EXECUTIVE SUMMARY

The Role of State Medicaid Directors:
A Leadership Imperative

by Andy Allison, PhD

The Author

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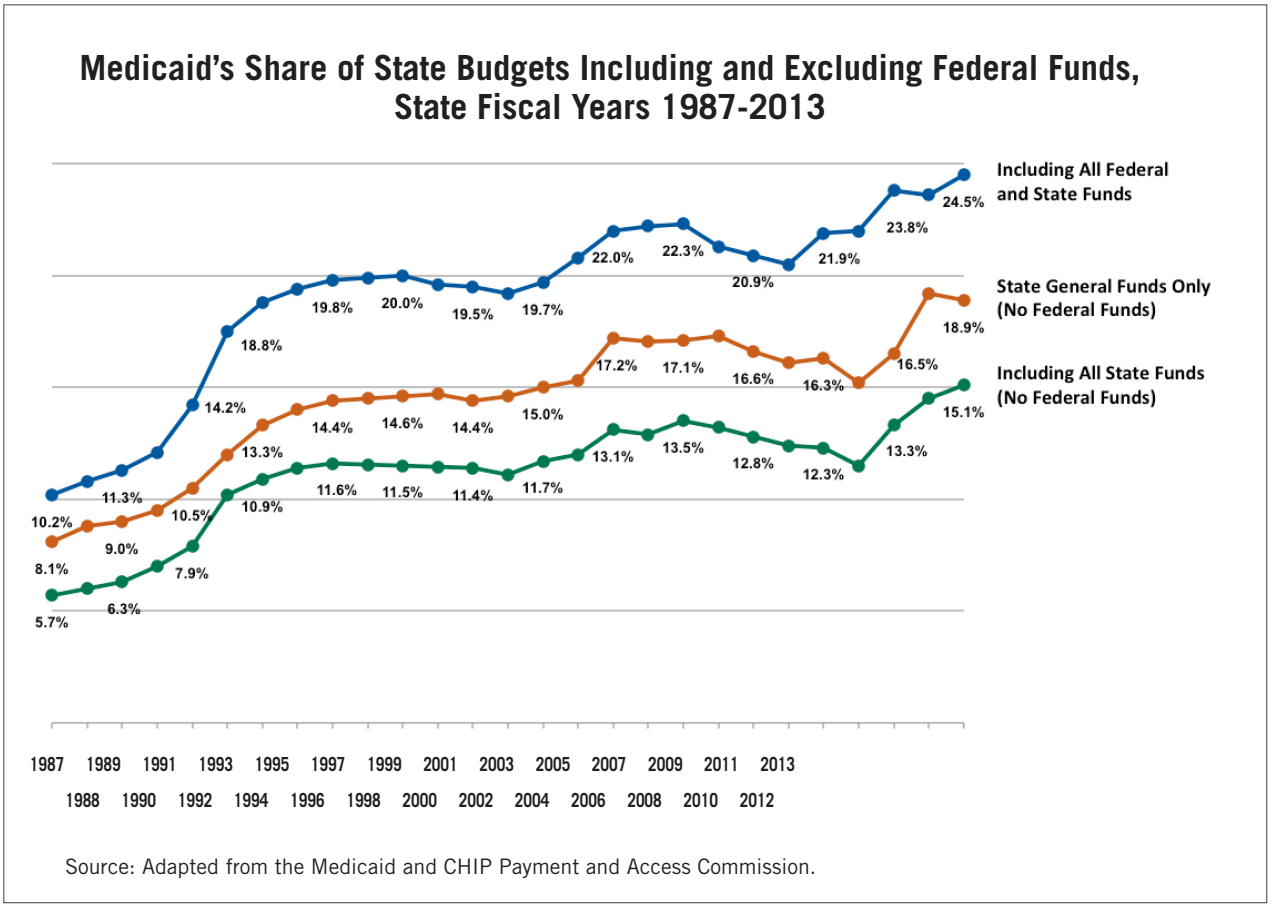
Introduction

By 2010, when the Affordable Care Act (ACA) was passed, the Medicaid program had grown to become the largest centrally administered public program in at least 40 states, and was a top-three budgetary obligation in 41 out of 50 states.[1] Since 1987, it has grown from comprising 10% of state budgets to comprising 25% in 2013 (see Figure 1).[2] At the national level, Medicaid was on a path to command nearly 10% of the federal budget by 2025,[3] and is the largest jointly funded federal/state program in the history of American federalism.[4]

Figure 1



Source: Adapted from the Medicaid and CHIP Payment and Access Commission.

The sheer size of Medicaid, its expected growth, and the significance of state program choices in the coming years—none more substantial than whether to participate in the ACA's now-optional expansion—have drawn attention to the adequacy of its administration. The leaders of state Medicaid programs face a sobering magnitude of challenges—challenges that will only continue to grow. For state governments, inadequate administration of what is becoming their largest budget item poses grave financial and political risks.

This report explores the current state of Medicaid program administration, particularly the adequacy of state investments in the role and compensation of Medicaid leaders. It builds on two recent reviews of Medicaid governance,[5,6] both of which describe the constraints and limitations placed on state Medicaid programs, develop a case for added investment in program administration, and begin to formulate a list of options for those investments. Unlike those reports, this report focuses specifically on states' investment in the leadership of Medicaid in recognition of the central and potentially pivotal role it plays in the overall form, scale, and effectiveness of state Medicaid administration.

With key points illustrated with the author's experiences as a Medicaid director for eight years in two states, this report attempts to accomplish this by

- documenting the current responsibilities of Medicaid programs and their potential impact on the US health care system;
- evaluating the organizational design of Medicaid programs in comparison to management theory;
- assessing Medicaid program leadership roles, authority, and compensation in comparison to current practice in private corporations and comparably large and complex public and nonprofit institutions; and
- presenting findings and recommendations to help Medicaid programs enhance their impact and fully meet their responsibilities.

Overview and Impact of Medicaid

State Medicaid leadership matters

State-level Medicaid policy and program choices affect the health and welfare of millions of program participants and have a measurable impact on both state and federal tax burdens. They carry with them huge potential spillover benefits to other states, and can lead to multi-billion dollar shifts in the flow of federal tax dollars to states. The variation in and impact of programmatic design and policy choices at the state level reinforce the need for capable program leadership.

Medicaid leaders do not work alone. They function within a web of authority and influence. However, Medicaid directors have responsibility for the program. They assemble and defend budgets. They sign contracts. They represent the state. They are accountable to the federal government for the compliance necessary to guarantee federal matching funds. With appropriate skills and authority, they can set forth and significantly influence the policy choices that are made regarding Medicaid and improve the health of their state's residents and their state's economy.

Many Medicaid directors have expressed frustration over a perceived mismatch between the program's challenges and the resources they can draw on to address them.[7] A core question is whether these frustrations are rooted in irreconcilable conflicts between the demand for Medicaid services and the resources to pay for them. Or, instead, might it be possible for states to identify and invest in improvements in public governance and leadership that would result in mutual gain to taxpayers and participants alike? It is the possibility of such uncompromising gain in the administration of one of the nation's largest government programs—and the largest in the history of American federalism—that motivates this preliminary look at the way in which states structure the leadership and governance of the Medicaid program.

Medicaid and its scale

As established in Title XIX of the Social Security Act in 1965, Medicaid is a source of federal matching funds that can be used to meet a state's important health needs—paying for medical care, long-term care, and supportive services for specific populations. The list of populations deemed "needy" by Congress and by individual states has grown significantly over the years, beginning with the elderly, the disabled, and poor single mothers, and now encompassing all low-income children and, at state option under the ACA, all poor nondisabled, nonelderly adults. Medicaid covers populations as widely variant in age and health status as the human condition allows.

As of 2014, state Medicaid programs were collectively the largest insurer in the country, covering 68 million Americans (and legal residents), representing a little over one-fifth of the US population (21%).[8] The Congressional Budget Office (CBO) projects that Medicaid will grow from 7.1% of federal spending in 2012 to 9.5% by 2025, and Centers for Medicare and Medicaid Services (CMS) actuaries project Medicaid will account for nearly one-fifth of growth in health spending over that period and increase from 2.7% of gross domestic product to 3.4%.[9]

States' role in designing and administering Medicaid

States share both program costs and program administration responsibilities with the federal government. Although the federal government periodically initiates policy change in the program—sometimes in dramatic scale, as with the passage of the ACA—in many respects, the federal role leans toward oversight of state actions. States are responsible for all direct program administration and much of the program's design.

The array of Medicaid's programmatic objectives and responsibilities listed below, from a report of the Medicaid and CHIP Payment and Access Commission (MACPAC),[10] portrays the breadth and complexity of Medicaid programs, and begins to suggest the nature and scale of a Medicaid leader's role in influencing the important choices that must be made:

- Define covered populations, benefits, and provider qualifications
- Define and make payments
- Design, operate, and oversee delivery systems
- Manage utilization
- Claim federal financial participation
- Determine participants' eligibility
- Implement enrollee protections and safeguards
- Collect and monitor program data
- Measure and manage quality and performance
- Defend state practices and reports
- Ensure program integrity

The impact of Medicaid policy leadership on the program

Observed differences in state Medicaid spending relative to the size of a state's economy reinforce program leaders' potential influence. Variation in the size of state Medicaid programs is substantial, with Medicaid comprising just less than 1.5% of gross state product in 2012 in Nevada and Wyoming, but nearly 5% in Maine and Vermont. States also differ widely in the size of their Medicaid program as a percentage of state-level health expenditures, from 8.6% in Nevada to 29.2% in New York.[11] In addition, states with lower per-capita income do not spend an appreciably different portion of their economy on Medicaid, again confirming the importance of policy choices made at the state level.

How Medicaid Influences the Rest of the Health Care System

Medicaid's importance does not stop at the program's edge. As the single largest local purchaser of health care in state economies and driver of up to 30% of the health care market,[12] the program has grown to such a size that states can potentially use it to effect broader change in state health care and health insurance markets. Examples include the impact of Medicaid on private insurance markets and state payment reforms supported by new federal grants. Beyond insurance markets and provider payment reforms, Medicaid policy decisions affect numerous aspects of a state's health care environment, including the state's clinical quality agenda, maternal and child health care, the training of new providers, and services available to former prisoners reentering society.

Spillover effects

The influence of Medicaid leadership can also extend beyond individual states, given the high potential for replication of program innovation. Leaders of the nation's Medicaid programs communicate with one another frequently through the National Association of Medicaid Directors (NAMD), as well as through many philanthropic and academic membership–based associations, and are supported in these efforts by a growing online information base. Their ability to share information magnifies the potential impact of Medicaid leaders in each state, giving each state Medicaid director—and members of each director's team—the opportunity to make decisions and bring about changes with billions of dollars in impact across the country.

Organizational Design of Medicaid Programs

To ensure Medicaid meets its significant and expanding goals and responsibilities, attention must be paid to how the program is organized. In doing so, is it appropriate to compare Medicaid to a private corporation? In spite of obvious differences in governance and purpose, for scale and complexity: yes. A look at revenue for publicly traded companies and total spending for Medicaid programs reveals that 41 of 51 Medicaid programs (including the District of Columbia) would have ranked among the Fortune 1000 in 2013, and a majority of programs would have been in the Fortune 500.[13] The breadth of people served, cost of services transacted, and complexity of operational processes required rival those of private sector counterparts. In addition, the scope of the economic and social impact of corporate chief executive officers (CEOs) is comparable to that of state Medicaid leaders even if their roles with respect to the number of employees, scale of physical infrastructure, or relationship to a corporate board of directors differ.

Principles of corporate organizational design and their applicability to Medicaid

If Medicaid programs bear some resemblance to corporations of similar size and scope, what can be learned from the principles of corporate organizational design?

Medicaid's product (or "business opportunity"). Medicaid's fundamental product is funding and delivering health-related services to needy populations. Since Medicaid's inception, the definitions of both "necessary" services and "needy" populations have widened, leading to the program's growth and increasing complexity.

Medicaid's business strategy. Over the last few years, Medicaid programs have increasingly focused on twin objectives: consolidating payments for an ever-wider collection of health care services—physical, behavioral, and supportive—for an increasing number of people, and more fully integrating and coordinating the delivery of those services. Tactics to meet goals of payment consolidation and service integration are increasingly oriented towards combining payment through Medicaid managed care organizations (MCOs), as in Kansas,

Texas, Iowa, Arizona, and Tennessee. Regardless of whether MCO tactics are employed, lessons learned from the study of corporations suggest that Medicaid's organizational design should reflect these new goals.

Is Medicaid really a collection of products and programs? In one interpretation, Medicaid could be defined as a multi-program organization, responding to multiple "business opportunities." These "programs," which could be viewed in terms of services (e.g., physical vs. mental health) or populations (e.g., nondisabled families vs. disabled individuals), would each have their own set of strategies and different organizational designs to serve each strategy.

This report makes the case, however, that the populations Medicaid covers and the providers who serve them should not be fragmented, and that a unified Medicaid organizational structure with clear accountability is consistent with a strategy of consolidating payments and integrating services to best meet the needs of states.

Medicaid's organization and position in state government

Given the prominence of Medicaid in state budgets and health policy, its relatively low profile in state executive branches is somewhat surprising. Approximately two-thirds of states operate their Medicaid program as a division within a superagency (58%) or as a subunit within a division within a superagency (7%), while the remainder operate Medicaid as a separate agency (35%).[14]

CMS requires, as a condition for receiving federal funds for Medicaid, that a single state agency be the point of administrative, financial, audit, and compliance contact for the federal government. Despite this accountability, states are not required to consolidate Medicaid's authority into a single agency. Indeed, many states have not done so, harboring what appears to be a growing mismatch between programmatic accountability on the one hand and programmatic control on the other.

Four-fifths (81%) of states manage services for the intellectually and developmentally disabled—a package of institutional and noninstitutional services funded almost exclusively through Medicaid—in another unit of government such as a sister division or another agency. More than one-quarter (30%) of states administer long-term services and supports for the aged through a separate division or agency, while two-thirds (64%) administer mental health services through a separate agency.[15]

Emerging models of Medicaid governance

A number of states have consolidated programmatic influence and aligned governance for Medicaid in response to the kinds of challenges noted in this report. In lieu of a full organizational consolidation, at least three approaches can be observed: states that have elevated the Medicaid director to the governor's cabinet; states that have consolidated Medicaid budget authority under the Medicaid agency; and states that have granted the

Medicaid agency some administrative independence or autonomy in areas such as procurement and personnel. Examples are noted below.

New York

The New York Medicaid director reports to the commissioner of health. However, given the size and importance of the Medicaid program, as a practical matter, the Medicaid director interfaces directly with the governor's senior advisers. While there are separate offices for mental health, substance abuse, and developmental disabilities, the Medicaid budgets for all three are consolidated under the Medicaid director. Finally, the Medicaid program is increasingly administered through private MCOs, all of which are regulated by the Medicaid agency.[16]

Arizona

With its governance and administration, Arizona has taken an even more formal approach to strategic alignment of Medicaid's emerging scale and purpose. Arizona Medicaid is a cabinet-level agency—and its director reports directly to the governor. While separate agencies for certain Medicaid-eligible populations exist as in New York, the state's legislature has voted to shift 100 Medicaid full-time employees back to the Medicaid agency, whose influence over service provision and budgeting is broader as a result of the agency's long-standing use of MCOs to administer the program. These contracts now include virtually all Medicaid-funded services. In addition, the Medicaid agency is exempt from the state's procurement rules, and roughly 30% of its employees work from home, a significant departure from traditional civil service.[17]

Tennessee

The director of the state's Medicaid program, TennCare, reports to the commissioner of finance and administration, but sits on the governor's cabinet and is ultimately accountable to the governor. The agency's placement in the Department of Finance and Administration allows it to leverage the significant authorities and administrative flexibility granted the commissioner. TennCare is administered through MCOs, consolidating administrative influence through these increasingly far-reaching contracts. TennCare's director is ultimately responsible for a consolidated Medicaid budget that includes all Medicaid-funded services. TennCare also boasts comparatively remarkable tenures among its director and senior staff. The current director has held the position for more than nine years and the deputy director has been with the program for more than 12 years. In addition, the average length of TennCare service for the rest of the executive team is eight years.[18]

Administrative and staffing resources

The best-designed organization will be ineffective if it does not have adequate resources to carry out its work. The resources devoted to the administration of diffuse Medicaid programs are small in comparison to those of commercial insurers. State Medicaid programs

typically employ a staff of 300 to 600, but this number can range in some states from fewer than 50 employees to more than 3,500 in California.[19] Nationally, the typical Medicaid program devotes 5% of its total expenditures to administration of the program (not including dollars that MCOs or providers devote to similar functions), amounting to $22.9 billion in federal fiscal year 2013.[20] In its June 2014 Report to the Congress on Medicaid and CHIP, MACPAC devoted a chapter to "Building Capacity to Administer Medicaid and CHIP." This report addresses the need for added capacity, but notes "there are few clear standards . . . and little strong evidence on best practices."[21]

Leadership and Authority in Medicaid

This report has already documented variation in the organizational structure and position of Medicaid in state governments—and thus variation in the role of its leadership. Analysis also indicates that Medicaid leaders are compensated less than leaders of comparable private and public sector organizations and maintain shorter leadership tenures.

Compensation of Medicaid directors and corporate CEOs

According to the 2013 NAMD operations survey, the most recent available survey that includes salary information, about one in 10 (9%) Medicaid directors earned more than $200,000 per year, about one-quarter (23%) earned between $150,000 and $200,000, and nearly two-thirds (64%) earned between $100,000 and $150,000.[22]

Corporate CEOs earn 10 to 20 times as much as Medicaid leaders and their pay increases significantly with firm size. Data show that CEOs in the top 1,000 corporations earned at least $1 million more for each 100-firm increase in their corporation's rank among the largest 1,000 corporations.[23] By contrast, leaders of larger Medicaid programs do not earn more than their peers.

While profit sharing and stock options are not possible in Medicaid, other private sector compensation arrangements could be—for example, pairing incentives with guaranteed or minimum employment contracts or setting compensation levels high enough to counter some of the risks that failure could pose to a director's future earnings. Employment contracts incentivizing longer tenures could provide both a measure of financial protection and a concrete investment in a Medicaid director's leadership platform, thereby enhancing prospects for a successful tenure.

Tenure of Medicaid directors and corporate CEOs

According to the NAMD operations survey, the average tenure of a Medicaid director as of 2014 was approximately 3.5 to 3.75 years, and most Medicaid directors had served less than three years.[24] At that time, there seems not to have been a single longtime director

who had held the position for 10 or more years. NAMD's survey reveals annual exit rates of, on average, one-quarter to one-third of Medicaid directors, likely peaking at or near the end of state-specific political cycles coinciding with gubernatorial elections. The distribution of Medicaid directors by years served is indicative of both "natural" and politically induced turnover.

By comparison, one study found an average tenure of just less than six years for CEOs of Fortune 500 firms during the 1998 to 2005 period, which is nearly 50% longer than the average tenure of a Medicaid director.[25]

Executive compensation and tenure in comparably large and complex public and nonprofit enterprises

If analogies to corporate leadership are limited, it may also be instructive to compare Medicaid leaders to the heads of more directly comparable public sector and nonprofit institutions.

Public university presidents. Public university presidents earn substantially more than Medicaid directors. Average total compensation among 198 public university presidents in 2013 was $531,000, or about 3.6 times the average pay of state Medicaid directors in 2014.[26] (See Figure 2.) As of 2013, the average tenure of 255 public university presidents was 5.3 years, nearly 50% longer than the average tenure of Medicaid directors as of 2014.[27]

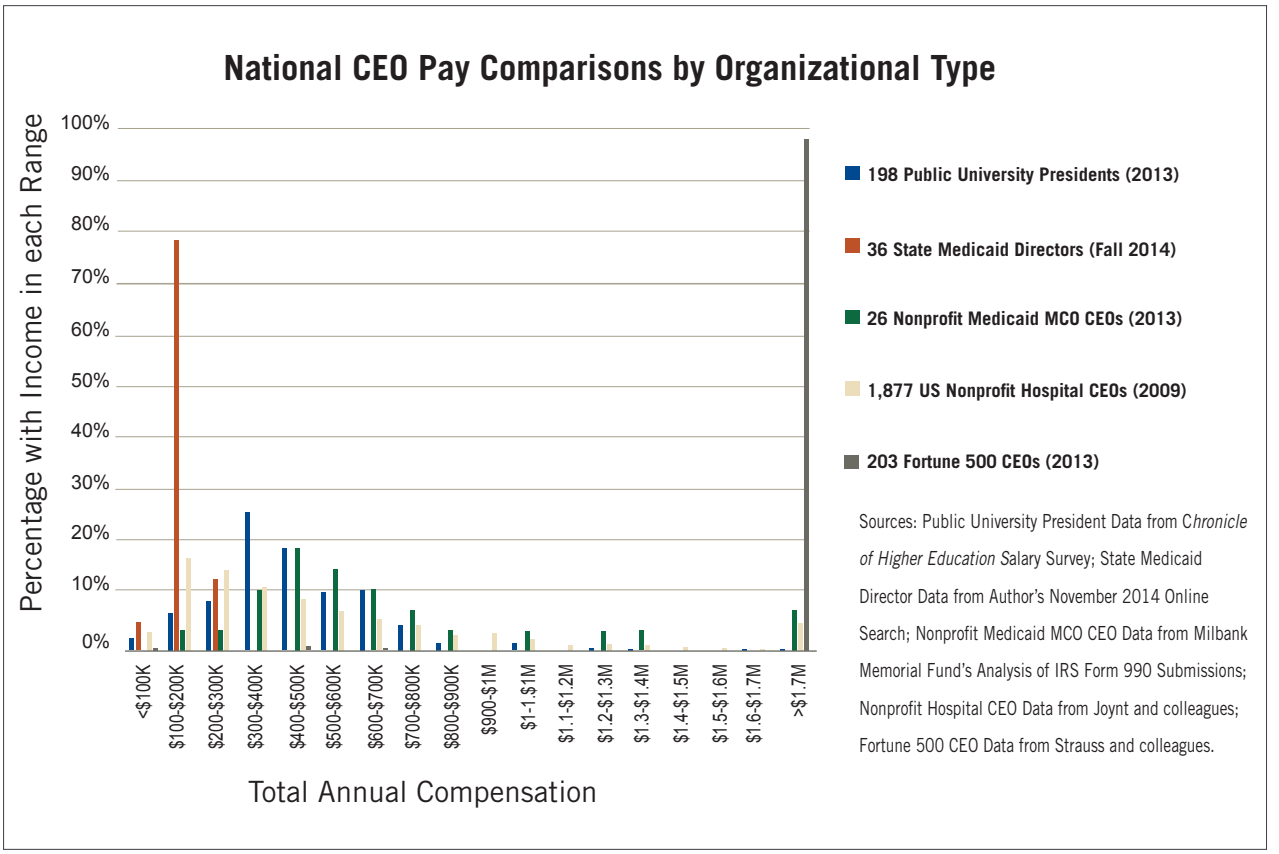
MCO CEOS. Medicaid MCO CEOs, whose organizations derive all or substantially all their revenues from the agencies Medicaid directors lead, have the most directly comparable private sector position to that of state Medicaid directors. MCO CEOs from a sample review of publicly available Internal Revenue Service (IRS) Form 990 tax documents[28] earned, on average, about 5.4 times more than the typical Medicaid director—$789,745 versus $146,753. Chief medical officers (CMOs), chief financial officers (CFOs), and chief operating officers (COOs) from these Medicaid MCOs each made, on average, more than twice that of the typical Medicaid director's salary. (See Figure 2.)

Executive compensation at nonprofit hospitals. The median CEO salary for 1,877 nonprofit hospitals in the United States was $404,938 in 2009.[29] Average compensation was $595,781, which was more than four times the average salary of a state Medicaid director in late 2014. Average compensation among CEOs of nonprofit teaching hospitals was another $150,000 to $425,000 higher, reaching an average compensation of more than $1 million for CEOs of major nonprofit teaching hospitals. All told, the average compensation for CEOS of nonprofit teaching hospitals in 2009 was more than six times the average compensation for a Medicaid director as of late 2014.[30] (See Figure 2.)

Medicaid leaders' salaries in a broad market context

The data in Figure 2 summarize the findings regarding compensation discussed in this report by presenting national tallies of CEO pay for Fortune 500 companies, public universities, Medicaid MCOs, and nonprofit hospitals in comparison to the pay of state Medicaid directors.[31] Medicaid directors do not only earn substantially less on average than these other chief executives, but nearly all Medicaid directors make less than nearly all of these other executives. The lack of overlap in Medicaid and other CEO pay suggests a profound lack of competitiveness for Medicaid director salaries at a national level.

Figure 2



Does the level of compensation matter in Medicaid?

There are at least two explanations for Medicaid directors taking and keeping the job despite noncompetitive compensation.

Altruism and the intrinsic value of public service. First, it may be that Medicaid directors are altruistic, driven to improve care and services for needy populations or to represent taxpayer interests in some other way—and that their altruism replaces financial compensation and makes up for at least some of the monetary gap. It may also be that some individuals are predisposed to public service—for example, to the challenge of making or regulating competitive markets as opposed to competing within them.

Career investment. A second explanation as to why a Medicaid director with high-earning capacity might accept the job is that he or she views it as an investment in future earnings opportunities. Indeed, it is widely understood that directors can expect to make more after their stints in public service. This raises the question of whether states might reasonably trade on the investment value of the Medicaid director position to attract and retain high-caliber leaders.

These explanations must be weighed against the economics of a competitive labor market and the organizational benefits of stable leadership. Although public sector leader compensation is generally discounted compared to private sector counterparts, there are precedents for market-based salary adjustments in government. This report raises the question of whether such adjustments are necessary for state governments to attract and retain the caliber of leadership required by complex Medicaid programs.

Key Conclusions and Recommendations

There has been little research focused on leadership of Medicaid, even though state Medicaid policy and program choices have an observable impact on the health and welfare of millions of program participants, have a measurable impact on both state and federal tax burdens, and almost certainly lead to multibillion-dollar shifts in the flow of federal tax dollars across state lines.

This report leads to the following conclusions:

- Medicaid is now usually a state's largest centrally managed program, financing and integrating comprehensive health care services for an average of 21% of state citizens, and comprising up to 30% of total public and private health care spending in a state.
- Medicaid programs have been steadily assigned new responsibilities as definitions of needy populations and needed services have expanded. The program has grown to become the major source of funding for behavioral health care, developmental disabilities services, and long-term care services.
- As a result of these expanded responsibilities, state Medicaid programs are big and complex, matching or exceeding the economic scale and civic impact of large private corporations and many of the nation's largest governmental organizations.
- Medicaid programs have significant impact on other parts of the health care sector and on other states across the country. States have begun to use their Medicaid programs to organize and lead systemic change in health care delivery systems, and these reforms, if successful, could help lead to meaningful improvement in outcomes and costs for health care across the country.

- Medicaid's organizational structure has not kept pace with major shifts in programmatic design and strategy. Most states continue to manage behavioral health care, services for those with intellectual or developmental disabilities, and/or long-term services and supports separately. The superagencies that often house Medicaid agencies inevitably place the program alongside these and other smaller or structurally subsidiary programs on an organizational parity with Medicaid, such as substance abuse agencies or functional support agencies like information technology and finance. Given the resulting imbalance between organizational changes on the one hand and preferred program strategy on the other, well-established management practice and analyses of the corporate sector indicate that Medicaid's organization has been neglected.

- The span of formal administrative control for Medicaid leaders often does not match the responsibilities of the program, raising the costs and difficulty associated with change, innovation, and effective management; diminishing the program leader's profile; and adding to the necessary skill set required for success.

- Pay gaps exist when Medicaid directors are compared to their peers in the private sector, in some comparable state-run enterprises, and in the health sector. Specifically, corporate CEOs earn 10 to 20 times as much as Medicaid directors while state university presidents and the CEOs of nonprofit hospitals and Medicaid MCOs earn about four to five times as much. Compensation for Medicaid directors is generally limited to salary, with no incentives for performance or longevity.

- Medicaid directors tend to stay only about half to two-thirds as long in their jobs as do their counterparts in the public and private sectors.

- This disparity in pay and leadership tenure is inconsistent with the public's interest in attracting and retaining leaders with capabilities equal to those of their counterparts in public and private institutions that match Medicaid's economic and civic impact.

The failure to restructure Medicaid's organization, give appropriate authority to its leadership, and develop meaningful strategies to recruit and retain leaders in a competitive labor market poses substantial financial, programmatic, and economic risks to taxpayers, providers, and program beneficiaries.

Recommendation #1

The current body of research and analysis does not support recommendations for specific levels of Medicaid executive pay, nor does it suggest ideal agency structure or agency resources in specific states. There is a paucity of information available to state policymakers in the execution of their duties as overseers of Medicaid.

Philanthropy, academia, and federal agencies with an interest in the impact, administration, and/or oversight of Medicaid should invest in the study of the program's leadership and administration to help establish evidence that can be used for effective state action.

Recommendation #2

Medicaid is a major source of financial risk and policy opportunity for governors and legislators. Yet the organizational design of Medicaid programs often reflects a "collection of programs" approach, with programs nested within one department or division but with services delivered by several others. This approach might meet stakeholder needs and have historical precedent, but it is an approach that is consistent with neither the emerging goals and strategic value of the program nor with management theory.

State leaders—including governors and legislators—should review the organization and leadership of programs largely funded through Medicaid alongside their goals for these programs. This would enable them to align their administrative structure with prevailing strategies for effective program delivery. While specific state circumstances may differ, this alignment is likely to bring Medicaid-funded services to a single cabinet-level agency and elevate the organizational placement of the Medicaid leader.

Recommendation #3

States do not pay Medicaid directors enough—relative to how private sector health care leaders are paid—to consistently attract and retain executive talent commensurate with the program's size, complexity, and value to taxpayers and participants. Director compensation packages limited to salary do not sufficiently align the incentives of directors with state program goals.

Governors and legislative leaders should commission compensation studies with appropriate sets of comparisons to better understand the levels and types of compensation needed for successful, stable Medicaid program leadership. The results of these state pay studies are expected to reveal, in most cases, the need for both substantial increases in compensation and the introduction of incentivized employment contracts.

Notes

1 National Association of State Budget Officers. (2010). *2009 State Expenditure Report*. Washington, DC: National Association of State Budget Officers. (Accessed July 21, 2015: https://www.nasbo.org/sites/default/files/2009-State-Expenditure-Report.pdf.) Higher education (but not K-12 education) or transportation are also classified as "centrally managed."

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3 Congressional Budget Office. (2010). *An Analysis of the President's Budgetary Proposals for Fiscal Year 2011*. Washington, DC: Congressional Budget Office. (Accessed July 21, 2015: https://www.cbo.gov/publication/21252); Congressional Budget Office. (2010). *Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline*. Washington, DC: Congressional Budget Office. (Accessed July 21, 2015: https://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf)

4 For Medicaid as the largest source of grant funding to states, see Wachino V., Schneider A., Rousseau D. (2004). *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*. Kaiser Commission on Medicaid and the Uninsured. (Accessed July 23, 2015: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/financing-the-medicaid-program-the-many-roles-of-federal-and-state-matching-funds-policy-brief.pdf.); For Medicaid as the largest of the federal entitlement programs jointly administered by states, see usgovernmentspending.com. (n.d.). (Accessed July 21, 2015: http://www.usgovernmentspending.com/entitlement_spending.)

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6 Griffin E., Riley T., Wachino V., Rudowitz R. (2013). *Managing a High-Performance Medicaid Program.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured. (Accessed July 21, 2015: https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8476-managing-a-high-performance-medicaid-program.pdf.)

7 Author's conversations with state Medicaid directors; See also Note 6 above.

[8] Center for Medicaid and CHIP Services. (2014). *Medicaid and CHIP: September 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*. Baltimore, MD: US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services. (Accessed July 21, 2015: http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-september-2014-application-eligibility-and-enrollment-report.pdf.); US Census Bureau. (2014). Population Clock. (Accessed December 18, 2014: http://www.census.gov/popclock/.)

[9] For data used in author's calculations of federal spending projections, see Congressional Budget Office. (2015). *March 2015 Baseline* from *Updated Budget Projections: 2015 to 2025.* Washington, DC: Congressional Budget Office. (Accessed July 21, 2015: https://www.cbo.gov/publication/45069.); For data used in author's calculations of health expenditures, see Centers for Medicare and Medicaid Services. (2014). *National Health Expenditure and Historical Projections 1960-2024*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed September 4, 2015: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.)

[10] See note 5 above.

[11] For total Medicaid spending in each state in federal fiscal year 2012, see Kaiser Family Foundation. (n.d.). *Kaiser State Health Facts: Total Medicaid Spending*. Washington, DC: Kaiser Family Foundation. (Accessed July 21, 2015: http://kff.org/medicaid/state-indicator/total-medicaid-spending/.); For gross state products, see Bureau of Economic Analysis. (2014). *Widespread But Slower Growth in 2013: Advance 2013 and Revised 1997-2012 Statistics of GDP by State*. Washington, DC: Bureau of Economic Analysis, US Department of Commerce. (Accessed July 21, 2015: https://www.bea.gov/newsreleases/regional/gdp_state/2014/pdf/gsp0614.pdf.); For per capita income calculated using population estimates, see US Census Bureau. (2013). *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013*. Washington, DC: US Census Bureau. (Accessed July 21, 2015:https://www.census.gov/popest/data/historical/2010s/vintage_2013/state.html.); For state Medicaid and total health spending, see Centers for Medicare and Medicaid Services. (2014). *Health Expenditures by State of Residence, 1991-2009*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed July 21, 2015: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html.)

[12] Author's calculations; CMS actuarial data show that Medicaid comprises 8%-30% of state health spending. This figure is also based on the author's experience and the assumption that, apart from Medicare, no other single purchaser, e.g., a single employer, could command that percentage of total state health care spending.

[13] For Medicaid data, see Centers for Medicare and Medicaid Services. (2013). *Financial Management Report for FY 2012 through FY 2013*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed February 23, 2015: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html.); For Fortune 500 and 1000 data, see fortune.com. (n.d.). (Accessed February 23, 2015: http://fortune.com/.) A "Fortune 1000" ranking by company revenues. (Accessed August 20, 2015: http://www.geolounge.com/fortune-1000-companies-2014-list/).

[14] National Association of Medicaid Directors. (2014). *State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors*. Washington, DC: National Association of Medicaid Directors. (Accessed July 21, 2015: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/14-297_namd_survey_final.pdf.)

[15] For data used in author's calculations, see note 14 above.

[16] Communications with Jason Helgerson and Deborah Bachrach, current and former Medicaid directors for the state of New York. June 2015.

[17] Communication with Tom Betlach, Arizona Medicaid director. June 2015.

[18] Communication with Darin Gordon, TennCare director. June 2015.

[19] Karlamangla S. (2015). Medi-Cal Director Talks Shortages and Modernization. *Los Angeles Times*. (Accessed May 24, 2015: http://www.latimes.com/local/countygovernment/la-me-jennifer-kent-20150525-story.html.)

[20] Across states, the average administrative load for Medicaid was 5% in FY 2013 and the median-ranked state spent 5.3% of total Medicaid expenditures on direct administrative costs. These statistics are from the author's calculations of state-level and overall national Medicaid administrative spending as a percentage of total Medicaid spending. For data used in calculations, see CMS publication cited in note 13 above.

[21] See note 5 above.

[22] National Association of Medicaid Directors. (2014). *State Medicaid Operations Survey: Second Annual Survey of Medicaid Directors*. Washington, DC: National Association of Medicaid Directors. (Accessed July 21, 2015: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ops_survey.pdf.) The Medicaid director salary information used in this report was augmented with the author's search of web-accessible salary data in November 2014, which yielded data on 38 program directors. Missing states are Alaska, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, Rhode Island, Washington, and Wyoming.

[23] Tervio M. (2008). The Difference That CEOs Make: An Assignment Model Approach. *American Economic Review.* 98(3):642-668.

[24] See note 22 above.

[25] Kaplan S.N., Minton B.A. (2008). *How Has CEO Turnover Changed?* Chicago, IL: University of Chicago. (Accessed July 21, 2015: http://faculty.chicagobooth.edu/steven.kaplan/research/km.pdf.)

[26] Salary computations exclude universities reporting partial-year figures. For compensation information used in author's calculations, see Newman J., O'Leary B. (2014). Executive Compensation at Public Colleges—Salary Survey. Last updated June 9, 2014. *Chronicle of Higher Education*.

[27] Tenures calculated as of June 30, 2013. For date of hire information used in author's calculations, see *Chronicle*'s survey cited in note 26 above.

[28] Unpublished analysis of available IRS Form 990 information for the members of the Association for Community Affiliated Plans by the Milbank Memorial Fund in support of this report. It included submissions from 32 Medicaid MCOs in 16 states and Washington, DC, in 2013.

[29] Joynt K.E., Le S.T., Orav E.J., Jha A.K. (2014). Compensation of Chief Executive Officers at Nonprofit US Hospitals. *JAMA Internal Medicine.* 174 (1):61-67.

[30] Ibid.

[31] Salary computations exclude universities reporting partial-year figures. For university president compensation information used in author's calculations, see *Chronicle*'s survey cited in note 26 above; For Medicaid director compensation data, see NAMD's second annual survey cited in Note 22 above; For Medicaid MCO CEO compensation data, see note 28 above; For compensation data for CEOs of nonprofit hospitals, see note 29 above; For Fortune 500 CEO compensation data, see Strauss G., Hansen B., Krantz M. (2014). Millions by Millions, CEO Pay Goes Up: 2013 CEO Compensation. *USA Today*. (Accessed July 21, 2015: http://www.usatoday.com/story/money/business/2014/04/03/2013-ceo-pay/7200481/.)