
- supporting their leadership teams.

To realize these goals, SMAs will need support from governors' offices, umbrella health and human services agencies, and state legislators to properly fund their efforts. This backing would enable Medicaid agencies to consider ways to coordinate across agencies and identify other state agency investments that would have long-term benefits in Medicaid.

Introduction

Historically, Medicaid has been viewed as the nation's public health insurance safety-net program for low-income individuals (many with complex needs) and the primary source of coverage for long-term services and supports (LTSS). The program continues to play this role, covering approximately 75 million low-income Americans and providing financing for over 50% of LTSS.[1]

Increasingly, however, Medicaid is also seen as an important player in improving population health.[2] Medicaid is the largest purchaser of health care at the state level, giving it the potential to use delivery system reforms to improve health outcomes.[3] Over the coming years, state Medicaid agencies (SMAs) will continue to evolve against the backdrop of the COVID-19 pandemic and its eventual aftermath. The National Association of Medicaid Directors (NAMD) has noted[4] several areas where SMAs are expecting to see the effects of COVID-19 over time, such as the impact of pandemic-related delays in care on the health of members and long-term Medicaid costs. Furthermore, nearly every SMA across the country is reporting that the pandemic is driving shortfalls in overall state budgets — with much uncertainty remaining about future impact.[5] While COVID-19 represents unanticipated challenges for SMAs, it reinforces that SMAs are continually facing growing demands.

To meet these demands, SMAs will require resources from governors' offices, health and human services agencies, and state legislative committees to develop key functions, which include benefit administration and oversight, data analytics, eligibility and enrollment, policy and regulation, provider engagement and contracting, and much more. SMAs will then be able to leverage these functions to achieve the ambitious policy goal of improving population health and to support the leadership teams on which success in both of these areas ultimately depends.

Balancing Competing Needs

As SMAs move to fulfill both their historic and emerging roles, they must continue to balance two important sets of competing needs: 1) balancing collaboration, regulation, and purchasing and 2) balancing daily operations with reforms. By clearly identifying the tradeoffs faced in these balancing acts, SMAs can make explicit and informed decisions about how to manage those tradeoffs.

Collaborating, Regulating, and Purchasing. The first set of competing needs is balancing the time an SMA spends collaborating with the time it spends purchasing and the time it spends regulating. For SMAs, collaboration with stakeholders both within state government (e.g., behavioral health agencies, insurance departments, and public health agencies) and outside of state government (e.g., consumer advocates, managed care organizations [MCOs], and

providers) is essential to further its goals. Without collaboration, an SMA cannot align operations and policy, develop buy-in and ongoing support, and further community education about the program.

And even as SMAs are collaborating with stakeholders, they also have an obligation to act as a regulator — primarily of MCOs (in states with managed care) and of health care providers. For instance, SMAs must ensure compliance with federal program integrity rules (e.g., ensuring that neither overpayments nor underpayments are made by MCOs to providers). The consequences for failing to effectively serve as a regulator can be significant, including the loss of federal financial participation.[6]

Even though SMAs historically exist as social service agencies, conceiving of them as government financing entities is more accurate from a functional perspective in the current era. SMAs do not directly deliver care or services, but they do purchase both on behalf of taxpayers to improve the health outcomes of members. Ensuring that collaboration, regulation, and purchasing advance SMA goals is a necessity, and doing so requires that underlying SMA functions are well defined and highly effective.

Current Operations with New Reforms. The second set of competing needs is the need to balance prioritizing current operational excellence with taking on new policy initiatives. Overinvesting in either of these two areas carries great risk for an SMA. If current operations are prioritized excessively, an SMA can easily find itself consumed with administrative processes that have little or no effect on individual health outcomes or system-level reforms. If new reforms are prioritized over operations, an SMA can find its effectiveness compromised.

Of these two areas, the greater risk is likely in the endless pursuit of new initiatives. Pressure to pursue reforms can come from many places outside of SMAs. For example, governors and legislatures may want to claim credit for innovations in the context of election cycles, or consumer advocates or providers may have unrealistic expectations of an SMA's capacity to take on a broader scope without additional resources.

In the end, SMAs need to be supported so they can meet at least minimum performance standards for current operations. After this threshold is reached, an approximately equal distribution of effort between pursuing reforms and improving operations is appropriate. If SMAs have the capacity to navigate their competing needs in this way, success will again largely rest on the extent to which underlying SMA functions are well defined and highly effective.

Strategies to Identify, Develop, and Manage Key Functions

Only those SMAs that have a full command of their capabilities can make bold policy reform a reality. The strategies identified below will help SMAs take actionable steps to improve performance of key functions that can then be leveraged to improve population health.

Strategy 1: Keeping Control of the Program While Outsourcing Functions to Accelerate Performance

SMAs will need to determine which functions need to stay in-house over the long term and which can be outsourced to be more effective and efficient. When the SMA's role is centered on acting as a transformative purchaser responsible for furthering population health, retaining responsibility for the full range of administrative functions can draw focus and resources away from transformation efforts.

The value of direct administration, however, is that the SMA ensures that it has a level of control that is aligned with its responsibility — as opposed to relying on vendors that do not inherently have such accountability. In the end, functions considered for retention in-house should be, as a baseline criterion, those that the SMA considers most critical to achieving its goals (e.g., policy and regulation) or required from a compliance perspective (e.g., eligibility). Moreover, outsourcing should be a strategy considered when an SMA has a clear understanding that doing so can accelerate performance for a price that the SMA is able to pay.

> Policymakers in both the executive and legislative branches need to **provide SMAs with adequate funding** to perform in-house functions effectively and to procure high-performing vendors for outsourced functions.

It follows that it is optimal to employ outsourcing largely in two situations. The first is for functions where the state cannot obtain the level of resources needed to administer the function successfully within state budget constraints or cannot structure the function flexibly enough within state personnel rules (e.g., member services). The second is for select components of functions that require highly specialized technical competencies that are difficult to obtain through recruiting in-house talent within state budget constraints (e.g., actuarial services, Medicaid management information systems maintenance and operations, and third-party liability identification and recovery).

Example: If an SMA is embarking on the design or redesign of an ambitious reform of its delivery and payment systems, it may find that during the design/redesign phase there is much to be gained from outsourcing certain functions. In this situation, it can be of tremendous value to outsource advanced financial analytics, comparative policy analysis, and independent evaluation. This can augment state capacity, ensure that national best practices are incorporated into policymaking and programmatic development, and provide an objective review of successes and failures to date.

Strategy 2: Active Management for MCO Contracts

With 40 states contracting with MCOs to serve over 50 million individuals on Medicaid at a cost of over $230 billion annually,[7] the majority of SMAs will need to consider how to manage their MCO contracts more effectively to ensure the highest level of performance. This is especially true in an environment where the SMA's role is centered on acting as a purchaser responsible for furthering population health.

To get the most out of their MCO contracts, SMAs should consider active contract management, using high-frequency data to improve cost and quality.[8] Such management allows SMAs to identify performance issues in real time in order to take immediate corrective action, see incremental improvement on prioritized policy outcomes, and support accountability for system transformation. Active contract management can be employed no matter the contract terms to drive MCOs toward the desired performance on outcomes.

> Policymakers in both the executive and legislative branches need to **stand behind SMA efforts to hold MCOs accountable** for the highest level of performance by directing MCOs back to SMAs to resolve any alleged issues with the SMA that may be cited by the MCO.

Example: If an SMA is attempting to improve population health through reducing unplanned pregnancies, SMAs can track and publicly report managed care performance in providing access to the full range of contraceptive methods compared to fee-for-service. The data collected can then be used to initiate policies such as providing performance bonuses to MCOs for contracting with providers who offer same-day access to the full range of contraceptive methods. It can also be used to foster competition among MCOs to be seen as a market leader in improving outcomes in an area that the state has prioritized.

Strategy 3: Federal Relationship Active Management

SMAs must also account for their relationship to the federal government, and specifically to the Centers for Medicare and Medicaid Services (CMS), given Medicaid's structure as federal-state partnership. With support from governors and legislatures, an SMA must employ a federal relationship management strategy that actively ensures that:

1. SMAs can demonstrate to CMS that minimum federal requirements are consistently met and, when not met, are addressed comprehensively and transparently.

2. SMAs can obtain flexibility in areas of financing and policy to advance state delivery system transformation goals, including but not limited to flexibility granted through waivers.

3. SMAs can call upon their governor to engage with the CMS administrator on select matters of the highest importance.

CMS financing and oversight provides the backdrop behind which an SMA carries out its functions related to both routine operations and broader reforms. Given this, the cultivation and maintenance of an open and productive federal–state relationship must be adequately resourced by an SMA at all levels of the organization, with responsibilities clearly defined.

This process will involve defining the unit of the SMA that owns the relationship with CMS from a functional perspective (e.g., policy and regulation) and ensuring that there are staff responsible for the operational processes associated with CMS engagement (e.g., state plan amendment development and submission or waiver development, submission, and reporting). Clear protocols need to be in place specifying how the designated area of the SMA engages with other areas of the SMA (e.g., financial operations) as necessary to meet CMS requirements. In addition, clear expectations must be set for when escalation to senior management should occur, including but not limited to the Medicaid director.

> Policymakers in both the executive and legislative branches, except when called upon by the SMA, need to **respect the unique relationship** between CMS and the SMA by not seeking to involve themselves in that relationship.

Example: If an SMA is engaged in a section 1115 waiver negotiation with CMS, decision-making and engagement can be delegated to staff with direct expertise and knowledge of CMS processes and the subject matter under discussion. These individuals can be supported in openly and productively working through as many outstanding issues as possible before escalating to Medicaid senior management. CMS staff and SMA staff can thereby build trust and develop solutions acceptable to both parties.

Strategies to Leverage Key Functions to Improve Population Health

The strategies that follow will help an SMA effectively leverage its investment in its key functions so that they contribute to improved health outcomes.

Strategy 1: Taking Concerted Action with Other State Agencies

SMAs can leverage policy and regulation to magnify the impact and reach of initiatives by aligning with state agency partners on efforts that contribute to improving population health. For instance, concerted action across an SMA and a public health agency can bring together the full capacity of Medicaid as a purchaser of health care services and the full capacity of a public health agency as a promoter of healthy behaviors and healthy communities to maximize the impact on population health.

This is not to underestimate the challenge in achieving this type of alignment because often SMAs and public health agencies have profoundly different accountabilities, cultures, and priorities. However, SMAs can and should take a leadership role in initiating this type of concerted action because of the benefits it can have for population health outcomes.

> Policymakers in both the executive and legislative branches should have a **willingness to make investments in human services programs and public health initiatives** outside of Medicaid. Such investments may ultimately yield Medicaid savings and magnify the outcomes that can come from SMA engagement in interagency efforts.

Example: If an SMA and a public health agency are both prioritizing efforts to address health equity, they can work together to engage and ultimately partner with providers focused on population health, including those participating in Medicaid accountable care organizations (ACOs), with community-based organizations (CBOs). CBOs, which are supported by public health agencies, can help address social determinants of health (SDOH) like housing. If this collaboration is further supported by statewide investments in affordable housing, the ultimate result of such partnerships can be improved outcomes in terms of both cost and quality for the Medicaid population and their communities.

Strategy 2: Establishing Joint Accountability for MCOs and Providers

SMAs will need to take actions to hold MCOs and providers accountable for delivery system reform that results in improved costs and quality. To do so, SMAs will need to rely upon high-performing key functions such as managed care oversight and provider engagement and contracting to ensure the success of alternative payment models (APMs) that can create joint accountability for MCOs and providers in a reformed delivery system.

Example: If an SMA requires MCOs to enter into contracts with provider entities that will become accountable for a defined population's total cost of care and quality outcomes over time, the SMA will empower providers, improve quality, and control costs through these value-based contracts. Starting with shared savings, provider entities can eventually share both savings and risk with the MCOs. To make such a schema work, high-performing data analytics and reporting and financial analytics are necessary for tasks such as setting total cost of care benchmarks and developing and incorporating quality measures into the APM.

> Policymakers in both the executive and legislative branches should **stand firm against attempts** by MCOs and providers to slow the pace of delivery system reform fostered by SMAs.

Strategy 3: Moving Beyond Social Determinants of Health Screening and Referrals

The increasing recognition that addressing SDOH is a necessary component of achieving health equity[9] strengthens the imperative for SMAs to address SDOH, especially given the current national conversation surrounding racism and racial injustices. SMAs will be expected to take meaningful action that will result in sustained progress.

However, in Medicaid, much work around SDOH has focused on screening and referrals for social services.[10] To fulfill its emerging role to reform the delivery system and affect population health in this area, SMAs need, with CMS support, to prioritize more initiatives that finance the delivery of the social services that address important SDOH, including education, employment, food, and neighborhood and physical environment (e.g., housing and transportation).[11]

> Policymakers in both the executive and legislative branches must have a **willingness to augment** SMA efforts to address SDOH through the delivery system by making direct and strategic investments in SDOH through mechanisms other than Medicaid.

Example: If an SMA is focused on moving beyond SDOH screening and referrals alone, it will need to build or purchase technology to track whether screening and referrals result in services rendered within the social services system. Additionally, it will need to develop a mechanism for managing performance of social service agencies to ensure needs are met. To support these efforts, CMS can be engaged to evaluate creative opportunities to finance addressing social needs through section 1115 waivers and other authorities. However, the SMA will need

its legal services to put forth compelling arguments for flexibility. The agency will also need to engage with providers and contract to manage the links between health care provider networks and CBO networks.

Strategy 4: Prioritizing Behavioral Health

Medicaid serves as one of the largest sources of financing for behavioral health (BH) services — accounting for 25% of spending on mental health services and 21% of spending on substance use disorder services.[12] Medicaid members with BH needs have a higher likelihood of having comorbid chronic physical conditions, leading to relatively high Medicaid expenditures.[13] In fact, the per beneficiary cost for individuals with BH diagnoses is four times what it is for those without these diagnoses, inclusive of care received for BH, LTSS, and physical health.[14] Given these realities, improving health outcomes for individuals with BH conditions is a core part of improving population health overall for Medicaid. Leadership teams in SMAs and BH agencies will need to foster concerted action to ensure success.

> Policymakers in both the executive and legislative branches should strongly consider **authorizing changes that foster alignment of authority and funding** between SMAs and behavioral health (BH) agencies up to and including integration of BH agencies into SMAs when appropriate.

Example: SMAs and BH agencies can collaborate to, for example, ensure that Medicaid ACO attribution models and APMs account for the specific challenges that individuals with BH needs face. This is especially true for individuals with serious mental illness. To address such needs successfully, data analytics and reporting are required to understand the needs of these individuals, as well as foster alignment, collaboration, and partnership across provider types in the BH sphere (e.g., community mental health centers) and the physical health sphere (e.g., federally qualified health centers).

Strategies to Support Leadership Teams

Strong SMA leaders are necessary to successfully develop and leverage key functions for population health. Enhancing both the capacity and the skills of leadership teams to manage key functions effectively requires a range of strategies.

Strategy 1: Retaining Medicaid Directors

Without a sustained improvement in the median tenure for Medicaid directors, which was 21 months as of March 2019,[15] it will be very difficult for agencies to reach their full potential to affect population health. State agencies' inability to retain Medicaid directors for longer tenures

compromises their ability to provide the kind of long-term and stable leadership that creates the optimal circumstances to develop key functions and leverage them.

The reasons for the high turnover include burnout, gubernatorial elections, opportunities in the private sector, and salaries.[16] Not all of the factors that influence Medicaid director tenure are easily addressed (e.g., gubernatorial elections or opportunities in the private sector), but some (e.g., burnout, lack of leadership development opportunities, or salaries) certainly could be if the will exists to do so. For example, states have shown that the limitations on competitive compensation can be overcome by creating alternative salary structures, as has been done in some cases with public university presidents.[17] Additionally, programs like the Center for Health Care Strategies (CHCS) Medicaid Leadership Institute (of which the author is an alumnus), which provide opportunities for skill and subject matter development critical to successful leadership, are invaluable.[18]

> Policymakers in both the executive and legislative branches need to **prioritize recruiting and retaining Medicaid directors** of the highest caliber by providing sufficient funding for SMA staffing to support the Medicaid director. They also need to **authorize the changes necessary to offer competitive compensation** as part of an overall effort to provide public acknowledgment and support.

Example: If a state is committed to increasing the longevity of its Medicaid director, employing two tactics may have an outsized positive impact. First, a state can provide adequate resources to its SMA, allowing a Medicaid director to lead an agency where there is enough staffing, technology, etc., to meet basic obligations. Second, a state can compensate a Medicaid director as competitively as possible relative at least to other Medicaid directors. According to NAMD, only four Medicaid directors have salaries of $210,000 or greater.[19] This salary range should be the norm given a Medicaid director's obligations and the sacrifices required to give the role what it demands. Together, these two steps could have a material effect on reducing burnout by setting a Medicaid director up for success and making clear that the person in the role is valued.

Strategy 2: Recruiting a Senior Management Team with Relevant Experience

The cultivation and support of other senior leaders within SMAs is critical given that these roles oversee the agency's key functions. Members of Medicaid senior leadership teams can oversee areas such as budget and finance (e.g., financial analytics and financial operations), managed care and oversight (e.g., managed care contract management and policy and regulation), and operations (e.g., member services and information technology). The ability to attract and retain high-caliber staff to support the Medicaid director and the SMA's overall team is as important as recruiting an excellent Medicaid director.

Different tactics can be deployed to attract and keep the right talent for these roles. One is to creatively examine state salary scales to identify classifications with reasonable compensation for this level of responsibility and work with governors' offices and other relevant executive branch agencies to post positions using these classifications even if they are not specific to Medicaid. Another is to recruit and mentor individuals with aptitude and potential but without the optimal level of experience — and accept this tradeoff as the most feasible path to high performance. Junior executives at MCOs or state government managers with experience in high-performing budget offices or SMAs represent one potential pool for future senior leaders. These individuals often have the type of payer or financial experience that can align well with many of the functions at an SMA. A third approach is to clearly define the competencies needed for leadership success (using a guide such as the Framework for Public Sector Leadership[20] jointly developed by the Public Sector Leadership Consortium consisting of CHCS, Milbank Memorial Fund, and NAMD) and provide targeted professional development opportunities for Medicaid senior management team members.

> Policymakers in both the executive and legislative branches should support a Medicaid director's efforts to **develop and sustain an effective Medicaid senior leadership team** by providing streamlined hiring pathways and resources for professional development.

Example: If an SMA is hiring, for instance, a deputy Medicaid director for budget and finance, it can look to other states with a record of Medicaid innovation in cost containment and attempt to recruit managers from those states with a demonstrated aptitude in key competencies such as accounting, budget development, financial analytics, and rate setting as well as managerial skills. With the right mentoring, that individual is likely to perform well, and the compensation level offered will not prove to be a decisive barrier.

Conclusion

Governors' offices, umbrella health and human services agencies, and state legislative committees ultimately make the enabling decisions that determine how SMAs are resourced and structured. It's important that these decisions set up SMAs for success in meeting their increasing responsibilities given the impact this will have on members and the delivery systems. The strategies outlined in this report are intended to buttress agencies as they develop high-performing functions, leverage these functions to achieve the ambitious policy goal of improving population health, and support leadership teams.

Medicaid is arguably the most important force for social justice in American life. It's urgent to support Medicaid leaders as they seek to enhance and leverage the key functions of SMAs on behalf of those they serve.

Notes

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