



The Role of State Medicaid Directors: A Leadership Imperative

by Andy Allison, PhD

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The Author

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This report is inspired by the remarkable examples of the nation's Medicaid directors, who have conveyed both their successes and struggles in innumerable conversations with me and through the ongoing work of their representative body, the National Association of Medicaid Directors (NAMD). I also want to thank the staff of NAMD for their support throughout this project and for sharing their expertise as well as data from their Annual Operations Surveys.

Message from the President

Dear Reader,

The Milbank Memorial Fund is fortunate to have a diligent and prudent investment committee of the Board, whose charter is to protect and grow the foundation's assets so the Fund can continue its charitable purposes.

If presented with the following investment opportunity, it is safe to say the committee would not recommend proceeding:

Fortune 1000 company—multiple lines of business, unclear organizational structure, a CEO paid one-fifth of the market rate, CEO turnover every two and half years, and a 100-member Board of Directors that is distracted and divided.

This, however, depicts the current condition of state Medicaid programs. Taxpayers would be justified in questioning how their taxes are being invested in the program by state officials.

Developing effective Medicaid organizational structures and leadership is one of the paramount challenges facing governors and legislatures. Medicaid has grown from a program that comprises 10% of state budgets in 1987 to 25% in 2013—and now finances care for about 25% of the population in most states. Failure to attend to Medicaid's organization and leadership will misspend taxpayer contributions, inhibit needed reform of health care delivery systems, and compromise the health of significant portions of a state's citizenry. Heightened responsibilities—and opportunities—for state governments under the Affordable Care Act only increase the importance of this task.

In this report, Andy Allison combines his experience running Medicaid programs in two states with an analysis of current trends in Medicaid policy, organization, and leadership—including a review of corporate management theory and practice—to examine both Medicaid's organization in state government and the roles, responsibilities, and expectations of program leadership. He then presents findings and recommendations for state leaders interested in pursuing this work.

The report is consistent with the Fund's mission of improving population health by connecting leaders and decision makers with the best evidence and experience. A strategic priority of the Fund is to help strengthen the ability of people in state government to make good health policy decisions, including decisions about Medicaid.

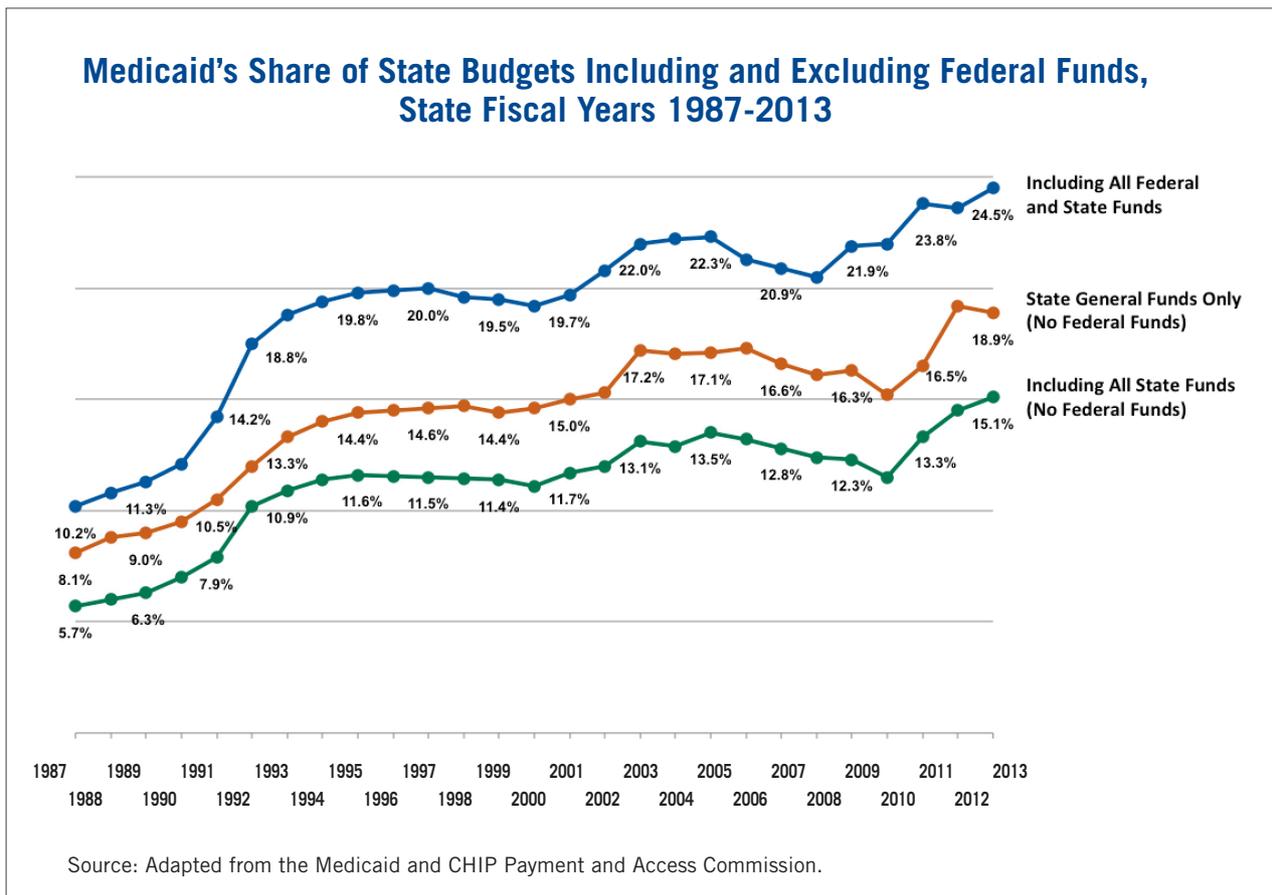
Because of their authority and relationships to multiple geographic and social communities, state governments have unique abilities to convene stakeholders and move policy levers to improve population health. The Fund works to improve the ability of state leaders to do this—developing evidence-based solutions that work for states and their stakeholders. Medicaid programs, in particular, present significant risks and opportunities for state governments. We hope this report will be a meaningful contribution to an issue of vital importance to the health of states and of their populations.

Christopher F. Koller
President, Milbank Memorial Fund

Introduction

By 2010, when the Affordable Care Act (ACA) was passed, Medicaid 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 9.5% of the federal budget by 2025,³ and was already the largest jointly funded federal/state program in the history of American federalism.⁴

Figure 1



In spite of this scale, at the time of the ACA's passage, over 16% of the nation's population remained uninsured, largely due to the extraordinary cost of health care in proportion to the incomes of a growing number of Americans.⁵ With the reinterpretation of the ACA by the Supreme Court in 2012, a *potential* expansion of the Medicaid coverage program to all nondisabled adults up to 138% of the federal poverty level was reaffirmed. With Medicaid expansion, participation in the program is now expected to exceed 75 million Americans

by 2025, while expenditures are projected to reach approximately \$1 trillion in that time frame.⁶ Historical growth rates, even without the ACA's coverage expansion, suggest Medicaid's eventual rise to rank as the largest state-operated program—both in terms of money expended and percentage of the populace receiving services—in nearly every state.⁷

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.

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—a 2014 report by the Medicaid and CHIP Payment and Access Commission (MACPAC)⁸ and a 2013 Kaiser Family Foundation report⁹—both of which describe the constraints and limitations placed on state Medicaid programs, develop a case for added investments 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, the 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 institutions; and
- presenting findings and recommendations to help Medicaid programs enhance their impact and fully meet their responsibilities.

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.¹⁰

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 improvements in the administration of what is becoming 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.

Overview and Impact of Medicaid

State Medicaid leadership matters

State-level 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, carry huge potential spillover benefits to other states, and can lead to multibillion 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. Legislators pass laws and budgets. Governors set priorities for the administration and align agenda among agency heads. Administrators procure services and perform personnel functions. External constituents—notably providers, enrollees, health plans and their proxies—seek to influence policymaking. 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.

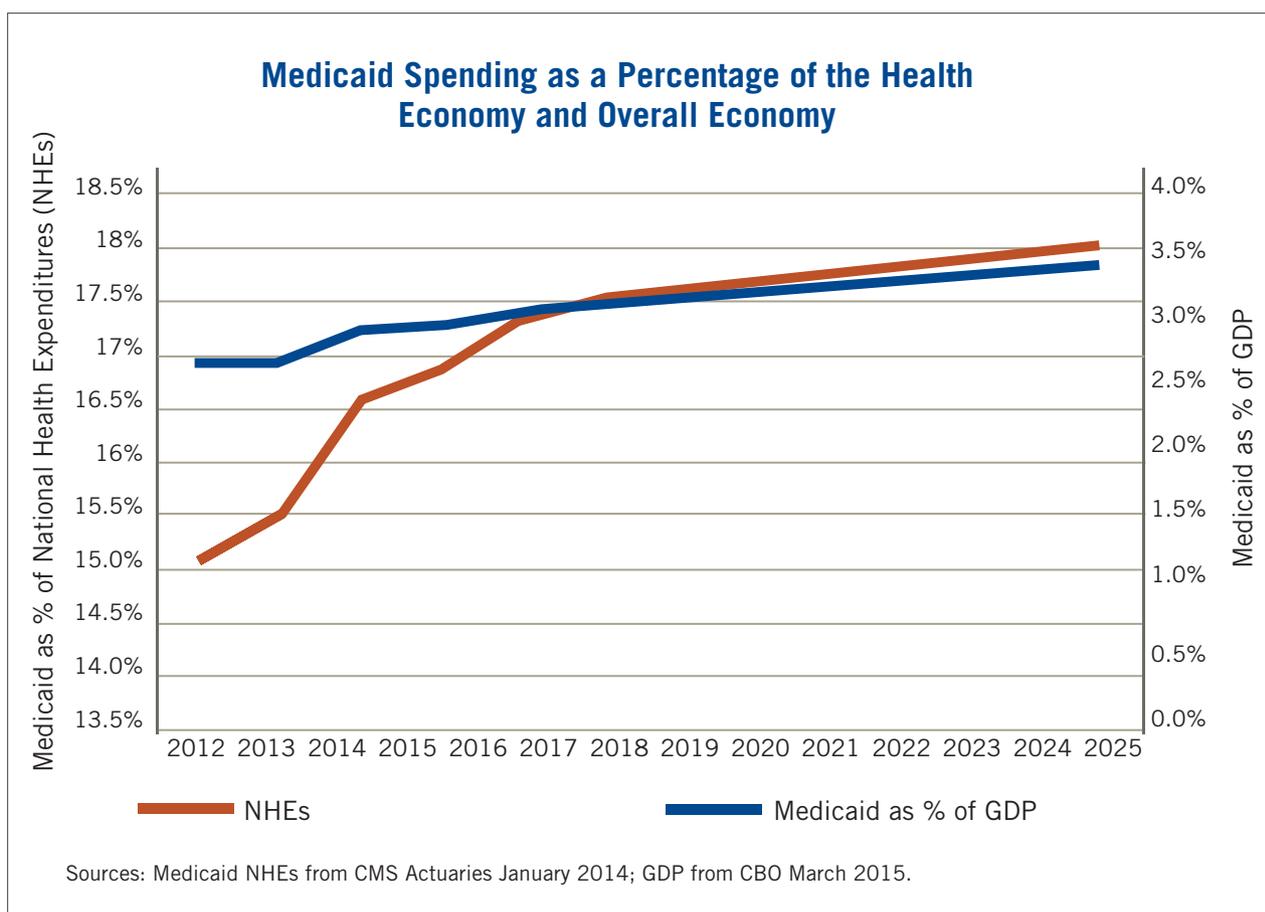
With appropriate skills and authority, Medicaid directors can set forth and significantly influence the policy choices that are made regarding Medicaid.

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, differing in composition across states from California, where 8.9% of program participants were disabled in 2011 (prior to ACA-related Medicaid coverage expansions) to Maine, with 28.3%.¹¹

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%)¹². State and federal Medicaid spending combined totaled approximately \$450 billion in 2013.¹³ Medicaid comprised 15.1% of national health expenditures (NHEs) in 2012, and Centers for Medicare and Medicaid Services (CMS) actuaries recently predicted that figure will rise to 18% by 2023.¹⁴ Aggregate Medicaid expenses have grown at a compound annual rate of 7% since 1992, and are projected by CMS actuaries to grow 6.1% annually for the next 10 years, driven mostly by increases in the number of people covered.¹⁵ The Congressional Budget Office (CBO) projects that Medicaid will grow from 7.1% of federal spending in 2012 to 9.5% by 2025, and 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 (GDP) to 3.4%.¹⁶ (See Figure 2.)

Figure 2



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. MACPAC's June 2014 report¹⁷ describes the states' role in designing and administering the Medicaid program, outlining a number of distinct responsibilities with significant effects on program impact.

The array of programmatic objectives and responsibilities detailed below 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. Medicaid directors and the policymakers they work with confront these challenging decisions in an increasingly intense political spotlight worthy of a program that now consumes an average of nearly one-quarter of state budgets and has a direct impact on many of their state's most vulnerable citizens.¹⁸

Define covered populations, benefits, and provider qualifications. Examples include:

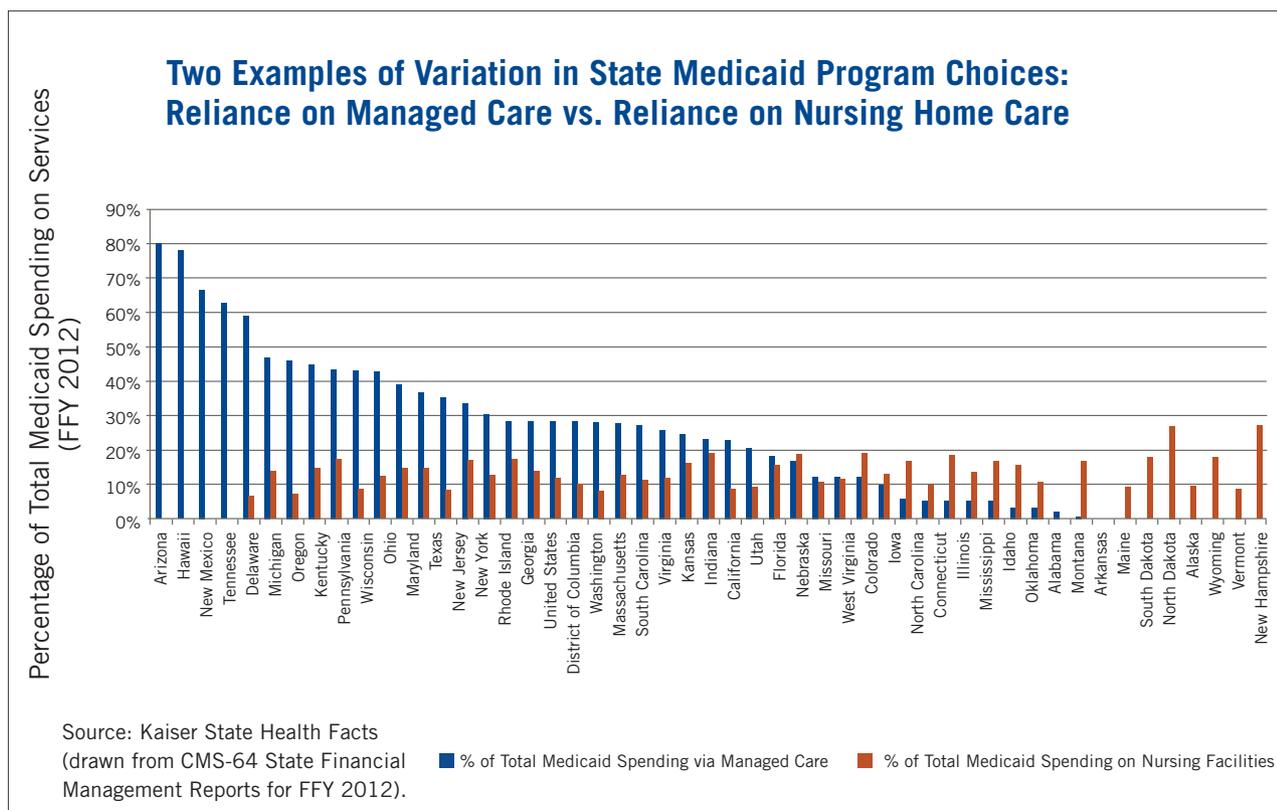
- whether—and how broadly—to extend coverage for noninstitutional long-term services and supports not covered under Medicare to low-income senior citizens;
- whether to take advantage of the ACA's Medicaid expansion to all adults up to 138% of the federal poverty level, originally written as a mandatory coverage category but rendered optional by the Supreme Court's decision in June 2012; as of June 2015, 30 of 51 states (including the District of Columbia) had decided to either expand Medicaid or obtain a waiver to use the money to expand private coverage;¹⁹ and
- how to define *habilitative* services for children who have developmental or exceptional health service needs, a conceptual obligation emerging from legislation passed in the late 1980s under the rubric of *early and periodic screening, diagnostic, and treatment* for all medically necessary services. This definition can have far-reaching consequences. In Arkansas, for example, a court interpretation of this open-ended obligation resulted in the establishment of *child health management services* and a state-specific class of providers that now treats nearly half of some counties' entire preschool populations.

Define and make payments. States assess existing outpatient and clinic-based reimbursement schedules to determine whether provider payments are adequate to secure access and reward high-quality care for program participants. Conversely, states review provider payments to ensure that their fee schedules (or the fee schedules of the managed care organizations they delegate with this responsibility) do not reward the overprovision of billable but medically questionable services, such as prescribing antibiotics for the common cold, or the corresponding underprovision of clinically valuable nonbillable services.

Design, operate, and oversee delivery systems. States must decide whether, and to what degree, insurance operations such as claims payment, provider contracting, and case management are to be administered by state employees, outsourced for an administrative

fee, or transferred to an external purchasing agent such as a managed care organization. To illustrate the scale of variation in state choices, two examples in Medicaid program choice are shown in Figure 3—reliance on managed care and reliance on nursing home care. State Medicaid spending via managed care ranged from 0% to 80% in federal fiscal year (FFY) 2012.²⁰ Conversely, the percentage of program spending devoted to nursing home costs—the original purpose behind the Kerr-Mills program, Medicaid’s precursor from the 1950s to 1960s—ranged from nearly 10% to nearly 30% during that same period.²¹ The dramatic variation in these rates is due in large part to public policies pursued by the states.

Figure 3



Manage utilization. A general example of utilization management is the identification of populations with health conditions most likely to over- or underutilize care. This includes the determination of care that would be more effective with state investment in enhanced patient monitoring, health coaching, care coordination, telephone interventions, in-home electronic monitoring and communications, nurse call lines and visitation, and so forth.

Claim federal financial participation by drawing down federal matching funds for Medicaid expenses. Medicaid directors are under constant pressure to maximize federal funding while protecting against the risk of federal audits. Two specific examples include:

- the need to correctly distinguish post-birth sterilization procedures, which qualify for 90% federal funding, from services related to a newborn delivery, which qualify for a state's regular match rate, ranging from 50% to nearly 75%—a conceptual and technical challenge requiring the unbundling and disentangling of services provided in a single hospital stay;²² and
- the need to design, adopt, and implement programs to increase the federal contribution to the state's Medicaid program in excess of the official federal statutory matching percentage by reimbursing providers using a combination of federal matching funds and state dollars that were generated by taxes or intergovernmental transfers from those same providers (generally but not specifically repaying providers for the tax or transfer and avoiding the use of state general tax revenue).²³

Determine participants' eligibility. This responsibility includes, for example, deciding whether, and to what extent, to adjudicate applicants' qualification under existing program rules by using state employees or by outsourcing all or part of that process to private contractors (e.g., eligibility "clearinghouses"), and/or whether to attempt to automate such decisions through sophisticated information systems akin to HealthCare.gov.

Implement enrollee protections and safeguards. One example of this obligation is state program oversight of unskilled in-home supportive services for disabled and/or elderly individuals who have elected to rely on themselves to identify, screen, and contract with service providers, who may include family members. Oversight of an explicitly self-directed program necessarily entails balancing the demands of program integrity and beneficiary protection against the values of beneficiary autonomy and empowerment.

Collect and monitor program data. An increasingly important illustration of this obligation is the need for Medicaid programs to decide whether to combine procurement of claims processing systems and services with the procurement of "decision support systems" (and accompanying analytic programming services) that collate claims and eligibility data and enable informative interpretation and analysis for purposes of strategic program management.

Measure and manage quality and performance. Two emerging questions for state Medicaid leaders that illustrate this obligation reflect the conceptual and operational challenge of tying provider payments to both performance and value:

- whether to redesign provider payments to incorporate incentives and rewards for high-quality care, patient outcomes, and cost efficiencies; and
- how to collect new quality and performance information from providers in a timely and accurate fashion to support these new payment methodologies (since this information is not captured in the claims payment process).

Defend state practices and reports. As the public face of accountability for Medicaid, directors must respond to the analyses of program information—some of which can be partial or faulty—by auditing agencies and third parties. For example, in January 2013, Arkansas’s legislative auditing arm used small sample audits of state eligibility determinations to erroneously project program-wide impacts of as much as \$500 million in “questionable payments.”²⁴

Ensure program integrity. Ensuring appropriate levels of fraud and abuse protections is a challenge for Medicaid leaders. Directors must, for instance, judge the value of claims, review systems, and weigh the value of those systems’ ability to identify fraud, waste, or abuse to state taxpayers and program participants, against the costs of implementing such systems, which include the following:

- The state costs of associated data collection, software installation, and maintenance; requisite follow-up investigations by state auditors; provider appeals; and collection of overpayments
- The provider costs associated with software-generated false-positive reports of questionable payments

The impact of Medicaid leaders on the program

The scope, scale, structure, and means of Medicaid programs are influenced by state policy choices and the leaders who make and implement them. The importance of state program leadership might be discounted if wide variation in Medicaid programs were simply a reflection of a state’s economic status, which one would expect to be broadly indicative of the health care needs of its citizens and the state’s capacity to help finance those needs. This section of the report documents the relation between state Medicaid spending and both economic output and overall health spending, revealing tremendous residual variation consistent with the importance of state policy choices and program leadership.

Variation in program spending is not tied directly to state wealth. The financial impact of the kinds of state-level program policy and operational choices described in the previous section can, over the course of five to 10 years, amount to hundreds of millions of dollars in annual expenditures, even in smaller states. Projected nationally, this implies a total financial impact of discretionary state-level programmatic choices of *at least tens of billions of dollars in annual public expenditures*—all of which is directly influenced by Medicaid leaders. Observed differences in state Medicaid spending relative to the size of a state’s economy reinforce this interpretation of 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 (GSP) in 2012 in Nevada and Wyoming, but nearly 5% in Maine and Vermont (Figure 4); 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 (Figure 5).²⁵ A 2015 study by the Kaiser Commission on Medicaid and the Uninsured found essentially the same level of variation across states in Medicaid spending per Medicaid enrollee, even when enrollees were grouped by broad categories of need such

as the aged, the disabled, adults, and children.²⁶ Apparently, any differences in Medicaid spending that might be explained by a state's relative wealth (per capita income) are dwarfed by differences between states that have nothing to do with relative wealth.

Figure 4

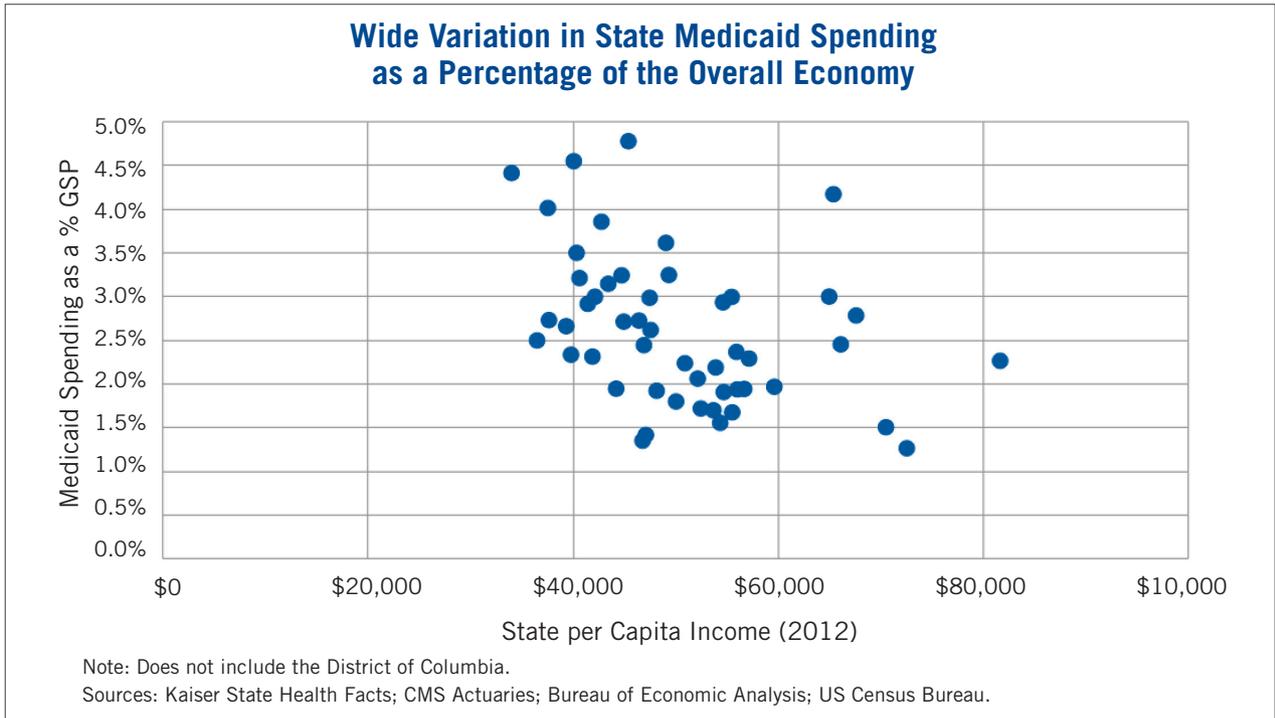
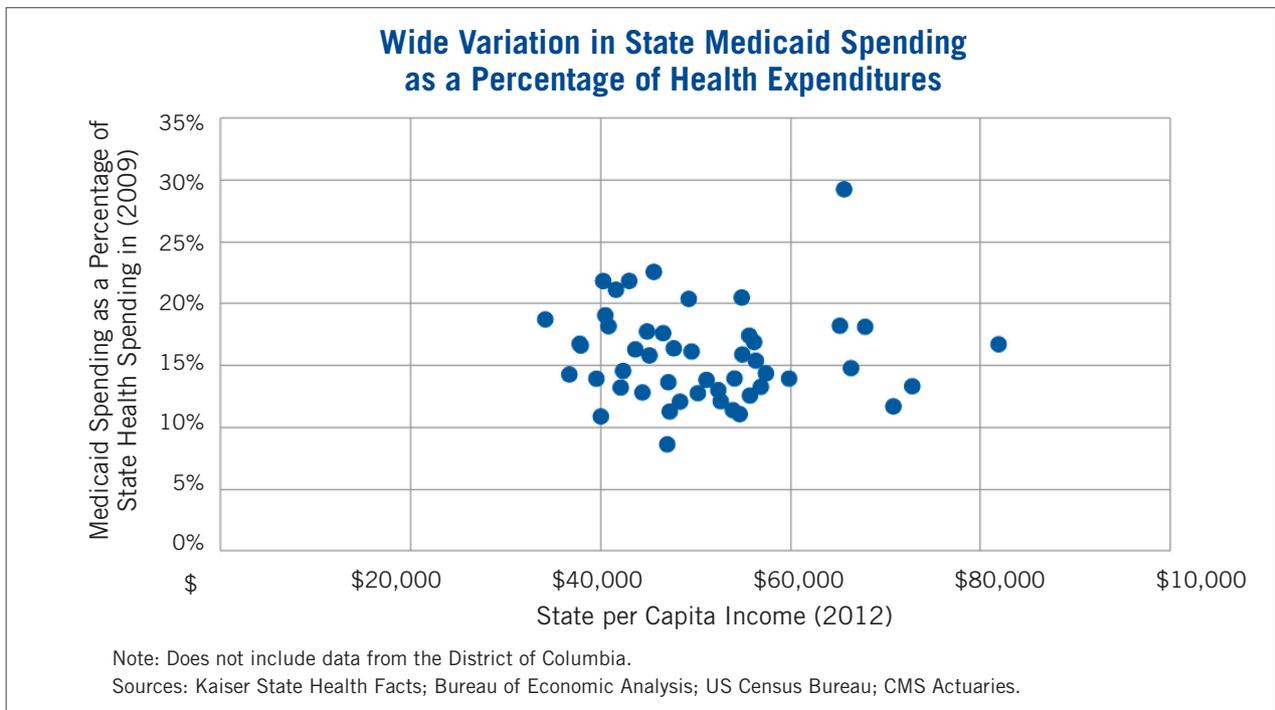


Figure 5



Variation in Medicaid spending is not a function of federal funding formula. The federal match rate formula is designed to offset, in a progressive fashion, the ability of wealthier states—which likely have a lower proportion of residents in need of medical assistance—to more easily shoulder the burden of assisting low-income residents. In at least one respect, this formula has succeeded—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 (Figure 4).

Spillover effects

The influence of Medicaid leadership can 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) and 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. Since individual states do not share in the nationwide benefits of their own innovations, no state has the financial incentive to fully invest in Medicaid program leadership and innovation. The spillover of potential benefits to other states permeates Medicaid’s reputation as a “50-state experiment.”

Medicaid’s Financial Impact in Two State Programs

To help put the responsibilities of Medicaid directors in context, during my tenure from 2006 to 2014 in the Arkansas and Kansas Medicaid programs, I would estimate the aggregate impact of state program choices and operational decisions made for the first five responsibilities listed above totaled at least \$1 billion in each state, as measured over a three- to five-year budget window. The following are examples:

- The managed care program that the state committed to, designed, and began procuring in Kansas was projected to save the state approximately \$800 million over its first five years.²⁷
- Federal audit liabilities avoided due to state policy changes and negotiated agreements with the federal government in Kansas totaled as much as \$200 to \$400 million.²⁸
- In Arkansas, the payment reforms and Medicaid “Private Option” redesign discussed on pages 18 to 20 are expected to have long-run budgetary impacts on a similar scale.

All told, billions in state and federal dollars were at stake in the key decisions made from 2006 to 2014 by Kansas and Arkansas—only the 35th (Kansas) and 29th (Arkansas) largest Medicaid programs in the country in federal fiscal year 2012.²⁹ Similar decisions with similar budget ramifications are continually being made in the other 49 Medicaid programs.

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,³⁰ the program has grown to such a size that states can potentially use Medicaid to effect broader change in state health care and health insurance markets.

Impact of Medicaid on private insurance markets

Medicaid can influence the private insurance markets with its benefit coverage decisions. In some cases, Medicaid coverage policies can set commercial standards—for example, in preventive health care coverage, women's reproductive health, and, more generally, in evidence-based coverage criteria such as for high-cost drugs. In other cases, commercial insurers develop their coverage to coordinate with Medicaid coverage, particularly for rehabilitative and early intervention services.

Medicaid can also fundamentally reshape the commercial health insurance marketplace. For example, Arkansas's purchase of "qualified health plans," as defined in the ACA, in the Arkansas insurance marketplace has the potential to transform the market for individual private insurance in the state and to foster greater competition and better pricing. (See the box on pages 17 to 20.)

State payment reforms supported by new federal grants

Medicaid's provider payment reform effort can influence the efforts of other payers. This has recently been reinforced in a series of large-scale federal grant programs designed to take advantage of Medicaid's size to help spur systemic change in the health care economy. States can use Medicaid as the catalyst for and driver of multi-payer reform—and thus, as a means of transforming entire health care markets. This can be done through Medicaid's independent actions, by coupling Medicaid's influence with coordinated purchases by other state health care programs (e.g., state employee health plans), or through the state's role as health care and health insurance regulator. Indeed, the federal State Innovation Models (SIM) grant program, which is funded through the Center for Medicare and Medicaid Innovation (the Innovation Center), is designed with exactly this purpose in mind:

Because of the unique powers of state governments, governors and their executive agencies, working together with key public and private stakeholders and the Centers for Medicare & Medicaid Services, can accelerate community-based health system improvements with greater sustainability and effect to produce better results for Medicare, Medicaid, and CHIP beneficiaries.³¹

With the second round of SIM grants in 2014, the Innovation Center had invested nearly \$1 billion, or just less than one-tenth of 1% of federal Medicaid spending over the period of time in which the grants were disbursed.³² Despite the proportionally small investment, the SIM program can be viewed as one of the most important commitments made by the federal government to support state innovations in Medicaid and health care. Among the awardees were 17 states that received relatively large-scale “testing” grants, each of which totaled tens of millions of dollars. States are using these grant funds to support payment and health system reforms, such as

- accountable care organizations;
- “episodes of care;”
- patient-centered medical homes; and
- health homes for special needs populations.

While large, these investments pale in comparison to the potential payoff. If even one of the individual models tested across the 17 states is successful, the value of that single innovation replicated across other states could save more than the cost of the entire grant program. (See the box describing Medicaid-led payment reform activity in Arkansas on pages 17-20.)

Additional policy impacts

Beyond insurance markets and provider payment reforms, Medicaid policy decisions affect a state’s health care environment in numerous ways. A few examples include the following:

- *Clinical quality agenda.* As the largest local payer, Medicaid can set quality improvement priorities for local health care providers based on measurement, reporting, convening, and contractual incentives to health plans and payers.
- *Maternal and child health.* Medicaid pays for more deliveries and covers more children than any other insurer. Its coverage and payment policies can improve the chance that children receive medical services in the crucial years of birth to age five, as well as influence the capacity of vulnerable school-age children to be both healthy and good students.
- *Prisoners reentering society.* Medicaid coverage and care coordination arrangements can affect the extent to which newly released prisoners have access to health services in general and behavioral health services in particular, profoundly influencing employability and recidivism rates.
- *Provider training.* In some states, Medicaid contributes to the costs of graduate medical education. Its payment policies can support the education and placement of particular provider types, which can enhance the health of the general population and Medicaid enrollees in particular.

Two Examples of the Impact of Medicaid Leadership

Arkansas's initiation of multi-payer payment reforms

I was recruited to lead Arkansas's Medicaid program in late 2011, primarily to help lead the state's nascent payment reform effort. Part of the appeal of the position for me was the opportunity to work on this effort with a well-trained and long-serving group of public officials and private leaders.

When I got there, the effort focused on establishing a new payment methodology for acute episodes of care that would direct incentive payments to key providers for the health care costs associated with a particular illness or intervention. As a health economist, I was drawn to the opportunity to pioneer innovation in the core challenge area of aligning incentives among patient, payer, and provider.

Arkansas's health care payment improvement initiative has been documented in the literature. Its specific innovations can be explored in detail on a public website (www.paymentinitiative.org). Three leadership challenges predominated:

- *Technical demands.* The effort is, at its heart, intended to establish new ways of paying for health care that incentivize providers for efficient, high-quality care—and don't reward less efficient or lower-quality care (as the prevailing fee-for-service system does). The design effort faced the greatest chance of success (and adoption by skeptical providers and policymakers) by striking a balance between economically pure formulas and achievable levels of new data collection and analysis. Finding that balance was a test of leadership capacities for state officials.
- *Operational hurdles.* Arkansas's payment formulas required significant amounts of analytic processing—using large amounts of claims level data to define and design the episodes. Succeeding in this effort required both an understanding of how such quantitative analysis is done and building operational experience in the collection, storage, and use of large-scale (and even multi-payer) insurance claims records.
- *Need for explicit policy leadership.* The Arkansas Health Care Payment Improvement Initiative (AHCPII) is an ambitious effort to use Medicaid as the lead and convening purchaser to marshal the state's major payers and self-insured employers in a systemic effort to change the way health care providers are paid. The effort required an initial statewide campaign of multi-payer meetings with providers to explain the new payment methodologies and ease the subsequent legislative approval process. To secure formal approval for the payment changes through Medicaid it was necessary to have an open public policy debate, which private payers could then leverage to help gain provider acceptance in their networks. Medicaid took center stage in what became a public and formal deliberation over the adoption of a new approach to

health care payment. I saw it as my responsibility to help carry that public debate—to address conceptual, operational, and broader policy questions related to the effort, to marshal design and implementation resources, and to invest my own reputation in the program’s success.

The effort appears to be succeeding—and has many of the elements needed to do so: consistent support from the governor, a coordinated effort by health policy leaders in the state, and budgetary commitment by the state to devote many millions of dollars in Medicaid and Innovation Center grant dollars to external vendors. Early results included the spread of the methodology from Medicaid to additional payers in the state (employers as well as private insurers), a growing understanding and acceptance of the new methodology by providers, real impacts on the costs and quality of care, and adoption of the new methodology by other larger states such as Ohio and Tennessee.³⁴

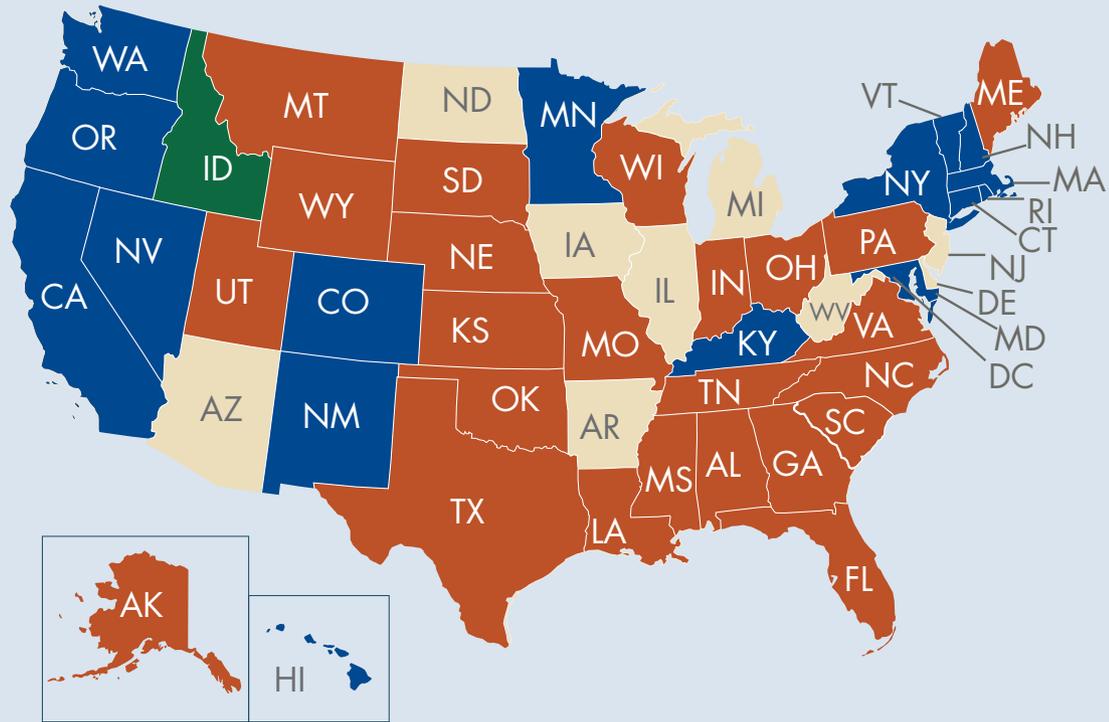
Arkansas’s “Private Option”

In April 2013, Governor Mike Beebe signed into law a bill called the Arkansas Health Care Independence Program, more commonly known as the “Private Option.” The new law carried with it appropriation of federal funds for the expansion of coverage to impoverished adults with incomes up to 138% of the federal poverty level, most of whom had previously been uninsured and ineligible for publicly financed coverage under Arkansas’s very stringent Medicaid eligibility criteria. The appropriation for the Private Option, like all state appropriations in Arkansas, requires a 75% vote in each chamber of Arkansas’s legislature every year it is maintained, a threshold the state has now met three times. The Private Option is an example of bipartisan compromise in a time nearly bereft of such pragmatism: it was initially adopted in a year in which both chambers of the state’s legislature were under Republican control for the first time since the era of Reconstruction. The public profile of the debate over the Private Option was unprecedented in my experience as a Medicaid director. For nearly two years, the Private Option merited frequent—sometimes daily—front-page headlines in the statewide newspaper in Arkansas. It garnered attention in blogs, the national press, and state and local press around the country. Its “public-private” approach was considered an alternative—and a potential compromise—in the 26 states that had not yet adopted the expansion (Figure 6).

The novel program design stimulated new policy guidance from the federal government and was first in a continuing series of state-specific deals negotiated with the federal government as an alternative to Medicaid expansion established by the ACA.

Figure 6

Status of State Individual Marketplace and Medicaid Expansion Decisions, as of September 30, 2013



Source: Adapted from State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of September 30, 2013. Kaiser State Health Facts, <http://www.kff.org/health-reform/state-decisions-for-creating-health-insurance>.

Since the Private Option was first passed in Arkansas, Iowa has implemented a similar program; New Hampshire has adopted an expansion that is to implement a private option during its second year; the governor of Utah has secured federal approval for a similar program; and the Private Option has surfaced as an alternative for expansion in a number of other states.

The impact of Arkansas's Private Option expansion goes beyond Medicaid. Allison,³⁵ Thompson and colleagues,³⁶ Bachrach and colleagues,³⁷ and MACPAC³⁸ describe the

Private Option's potential impact on the private insurance market, which lies at the heart of the program's design. The Private Option entails the use of Medicaid expansion dollars to purchase private insurance policies, i.e., qualified health plans for low-income adults who do *not* have exceptional health care needs. Because low-income adults are younger, on average, than other adults, and because the Private Option systematically diverts higher-needs adults back to the traditional Medicaid program, it provides the new individual insurance marketplace in Arkansas with a large number of relatively young and healthy policyholders. If successful, the Private Option could make Arkansas's individual market for health insurance healthier and younger than other markets around the country and, as a result, could make Arkansas the strongest individual market for insurance in the country for a state with its demographic profile.

The Private Option came about in my seventh year of Medicaid program leadership, and was the most challenging, engrossing, and rewarding leadership opportunity in my career. My role as Medicaid director was to help lead negotiations with the federal government and manage implementation of the Private Option—including developing benefit plans and enrollment operations. Helping lead its design, adoption, and implementation was both a privilege and challenge, and I found myself drawing on the training, experience, and professional network I'd built up over a long career in related fields. As noted, the Private Option had a high profile in one of the defining social policy debates of this era. Fulfilling my role carried with it a decision to invest in a novel, high-profile, and politically risky initiative.

Organizational Design in Corporations

To be effective and have a positive impact, programs must be well organized and well led. The stakes for getting the design and leadership of Medicaid programs right are high and will get higher. So how are states doing? This section, and the sections that follow, compare the organizational design and governance of Medicaid to management theory and to organizational design and governance in both private sector and comparable public sector or nonprofit practices.

Is it even appropriate to compare Medicaid to a private corporation? For scale and complexity: yes. A look at revenue for publicly traded companies and total spending for Medicaid programs reveals that 40 of 51 Medicaid programs ranked among the Fortune 1000, and a clear majority of programs were as large as a Fortune 500 company in 2013.³⁹ The similarities between private corporations and Medicaid are, however, limited. The largest American corporations have significantly more employees than Medicaid programs—only a handful of Medicaid programs employ more than 1,000 people. As a payer, or public insurer, Medicaid's expenditures primarily flow to contracted providers of health care goods and services, rather than to program operations. In general, companies with similar revenue to that of Medicaid programs have broader geographic reach, adding to the complexity of producing, marketing, and selling their goods and services.

Despite these differences, private corporations are compared to Medicaid agencies in this report for two reasons. First, management and governance of private companies and corporations are a focus of research by the academic community. Second, the roles of corporate chief executive officers (CEOs) and state Medicaid leaders are comparable based on their scope of financial or social impact, despite the difference in the number of employees or physical infrastructure of the organizations they lead. Witness, for example, the well-known upstream influence that Walmart, the world's largest corporation, has had on retail supply chains given its size in the discount retail sales sector—even though Walmart produces very few of the products it sells. This is analogous to Medicaid's partial impact on a local health care delivery system.

The study of private corporations has not led to well-accepted models of corporate organizational structure. Instead, there has been alignment around key principles, or decision rules, for the selection of an organizational design, which merit examination and comparison to Medicaid programs.

Principles of corporate organizational design and their applicability to Medicaid

The principles involved in the establishment of a company and its organizational design are intertwined, as one would also presume them to be in a public agency. This section summarizes those principles with a view towards helping state policymakers decide which apply to Medicaid.

What drives organizational design? Prevailing theories of the existence and design of firms are essentially those of employment in that they explain how a (new) firm's decision to hire can align motives and reduce the transaction costs among those needed to engage in a coordinated activity.⁴⁰ In *The Modern Firm*, business economist John Roberts writes, "Achieving high performance in a business . . . [entails] . . . a fit among three elements: the strategy of the firm, its organizational design, and the environment in which it operates."⁴¹ Given a "business opportunity," the challenge in establishing and organizing a firm is to develop a strategy to exploit that opportunity. With a business opportunity and a strategy, a firm can then determine an organizational design—all else being equal, organizational form follows the organization's purpose and strategy, writes Roberts.⁴²

These principles of organizational design apply not only at the outset but also throughout the duration of a firm's existence. As organizational goals and strategies change, so too will an organization's ideal structure, although potentially with some lag. Roberts emphasizes that in a turbulent business environment—and Medicaid's environment would likely qualify given its growth and the passage of the ACA—the transition costs of organizational change may justify a lag in structural response to strategies. Organizations can only change so fast, and organizational drag inevitably slows the pace of change in business strategy (and output) itself.

Medicaid's product (or "business opportunity"). As explained earlier, 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, creating the complexity noted here. For example, Medicaid coverage has broadened to include noninstitutional long-term services and supports,⁴³ which has come to include care coordination services designed to ensure both that the aging population's physical, mental, and supportive services providers communicate with one another and that provider responsibility for each of a beneficiary's needs is explicitly and appropriately assigned. In many states, community-based (noninstitutional) care for the aged and the disabled now comprises at least 10% of Medicaid spending, and coordination of all services for these populations is a top priority for directors.⁴⁴

Medicaid's business strategy. The core challenge of identifying an organizational strategy for the Medicaid agency entails specification of the program's output and operations, and how to apply them to the business opportunity. 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. State Medicaid directors rank these objectives among their highest priorities to meet constituent demands for accountability. In striving to meet these objectives, Medicaid programs are guided by general health system goals, such as those put forth by the Triple Aim.⁴⁵ 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, Medicaid's organizational design should reflect these goals.

Is Medicaid really a collection of products and programs? In an alternative 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.

Should Medicaid be (1) split into multiple organizations, each representing a different line of services; (2) split into multiple organizations representing distinct populations; or (3) combined in a single organization spanning both populations and services? For a politician, treating Medicaid as an aggregate of either services or populations acknowledges the history of the program's growth and attempts to allow the needs of the many and varied constituencies to be met—by choices of budget, oversight, and programmatic focus. For an economist, the answer to this critical question depends on whether the transaction costs and incentives associated with separately managing and aligning Medicaid's increasing array of products and services still add value. For an oversight body—a governor or a legislature—what organization structure best assures the cost-effectiveness of services provided? This report makes the case 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.

Organizational Design in Medicaid

The previous section argues that Medicaid’s organizational form should be driven by strategic goals for delivering its core “product”: health-related services. Today’s Medicaid product increasingly combines physical, behavioral, developmental, institutional, and community-based long-term services into more coordinated service packages. Nevertheless, many states have a structure that divides state administrative responsibility and leadership for services that are intended to be presented as a coherent package to program participants. Often this organizational separation manifests itself as either a divided stream of funding for unpackaged services, or a combined stream of funding but divided administrative “control” over health, special, and supportive services. This section documents the nature and prevalence of multi-organization Medicaid programs.

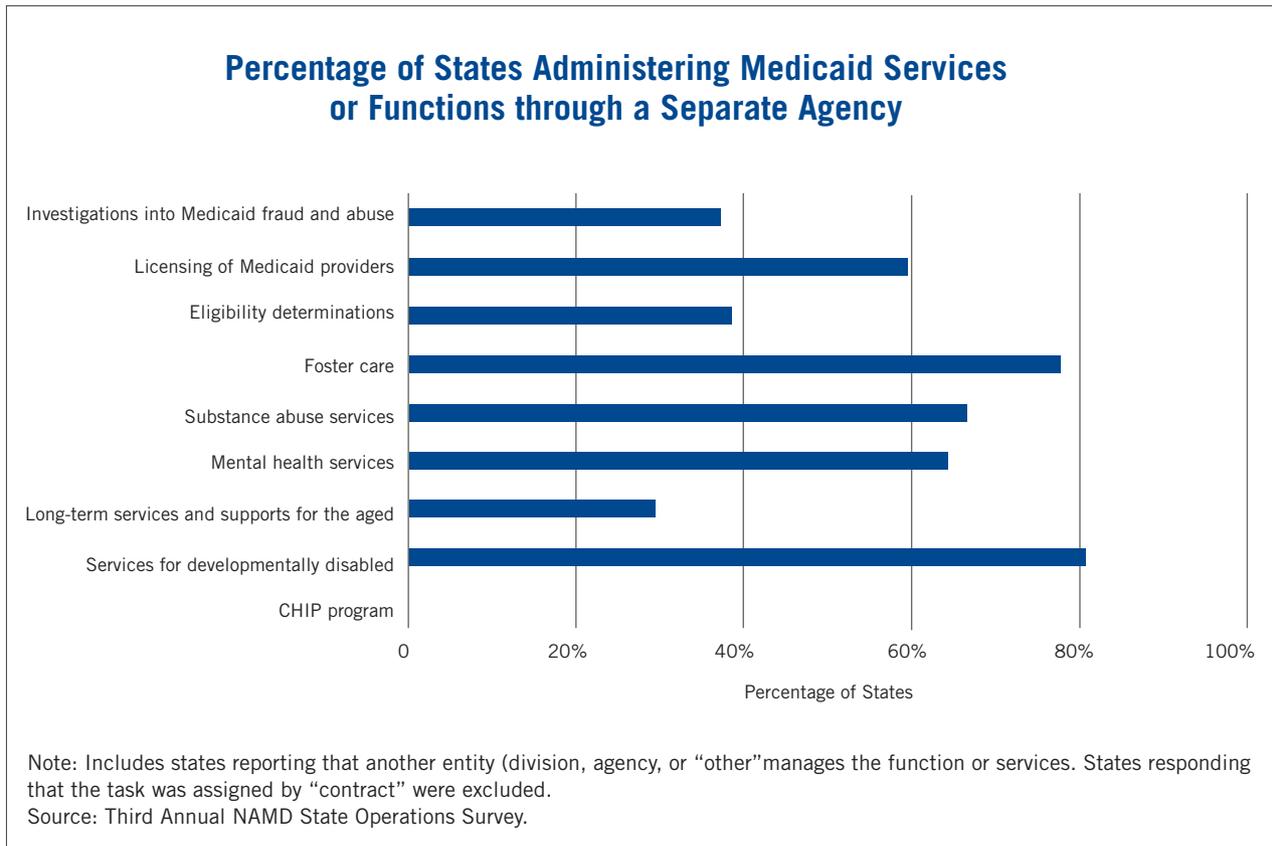
Organizational role

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%).⁴⁶ The type of agency under which a Medicaid program operates is diversifying, although the vast majority of programs began as a subunit of a broad human services superagency. Many remain a subunit despite Medicaid’s growth, which renders it much larger than its “sister” programs as measured in program expenditures and number of participants. In Arkansas, for example, the Department of Human Services operates child care programs, foster care programs, and other programs for needy populations in addition to Medicaid. But Medicaid—operated as a division within the agency—comprises at least 80% of the department’s overall budget. While there has been a trend towards separating Medicaid from other assistance programs, most states have not yet taken this step.

Medicaid could be defined as a multi-program organization, responding to multiple “business opportunities.”

States also vary as to whether the Medicaid unit of government (whether that be its own agency or a division) operates the services and programs that are funded largely or completely by Medicaid. 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.⁴⁷ (See Figure 7.)

Figure 7



All told, these three types of services comprised approximately one-third of Medicaid spending nationally in fiscal year 2013, not including payments for these services made through capitated managed care arrangements.⁴⁸ The populations in need of those services also receive a disproportionate amount of medical services, and in total, accounted for 63% of all Medicaid spending nationally, and a majority of total Medicaid expenditures in all but three states in fiscal year 2011.⁴⁹ Structuring state government by service greatly increases the need for administrative coordination between agencies and contributes to a fragmented view of both the Medicaid program as a whole and the needs of individuals served by the program.

The federal government—the primary funder of Medicaid services—is notably quiet on the question of organizational design of state Medicaid programs. According to 42 Code of Federal Regulations §431.10, which was most recently amended in 2013, states are required to “specify a single State agency established or designated to administer or supervise the administration of the plan.”⁵⁰ This “single” agency is prohibited from delegating “to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.” States are required to submit to CMS an organizational chart to identify allocation of responsibility for Medicaid administration, but

specific language regarding the form or composition of that structure has been removed. Nevertheless, it is the responsibility of the single state agency to be the point of administrative, financial, audit, and compliance contact for the federal government. State auditors and legislative oversight bodies sometimes follow suit, targeting the Medicaid director and his or her agency (or “division”) with accountability for all Medicaid-funded program risks. There are, in other words, regulatory and fiduciary implications for a state’s so-named “Medicaid director.” Despite this accountability to the federal government (and sometimes to state auditors and legislative oversight committees), 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. While Medicaid directors are sometimes given informal or project-based “matrix” authority over sister agencies housing substantially Medicaid-funded programs, the lack of formal supervisory control can make management of such interagency projects and initiatives more difficult, more time-consuming, and more contentious.

This diffusion of accountability and control can meet the needs of different constituencies and populations, but violates one of the traditional principles of management dating back to industrial analyst Henri Fayol (1841-1925). His “unity of direction” principle⁵¹ posits that if an organization has a singular goal or plan, it should be managed by a single person within the organization, resulting in an intentional alignment of organizational objective and form. Medicaid’s remarkable evolution and transformation over the last five decades present a clear opportunity for states to purposefully review existing Medicaid leadership structures and reporting relationships in light of these management principles.

Emerging models of Medicaid governance

We have seen that, in many states, Medicaid’s organization does not match emerging service models and programmatic strategies. But a number of states have taken alternative paths to consolidate programmatic influence and align governance to the kinds of challenges noted in this report. These alternative paths represent a balance often needed when redesigning public administration—between central and distributed authority, and between theory and political realities. 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. Three states are highlighted below: each one has adopted at least two of these approaches.

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.⁵²

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.⁵³

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.⁵⁴

Administrative and staffing resources

A careful examination of overall administrative or managerial capacity is beyond the scope of this report. However, the best-designed and led 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, defined as units of government controlled by the state Medicaid director, typically employ a staff of 300 to 600, but can range from fewer than 50 employees in some states to more than 3,500 in California.⁵⁵ 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 2013.⁵⁶ These staffing and administrative cost ratios compare favorably to private insurance carriers—even discounting the difference in “administrative cost load” attributable to private carriers' profit

and capital finance expenditures. This comparison is often used to denigrate private insurance, but the observed difference in load could also indicate underspending by Medicaid agencies.

In its June 2014 *Report to the Congress on Medicaid and CHIP*, MACPAC devoted a chapter to “Building Capacity to Administer Medicaid and CHIP,” laying out formal responsibilities as well as emerging challenges for Medicaid directors. This report on Medicaid administration is the most recent to address the need for added capacity, but notes “there are few clear standards...and little strong evidence on best practices.”⁵⁷

Directors’ greatest obstacles

The MACPAC report identifies a number of obstacles for states in meeting program objectives and requirements. The first two obstacles identified in that report tend to limit state investment in Medicaid leadership and in the development of strategic initiatives by Medicaid leaders:

- *State disincentives for administrative spending.* Medicaid agencies run on administrative overhead ratios smaller than those of their commercial insurance counterparts. The growth in Medicaid managed care amounts to an outsourcing of Medicaid administrative functions, further dampening the weak political will that exists for building management capacity to oversee these MCO contracts and other aspects of the program. MACPAC’s report laments the underinvestment in program administration, describing a counterproductive “zero-sum” budget dilemma facing state Medicaid programs that must choose whether to shift available state dollars away from services to state administration.
- *Short-term outlook for investment.* MACPAC insightfully recounts the challenge that Medicaid directors face in securing support for promising administrative investments because the financial payoff occurs after a short political budget window has closed.

Remaining obstacles included in MACPAC’s list tend to slow the pace of potential change in state programs and generally raise the demands on state leaders to successfully lead change efforts:

- Inflexible civil service rules and the need for greater technical expertise
- Increasing (business information) system demands and complexity
- Lack of administrative performance standards and measures
- Need for staff training.

The private sector, in its administration of Medicaid benefits on behalf of state agencies in the form of managed care, is one potential benchmark for investment needed in the management of health care services. MCOs vary in the amount they dedicate to administration, but often devote 6% to 10% of total costs, which is substantially *more* than that dedicated

by the Medicaid programs they are partially replacing. Indeed, the implicit boost in administrative capacity may be one rationale for states that are considering implementing managed care. Regardless, the persistence of administrative loads in Medicaid MCOs over many years, often under highly competitive conditions, and without apparent increase in total Medicaid spending, is a strong indication that state Medicaid programs may be underinvesting in program administration.

Although personnel costs are not available in financial reports at the national level, a NAMD state operations survey indicates that no more than \$2 to \$3 billion of state administrative expenses nationally could be attributed to direct personnel costs, with the rest devoted to outsourced or contracted costs and information systems.⁵⁸ In Medicaid programs, it is not uncommon for there to be more full-time employees devoted to program administration through external contracts than in the agency itself. Another large contingent of Medicaid-funded administrative costs and personnel is controlled by sister divisions and agencies (e.g., the developmental disabilities, long-term services and supports, and mental health units described earlier).⁵⁹

Medicaid leaders themselves often point to their need for a strong cadre of capable senior managers to effectively administer the programs. MACPAC's chapter on administrative capacity highlights state staffing needs, citing the potential for greater investments in training and technical expertise, and more flexibility in civil service rules.⁶⁰ The Center for Health Care Strategies (CHCS) and the state of California (see below) serve as examples of efforts that may hold promise for raising the overall level of administrative capacity to match the Medicaid program's emerging scale and complexity.

Ongoing efforts to build administrative capacity

At the state and national level, there have been efforts to strengthen the capacity of Medicaid and state leadership. In 2009, the Robert Wood Johnson Foundation established the Medicaid Leadership Institute, directed by CHCS, as a vehicle to build the leadership and technical skills of state Medicaid directors. Over five years the program trained 30 Medicaid directors, including the author, from 28 states. The National Governors Association and CHCS plan to renew the program, adding a new focus on governor's health policy advisors. Similar capacity-building work is conducted by the Pew Charitable Trusts. At the state level, a number of regional philanthropies have partnered with the state of California to train 300 mid-level managers in the state's Medicaid agency, and other states have expressed interest in similar efforts.⁶¹

Leadership and Authority in Corporations

If the dynamics of a competitive labor market apply to the role of state Medicaid director, then a key requirement for successful recruitment and retention is to establish a level of authority and compensation sufficient to attract and retain strong leaders. Do state Medicaid programs do that? As a first step in answering this question, this report examines the role and compensation of corporate leaders who head organizations that have comparable economic and civic influence.

The role of corporate leaders

An organization's leader usually oversees the breadth and depth of the organization itself. In the corporate world, it is usually the board of directors that is accountable for this span of control and that decides how to allocate and use this control to achieve the business's aims—much as the governor and policy leaders of a state decide the same for Medicaid. How much of that control is allocated to the corporation's leader? The Business Roundtable, an association representing CEOs of leading US companies, explains in a recent summary that the CEO is usually charged with the following responsibilities:

- Running the corporation's day-to-day business operations
- Strategic planning
- Identifying, evaluating, and managing risks
- Making annual operating plans and budgets
- Selecting qualified management and establishing an effective organizational structure
- Accurate and transparent financial reporting and disclosures⁶²

A well-performing corporate board holds the CEO accountable for performance in these responsibilities. The CEO in turn builds the organization necessary to fulfill them.

The Business Roundtable also identifies nine guiding principles addressing the purpose and function of a board of directors as well as management.⁶³ The third and seventh of these guiding principles are especially pertinent:

It is the responsibility of management, under the oversight of the board, to develop and implement the corporation's strategic plans, and to identify, evaluate and manage the risks inherent in the corporation's strategy.

It is the responsibility of the board, through its compensation committee, to adopt and oversee the implementation of compensation policies, establish goals for performance-based compensation, and determine the compensation of the CEO and senior management. Compensation policies and goals should be aligned with the corporation's long-term strategy, and they should create incentives to innovate and produce long-term value for shareholders without excessive risk. These policies and the resulting compensation should be communicated clearly to shareholders.

According to the Business Roundtable, a number of specific roles and obligations of the corporation's board of directors are implied by these principles: "The selection, compensation and evaluation of a well-qualified and ethical CEO is the single most important function of the board."⁶⁴ The board should also address the certainty of management turnover by "developing senior management personnel" and by explicitly "planning for succession" at the CEO level.⁶⁵

Leadership and Authority in Medicaid

The remainder of this report looks at management theory as it applies to the Medicaid setting, and describes the prevailing authority and compensation of Medicaid directors across the country. It compares the role of Medicaid director to three similar CEO roles: CEOs of Medicaid MCOs, public university presidents, and nonprofit hospital (or health system) executives.

Do Medicaid directors play a CEO-type role for Medicaid?

Although the Business Roundtable's description of a CEO's role resonates with a Medicaid director's typical role—involving program design, strategy, budgeting, personnel, operations, and program integrity—a Medicaid director's span of control and influence over organizational structure often differs from that of the CEO. As the Business Roundtable notes, the CEO should run “day-to-day business operations.” This raises the question of whether states have appropriately defined Medicaid's business operations. States must decide for themselves which aspects of Medicaid programming fit together in a coherent business operation. The decision could depend on how states define the Medicaid product—as a set of independent services or a broad package of coordinated and integrated services.

The theory presented here suggests that the Medicaid program would be better served if its organization were unified and the Medicaid director, like a CEO, had a corresponding high level of responsibility and authority. When Medicaid is “partially unified,” and the director has responsibility for, but limited authority over, all programmatic outcomes of the program, strategic and operational coordination falls to informal levers of influence. In a disaggregated Medicaid program, the director might be accountable for federal compliance, but not fully responsible for budget and/or program. This places the leader in an administrative role—and puts program performance at risk.

Despite the Medicaid program's size and broad impact, states are a long way from setting up their Medicaid agencies to resemble corporations run by CEOs. However, even a partially unified program view of Medicaid—with recognition of a Medicaid director's expansive public accountability—suggests the need for a more consolidated budget and greater organizational authority, independent of other agencies, and led by a senior Medicaid director, thus bearing a resemblance to the design and leadership of private corporations of similar size and complexity. One could also argue that successfully meeting the challenges of consolidated financial accountability for a vast and complex array of purchased services with limited authority—as set forth to varying degrees in the Medicaid organizational structures identified in Tennessee, Arizona, and New York—requires an equally sophisticated and rare set of leadership skills as found in a CEO of a similarly sized private sector organization.

The case for high-caliber Medicaid directors

Assuming some sort of unified organization and resulting leadership responsibilities, Medicaid directors need to understand and, if not personally master, then at a minimum be able to marshal and coordinate an imposing skill set and library of experience such as:

- Conceptual understanding of the provider markets in which Medicaid reimbursements operate to secure access for covered beneficiaries
- Deep knowledge of program characteristics, covered services and populations, and the interrelationships among service coverage, payment, and providers
- Analytic capacity to understand the fiscal “hydraulics” of Medicaid financing through federal matching payments so as to deploy mechanisms that maximize the percentage of program costs borne by the federal government
- Interpersonal skills to effectively communicate with highly educated medical providers, health system administrators, community leaders, state legislators, federal agency leaders, governors and other state officials and, in most cases, state and national press
- Managerial experience, organizational savvy, and an ability to lead large, complex projects with operational, technical, and quantitative components
- Personal relationships, expertise, prior achievements, or other sources of demonstrable competence and reputation sufficient to engender confidence and trust among policymakers and state health leaders

This list builds on the responsibilities of Medicaid directors as outlined in the 2014 NAMD survey of its membership.⁶⁶ The list illustrates the high caliber of leader needed in the role of Medicaid director—a need that will only grow—and frames the question of whether, in a competitive labor market for executives with health sector savvy and expertise, states can expect to recruit and retain such leaders at existing levels of compensation.

Principles of Corporate Executive Compensation

Compensation is an important consideration when trying to attract and retain leaders in any field. This report aims to present a starting point for decision makers to reevaluate how much they pay Medicaid leaders. This section examines the corporate sector, focusing on principles of economic behavior exhibited by corporations and their leaders, and applying lessons learned to state Medicaid programs. The section that follows compares state Medicaid program approaches to leadership with those of a broader set of public and nonprofit institutions.

Compensation of CEOs

Corporations consider an array of factors when structuring a CEO compensation package, including organization size, “agency,” and performance incentives.

Organization size, “agency,” and CEO performance incentives. The greatest single predictor of corporate CEO pay appears to be firm size, which analysts attribute both to the notion that big firms must hire more capable CEOs due to the difficulty of the job and to the idea that more capable CEOs can expand the size of a firm (and therefore earn more).⁶⁷ The

relationship between a CEO and the size (or success) of a corporation can be confounded, however, by the issue of “agency.” Shareholders delegate corporate decision making to boards of directors, and boards, in turn, delegate certain decision-making rights to the CEO and other executives, essentially tasking those executives to act as “agents” of the board and the owners of the corporation.

In his summary of CEO pay, Kevin Murphy addresses the issue of agency in executive compensation. The “agency problem,” writes Murphy, stems from the “conflict that arises when decision makers do not bear 100% of the wealth consequences of their decisions.”⁶⁸ Writing in 2013 on the heels of public revelations regarding the role that some risk-taking CEOs may have played in the economic crisis that began in 2007, Murphy observes that “while the current controversy over executive incentives has focused on excessive risk taking, it is worth noting that the challenge historically has been in providing incentives for executives to take enough risk, not too much risk. Executives are typically risk-averse.”⁶⁹ If corporate leaders are overly risk-averse, they may miss some opportunities to increase their firm’s performance. Profit sharing and stock options are methods of incentivizing private sector leaders to take ownership of the firm so that they will take the right amount of risk and maximize return on investment.

Measuring the CEO’s contribution. A key constraint in determining executive compensation and performance incentives is the difficulty of measuring the success of an organization—and the even more difficult challenge of measuring the role of the executive in an organization’s success. Murphy notes that the ideal measure of a CEO’s success is the CEO’s “personal contribution to the value of the firm,” but observes that this contribution, which could come in both the CEO’s actions and in the impact the CEO has on others’ performance in the organization, is almost never directly measurable.⁷⁰

Compensation of Medicaid directors

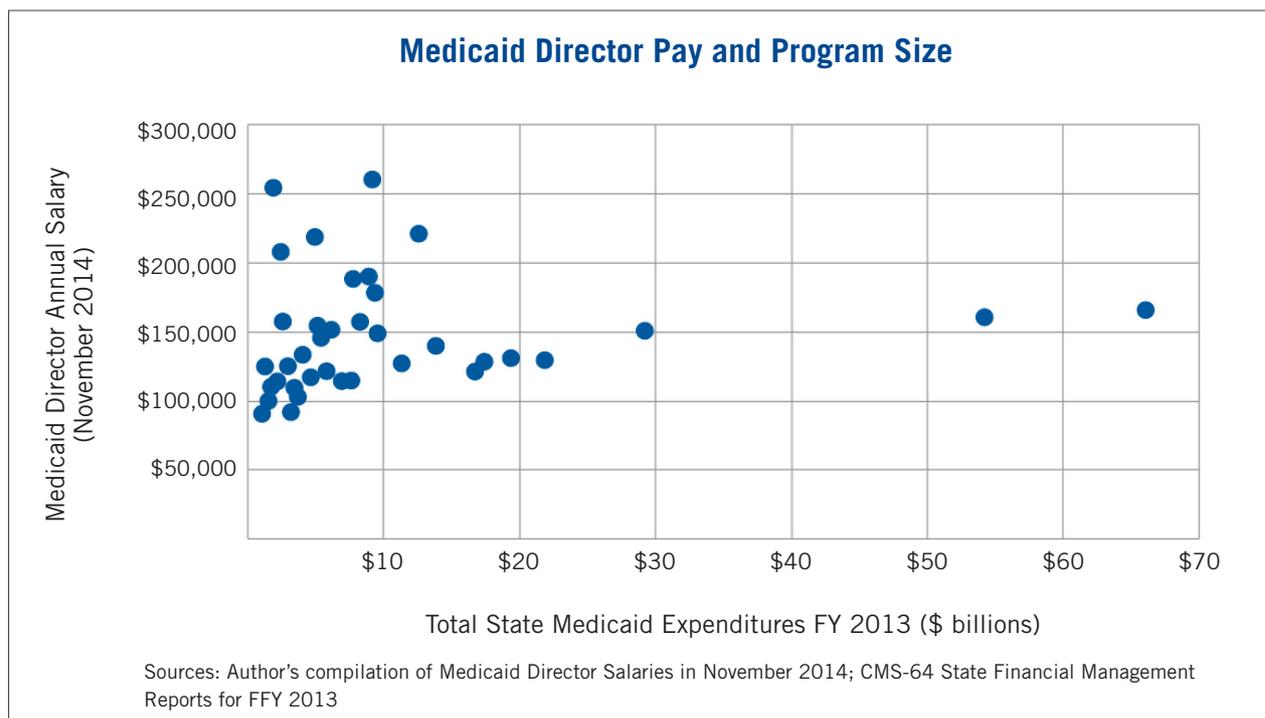
CEO employment packages address a range of compensation elements to help firms attract and retain only the most effective CEOs and to incentivize them to maximize firm performance.⁷¹ This report was able to identify little, if any, comparable effort by states to (1) study compensation and (2) structure compensation in such a way as to attract and retain only the most effective Medicaid directors.

According to the NAMD operations survey conducted in 2013, 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 \$150,000.⁷² This distribution strongly indicates both the influence of civil service pay scales, which often top out well below \$200,000, and the employment of many Medicaid directors within the civil service or “classified” service, both of which contrast with the heads of corporations and even those of other large entities such as state universities, nonprofit hospitals, and high-profile public university sports teams, who are typically employed on unclassified terms codified in individually negotiated contracts.

NAMD's 2013 data do not include salaries at the individual level. However, a search of web-accessible salary data in November 2014 identified salary levels for Medicaid directors in 38 states.⁷³ These salaries were often applicable to state fiscal year 2014, but also included several applicable to either fiscal year 2013 or 2015. The mean salary for the 38 directors identified in the web search was \$146,753, while the median was \$132,000. The distribution of the web-search data is similar to that collected by NAMD in 2013 with one notable exception: the percentage of salaries above \$200,000 had grown to 14%, representing five states (out of the 38). This implies that at least two states had raised their director's salary into this top category since the NAMD 2013 survey.

Corporate CEOs earn 10 to 20 times as much as Medicaid leaders and their pay increases with firm size, but Medicaid leaders' pay does not. An analysis of data published in an article in the *American Economic Review* revealed 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.⁷⁴ By comparison, the relationship between program size and Medicaid directors' compensation is weak and, when present, amounts to less than \$7,500 per 10 percentile (five-state) increase in program size. (See Figure 8.)

Figure 8



Aligning compensation incentives with state goals. The practice of incentive pay is nearly universal in the corporate world. The costs associated with not addressing the agency “problem”, CEO risk aversion, and similar factors, are sufficient to compel boards to institutionalize incentive-based packages. This report could not identify similar packages for any Medicaid leader. Clearly, such incentives will be more difficult to adopt in the public sector, not least because the Medicaid program’s performance is difficult to measure and uncertain, given the absence of a unifying objective such as profit. It is worth asking whether Medicaid directors could be incentivized to act on behalf of state residents and taxpayers. If, for example, executives of state governments’ largest organizations (i.e., Medicaid programs) are similarly predisposed against taking an appropriate amount of risk in their organizational leadership, states may want to consider taking measures to address this risk aversion.

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.

Measurement of the Medicaid director’s contribution. Just as it is difficult to measure CEO performance, states and Medicaid directors have similar challenges in attributing success and failure to job performance. For example, health costs and savings are typically shared with Medicaid MCOs to which the responsibility of managing such costs is often delegated. State MCO contracts commonly include millions of dollars in performance-related incentives, encompassing exactly the same outcomes to which a Medicaid director is held accountable. While performance may be difficult to measure, states have clearly established a precedent for both measuring and rewarding the performance of MCOs and other vendors but have not extended this practice to program leaders themselves. This disparity in employee versus contracted incentives differs markedly from corporate theory and practice.

Tenure of Medicaid directors and corporate CEOs

According to the NAMD operations survey, the average tenure of a Medicaid director in 2014 was approximately 3.5 to 3.75 years, and most Medicaid directors had served less than three years.⁷⁵ 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. Anecdotally, it is apparent that some directors survive political transitions from one governor to another, but the large number of directors with just one to two years of experience, a tenure consistent with a cohort of directors beginning in 2013 (after the most

recent round of gubernatorial elections), indicates that such transitions induce turnover. According to the 2014 NAMD operations survey, at least 72% of directors are political appointees or are “at-will” employees exempt from civil service protections, and thus subject to dismissal when governorships change.⁷⁶

By comparison, Kaplan and Minton find an average tenure of just less than six years for CEOs of Fortune 500 firms during the 1998 to 2005 period,⁷⁷ which is at least 50% longer than the average tenure of a Medicaid director. The Conference Board reports recent increases in average tenure for departing CEOs of Fortune 500 firms: the average tenure of departing CEOs in 2012-2013 was 8 to 10 years (8.1 in 2012 and 9.7 in 2013 vs. 10 in 2000).⁷⁸ While tenure among departing CEOs is not a direct measure of average tenure, the combined weight of evidence suggests tenures are 50% to 100% longer for corporate CEOs than for Medicaid directors. Combined with data on average tenure of all Fortune 500 firms, the Conference Board information directly implies a meaningful number of Fortune 500 CEOs with 10-plus years in leadership positions, a length of tenure matched by no active Medicaid director as of the publication of this report.⁷⁹

To sum up, Medicaid directors are paid a fraction of the compensation earned by the heads of comparably sized for-profit corporations, and they lack the performance incentives that their corporate counterparts receive. Not coincidentally, they stay at their jobs for much shorter periods.

Executive Compensation and Tenure in Comparably Large and Complex Public and Nonprofit Enterprises

Apart from obvious differences of ownership and profit, basic tenets of management apply to private corporations and public programs alike. In fact, examples outside of the corporate realm could shed light on—and bring change to—the compensation and tenure of state Medicaid leaders. Three such examples are explored below: presidents of public universities, CEOs of nonprofit Medicaid MCOs, and chief executives of nonprofit hospitals and health systems.

Compensation of public university presidents

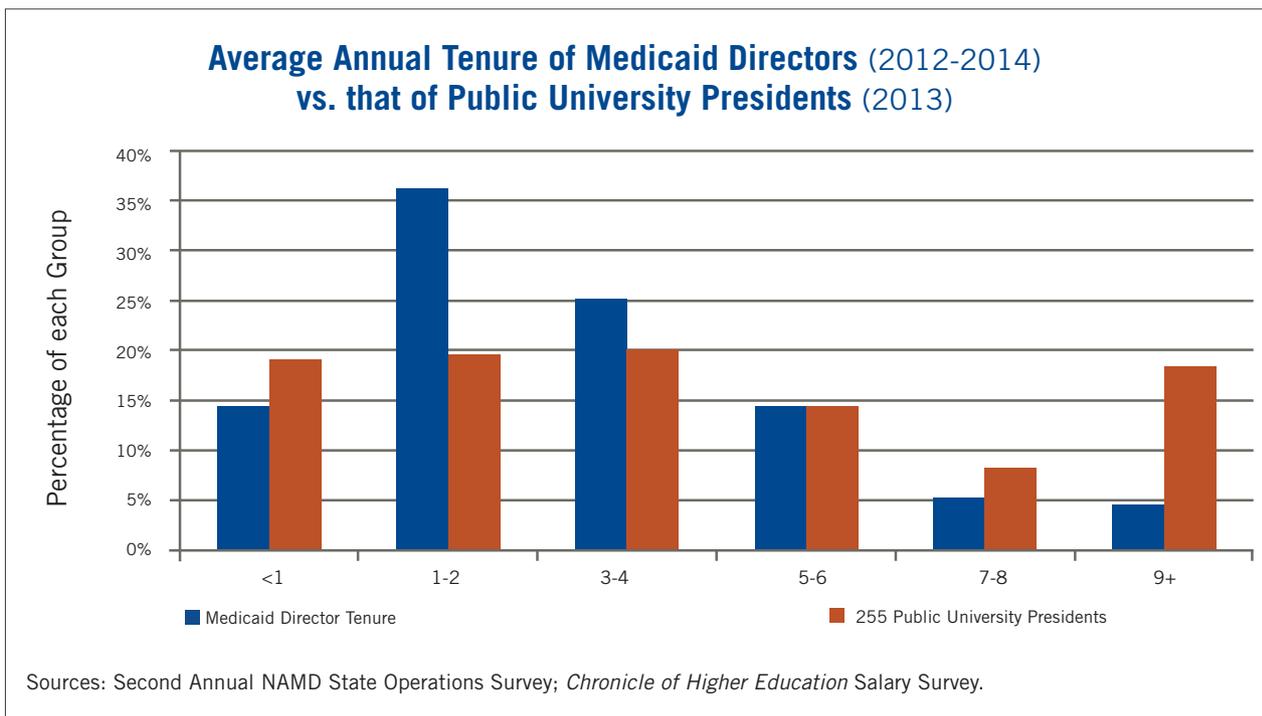
Public university presidents tend to manage more employees (5,000 to 10,000) but smaller budgets (\$100 million to \$5 billion) than state Medicaid directors.⁸⁰ Public university presidents earn substantially more than Medicaid directors. According to the *Chronicle of Higher Education*, average total compensation among 198 public university presidents in 2013 was \$531,000,⁸¹ or about 3.6 times the average pay of state Medicaid directors in 2014. The upper level was substantially higher for university presidents—the nation’s highest-paid public university president earned 23 times more than the nation’s highest-paid Medicaid director—while only nine university presidents earned less than the highest-paid Medicaid director. Presidents of larger universities tend to make more, although this varies

greatly. An analysis of 144 available observations from the *Chronicle of Higher Education's* dataset (excluding partial-year presidents and universities with missing budget information) revealed that each \$1 billion increase in revenue added between \$88,000 and \$249,000 in annual compensation to the president's pay, on average.⁸²

Tenure of public university presidents

As of 2013, the average tenure of 255 public university presidents was 5.3 years,⁸³ nearly 50% longer than the average tenure of Medicaid directors as of 2014. Figure 9 shows a distinct shortfall in tenure for Medicaid directors. Roughly speaking, a disproportionate percentage (an additional +16%) of Medicaid directors hold the job for either one or two years (1<=X<3 years), while approximately that added percentage (17%) of university presidents are in the job more than six years. This implies that if Medicaid directors matched university presidents in tenure, between eight and nine Medicaid directors around the country would have seven or more years of experience instead of just one or two. In 2013, more than 12% of the 255 university leaders had tenures exceeding that of the longest-serving Medicaid director. Across all states, the cumulative deficit in the total experience of the nation's Medicaid directors—compared to what it would be if directors stayed as long as the nation's public university leaders—is at least 85 years.

Figure 9



Executive compensation in MCOs

An analysis of current trends suggests that the role of Medicaid MCO CEOs seems to be the most directly comparable private sector position to that of state Medicaid directors. A majority of states rely on MCOs to deliver services to beneficiaries. As of fiscal year 2013, 39% of Medicaid spending nationally was administered through capitated payment made to MCOs.⁸⁴ MCOs develop provider networks, process claims, and manage the care of members. At least 30 million Medicaid recipients received some or all of their services through these arrangements in 2011, and the number is growing rapidly.⁸⁵ There are typically several MCOs operating in any given state, and in all but one state (Kansas) a percentage of the Medicaid program is operated through MCOs. Since multiple MCOs share only a portion of the responsibility for administering Medicaid in any given state, the scale of operation and scope of programmatic responsibility are smaller for any given MCO than for the Medicaid director in that state. Key differences also include state Medicaid directors' legal responsibility for the program as well as their role in working with policymakers to determine the strategic direction of the program (e.g., its size, form, and service delivery model).

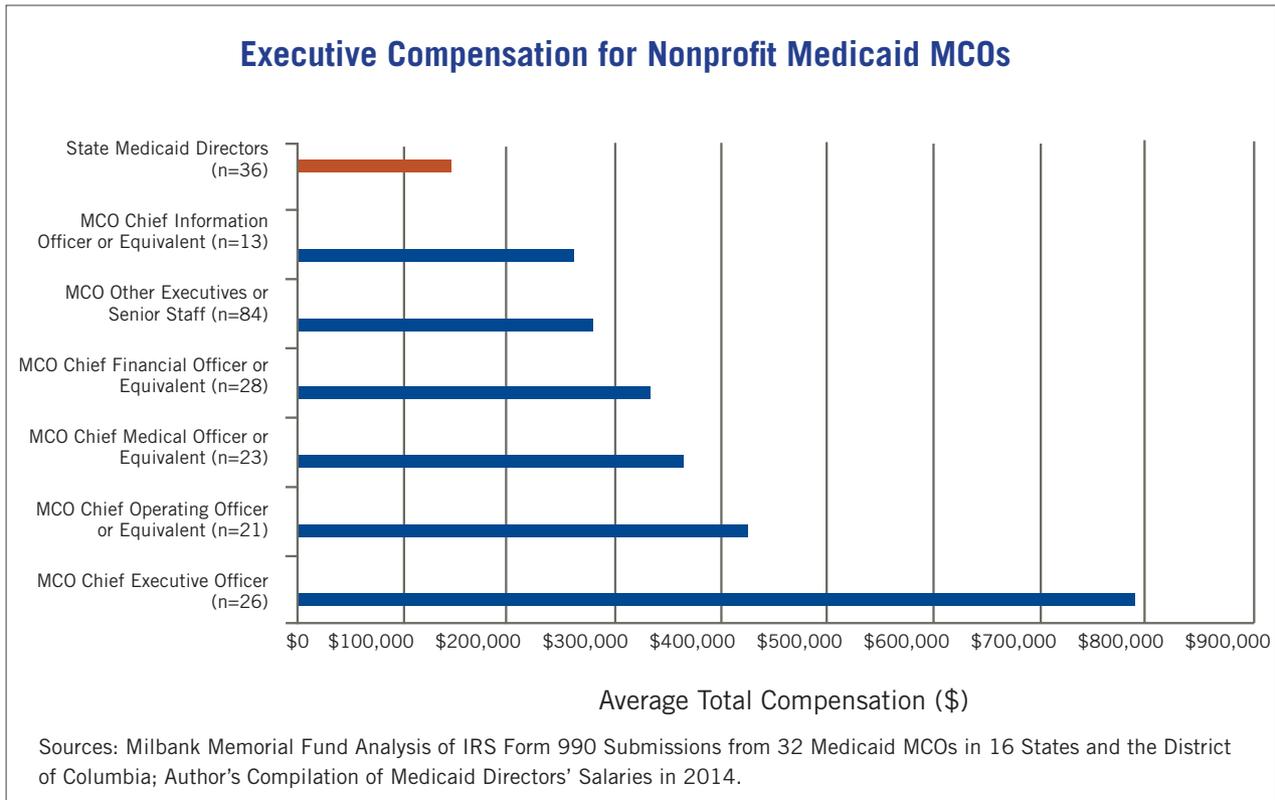
CEOs of Medicaid MCOs, by contrast, have a more direct personal fiduciary responsibility to owners of their private organizations, but do not qualify for the same legal immunities as their public servant counterparts.

When beneficiaries and programmatic responsibilities are outsourced to an MCO, that MCO bears a direct operational role. Nevertheless, a comparison of executive compensation between Medicaid directors and MCO CEOs is particularly salient given the fact that the MCO role is at least a partial outsourced equivalent.

An analysis of current trends suggests that the role of Medicaid MCO CEOs seems to be the most directly comparable private sector position to that of state Medicaid directors.

Information on the executive pay of about 200 senior executives at Medicaid MCOs with a nonprofit tax status was collected from publicly available Internal Revenue Service (IRS) Form 990 tax documents.⁸⁶ A summary of findings is presented in Figure 10, which arrays salary information by position. MCO CEOs from this sample 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, and the residual group of 84 health plan executives listed on the organizations' tax forms earned nearly twice that of the typical Medicaid director's salary.

Figure 10



Executive compensation at nonprofit hospitals

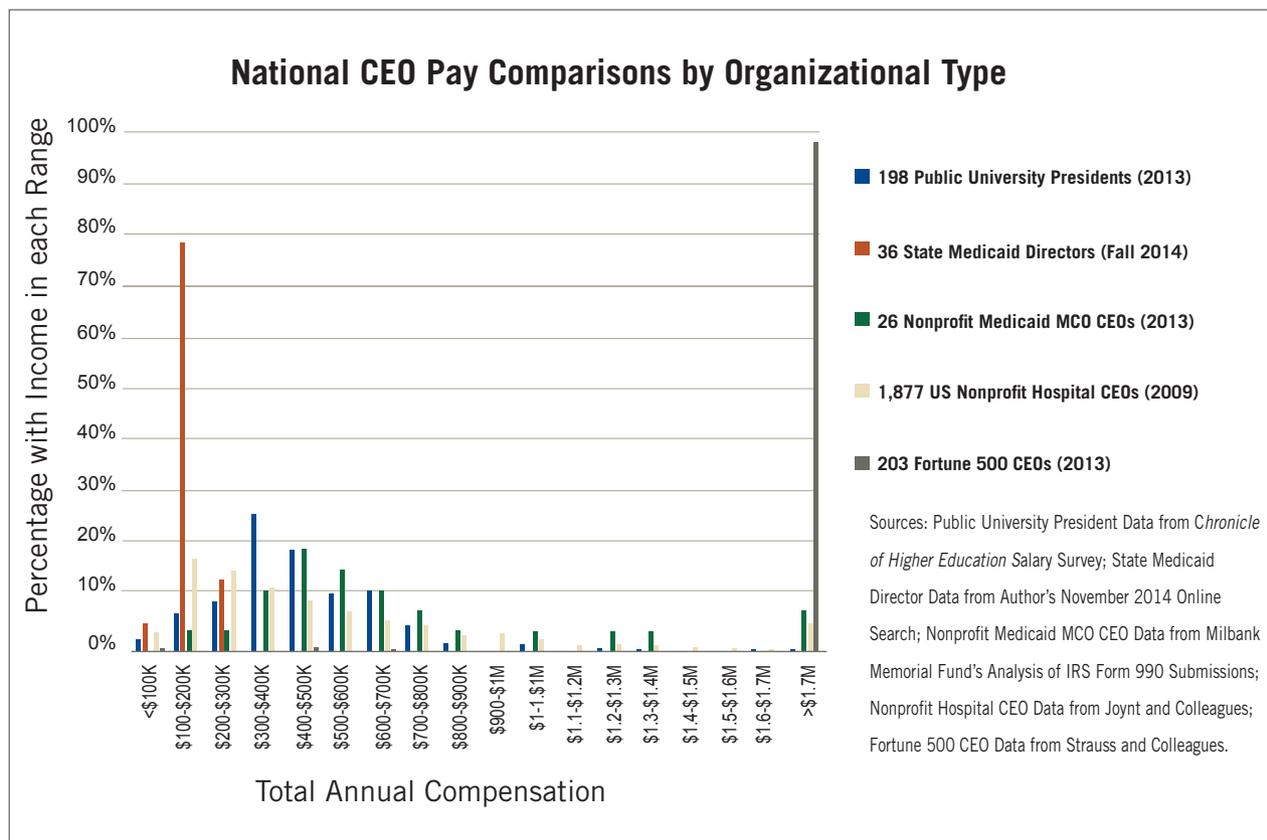
A comparison of Medicaid leaders to leaders of large nonprofit hospitals is relevant because many charitable health care institutions derive a sizable portion of their revenues from Medicaid payments. Given their role in the provision of care to a meaningful proportion of Medicaid recipients, their skill sets also suggest overlap with the potential pool of state Medicaid directors. These hospital leaders interact with Medicaid and the local health care environment constantly. In terms of size, nonprofit hospitals employ 10 or even 100 times more employees than Medicaid programs, but are much smaller than the largest Medicaid programs in terms of expenses. There is some overlap in financial scale though: the 50th largest nonprofit hospital in the United States would have ranked as the 32nd largest Medicaid program in 2013.⁸⁷ Further reinforcing this comparison is the professional proximity of these hospital leaders to Medicaid leaders in the nature of their work (publicly financed health care), their organization's direct relationship to the Medicaid program (many of these institutions are heavily dependent on Medicaid funding), and in many cases, a direct professional working relationship with Medicaid directors.

The median CEO salary for 1,877 nonprofit hospitals in the United States was \$404,938 in 2009, according to a study by Joynt and colleagues.⁸⁸ 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 of nonprofit teaching hospitals in 2009 was more than six times the average compensation of a Medicaid director as of late 2014. Joynt and colleagues also found a clear relationship between hospital size and CEO pay, with each added bed worth approximately \$550 in annual compensation, representing an added \$110,000 in pay for an additional 200 beds.⁸⁹ Private health system (including nonprofit hospitals) and hospital leaders earned even more. Results from Mercer's 2012 Integrated Health Networks Compensation survey indicated the following:⁹⁰

- At least 75% of all big-system (> \$1 billion in revenue) CEOs earned at least \$982,000 in 2012.
- At least 50% of all big-system chief nursing officers earned at least \$282,000.
- At least 75% of all big-system CFOs earned at least \$310,000.

Figure 11



Medicaid leaders' salaries in a broad market context

The data in Figure 11 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 38 state Medicaid directors.⁹¹ 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.

Is the same true at a local level for any specific Medicaid Director? A report from the *Philadelphia Inquirer*⁹² provides information on compensation of executive-suite officials in nonprofit health systems in the Philadelphia region in 2010. Based on IRS Form 990 submissions, the Philadelphia data are useful both because of their regional focus and because they include a representative distribution of non-CEO executives such as CFOs. Both area health system CEOs and CFOs are included in the data as well as non-CEO and non-CFO executives (such as directors of nursing and chief information officers), all of whom might be considered as future Medicaid directors. The geographic comparison is especially relevant given the likelihood of frequent professional interaction between the Pennsylvania Medicaid program and executives and senior leaders at Philadelphia-area hospitals. The data in Figure 12 reveal that Pennsylvania's Medicaid director, who earned about \$130,000 annually as of November 2014, earns less than almost every single professional counterpart he or she might interact with in Philadelphia-area hospitals—typically at least \$100,000 less, but often the gap is much larger.⁹³ Even the nation's highest-paid Medicaid directors earn less than the vast majority of Philadelphia-area health system CEOs, CFOs, and more junior executives.

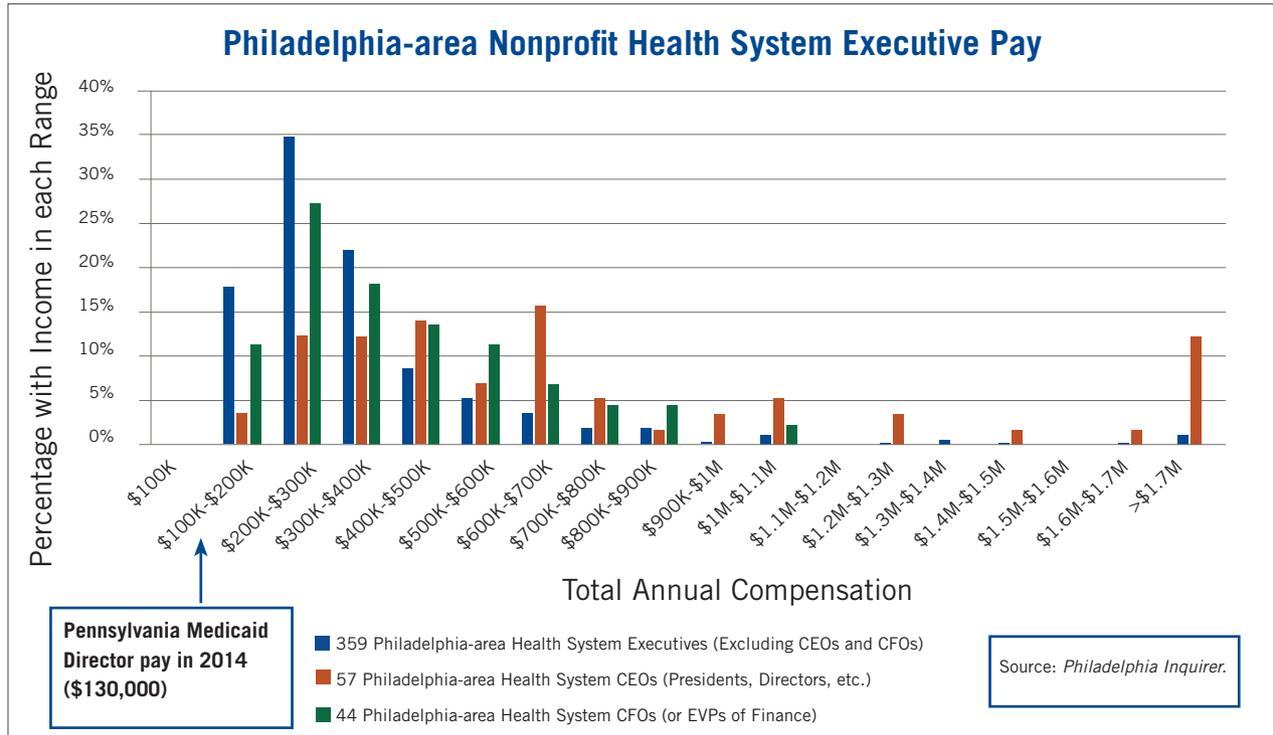
Does the level of compensation matter in Medicaid?

As has been demonstrated, Medicaid directors' pay does not approach the compensation of their counterparts in the corporate, hospital, insurance payer, and university markets. Is it nonetheless reasonable for states to expect to be able to recruit and retain the caliber of skill, talent, and experience that controlling authorities of these other organizations believe to be necessary for a leadership role?

There are at least two explanations for Medicaid directors taking and keeping the job despite possessing traits worthy of CEO-level pay in other organizations: altruistic predisposition to public service and career investment.

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. This predisposition could prove valuable to both public employees and employers. To the extent public service entails

Figure 12



unique job traits, public salaries may not need to be as high to attract the best candidates. There is a well-developed economic literature supporting the existence of factors that positively (or negatively) compensate for observed wage differences in otherwise similar jobs. In the case of Medicaid directors, however, their short tenures appear to indicate that the job itself is not attractive enough to compensate for the lack of financial remuneration.

The nature of the job—heading a public program on behalf of the governor, policymakers, and taxpayers—leads to questions about the degree to which states may wish to rely on altruism or a predisposition to public service as a means of attracting and retaining talented leaders. The undercompensation of Medicaid leaders leaves states vulnerable to the problem of agency that dominates the literature in the study of CEO compensation. Are employment contracts (or civil service terms) strong enough to ensure that directors work towards policy and program objectives? Without the introduction of incentives or oversight measures, such as increased reporting and checks on directors’ discretion and authority, the answer must certainly be no—except in those circumstances where a CEO-caliber Medicaid director’s ideology and personal altruism align with those of policymakers.

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.

The most compelling counterargument to reliance on this type of implicit compensation or “opportunity pay” is to observe that society’s other important institutions (corporations, public universities, and nonprofit hospitals) set compensation in order to retain executives for long periods of time. These other institutions rely less, or not at all, on the value of the CEO position as a stepping stone or training ground. It appears that other important institutions value their ability not only to attract relatively high-caliber talent, but also to retain that talent in the executive position. Indeed, opportunity pay is self-limiting, and diminishes rapidly with tenure, as a Medicaid director’s ability to trade future earnings for present undercompensation rapidly becomes more of an opportunity cost than an investment.

It can be reasonably posited that if Medicaid is structured as a consolidated agency, its leader should be seen as a member of the governor’s cabinet—compensated at similar levels and serving at the pleasure of the governor. The merits of a Medicaid director receiving preferential treatment for compensation and job security depend in part on the desirability of acquiring a strong, long-tenured director—and the extent to which that person is more likely to be attracted by these benefits. This report demonstrates that establishing strong and stable Medicaid leadership is not merely desirable but necessary for a program that comprises nearly one-quarter of a state’s budget.

It is worth noting that when states are in direct competition with the private sector for scarce labor—physicians and nurses, information technology (IT) directors, economic development directors, and public university athletic and administrative leaders all come to mind—they often develop compensation packages that are competitive with the private sector. To date, Medicaid directors have not been part of this select group. This report argues that they merit consideration.

Discussion

Medicaid is typically a state’s largest centrally administered program, touches the greatest number of citizens, commands on average nearly one-quarter of a state’s budget, and is growing faster than the rest of state government. The states themselves exert significant control over the size, scope, delivery, and efficiency of their Medicaid programs, despite the federal government’s oversight and financing. The influence of a state Medicaid program extends beyond the program itself to the health care system and health insurance markets in the state—and often can extend beyond a state’s borders to other Medicaid programs around the country. If the impact of the Medicaid program is not well understood by the state legislators, governors, and government officials who exert direct influence over administrative budgets and personnel decisions affecting Medicaid leadership, the potential for state underinvestment in Medicaid leadership and administrative capacity could amount to staggering losses in the public’s wealth and welfare.

Significant risks associated with current state practice

The evidence presented in this report indicates a deep incongruity among states' administration of the Medicaid program, the theory and practice of corporate leadership and governance, and executive compensation in comparable public and nonprofit organizations. This does not directly imply that state Medicaid programs are currently underperforming or that a particularly capable group of state leaders cannot overcome any structural deficiency in the governance of their Medicaid programs. It does, however, point to a number of systemic risks summarized below.

The risk of distributed programmatic control. The Medicaid program has grown to become a major, if not the dominant, source of funding in states for behavioral health care, developmental disability services and long-term care programs, and for the operational function of eligibility systems. Most states manage one or more of these services and operations separately (see Figure 7). In this regard, there are competing reasons for managing some components of the Medicaid program outside of the Medicaid organization itself, for example, to establish a separate representative for special populations or to coordinate eligibility operations with programs that serve an overlapping population. But removing (or keeping separate) large portions of the Medicaid program from the managerial purview of the Medicaid organization itself can also make coordination of services, policy, and direct operation of shared programs difficult. Overcoming disagreements and delays in the policy planning process often requires mutual, but independent, appeals to the head of the agency—this can confuse staff and slow cross-divisional work on common efforts to redesign services, beneficiary qualifications, and provider payments. Divided responsibility increases the complexity of the Medicaid director's job and limits the ability to put in place the management practices necessary to improve the cost-effectiveness of Medicaid-administered services.

The superagencies in which Medicaid is often housed sometimes place the program alongside other smaller or structurally subsidiary programs at organizational parity with Medicaid, such as behavioral health, substance abuse, or developmental disabilities agencies, or functional support agencies like IT and finance. While such placement may give these programs representation for population-specific services that historically have been under-resourced, most states are now on a path to greater parity in the provision of these services. The emerging priorities are to consolidate financing and ensure coordination—if not consolidated delivery—of services. Given this, states may want to revisit the organizational relationship between these Medicaid-funded services and the Medicaid program itself.

A number of states have taken steps to formally unify Medicaid programs within the Medicaid agency, to consolidate the budgeting for these services, to elevate the Medicaid director to the governor's cabinet, and/or to grant the Medicaid agency flexibility in procurement or personnel. Nevertheless, Medicaid's organizational structure in many states has not kept pace with major shifts in programmatic design and strategy. A program that requires the level of state resources that Medicaid does demands a well-resourced, coherent administrative strategy.

The risk of diluting public policy leadership. Another potential byproduct of distributing responsibilities for the Medicaid program across state government is that issue representation and policy leadership could be weakened. For instance, a state could split responsibility for elderly recipients who need long-term home care between a Medicaid director (responsible for delivery of medical services and integrating physical and behavioral health services and long-term services and supports financed by Medicare and Medicaid) and a counterpart agency for long-term care services for the aged (responsible for in-home long-term care services). Who will set policy priorities for services for this population and how will these services align with other health priorities? Who will lead discussions with federal officials regarding the state's priorities or represent the administration in legislative negotiations?

Giving Medicaid a more prominent organizational structure could enable a state to recruit and invest in a leader with the potential to use Medicaid's considerable levers to achieve the administration's health policy objectives. A strong and competent Medicaid director, with a larger public profile, can more easily build administrative resources and marshal stakeholder support for the types of reforms that improve the health of populations and spend public dollars more efficiently.

The risk of undercompensation. Even with elevated or more coordinated Medicaid oversight, poor compensation for a Medicaid director in a competitive labor market will fail to attract and retain the caliber of leader needed for such a large and complex program.

Judging from the available evidence on the amount and form of Medicaid director compensation versus comparable private organizations, there appears to have been little effort by the majority of states to structure compensation in order to attract and retain the most effective Medicaid directors. While approximately half of all state Medicaid programs would rank in the Fortune 500, and 40 states would rank in the Fortune 1000, Medicaid directors earn, on average, less than \$150,000 per year, or between one-tenth and one-twentieth of a typical Fortune 500 or Fortune 1000 CEO's pay. Even if Medicaid directors are not seen as members of the same potential labor pool as CEOs despite similarities in the size, complexity, and economic influence of the two types of organizations, an analysis of their compensation compared to that of the leaders of other public and nonprofit organizations with similar purpose, scale, and impact reveals smaller but still substantial pay gaps. As noted previously, state university presidents earn about 3.6 times as much as Medicaid directors, nonprofit hospital CEOs about four times as much, and Medicaid MCO CEOs about 5.4 times as much.

The pay gap may be greatest in states with large Medicaid programs since—unlike in the private sector, state universities, and nonprofit hospitals—there is no correlation between the size of a Medicaid program and the pay of its director. While states may wisely choose not to establish an incentive for Medicaid directors to increase public Medicaid spending (as CEOs are incentivized to increase firm revenue or size), states with larger, more complex programs face the risk of underperforming if they do not propose some type of compensation premium for the Medicaid director's role.

The risk of undercompensation may be even greater when attempting to retain Medicaid leaders. The median tenure of a Medicaid leader is less than three years—a short period to establish any degree of program mastery, sense of prioritization, or focused effort. Stability in Medicaid leadership—such as that associated with successful programs and organizations—could be improved with a combination of increased pay, higher-organizational prominence, and some type of tenure assurance. For a governor, such elevation of a position could create the risk of unequal treatment among cabinet members. However, some degree of differential compensation of colleagues in an administration, driven by labor market realities, already exists: leaders of a program that consumes an average of nearly one-quarter of the state’s budget should be included in this company.

The risk of inattentive governance. Private sector corporations are governed primarily by a board of directors, which is comparable to the governor and legislature of a state who are responsible for Medicaid.

As noted earlier, the Business Roundtable specifies some roles and obligations of a corporation’s board and maintains that “the selection, compensation and evaluation of a well-qualified and ethical CEO is the single most important function of the board.”⁹⁴ The Business Roundtable’s governance principles as applied to Medicaid clearly point to the need for governors and state legislatures to

- identify a common set of goals and strategies for the Medicaid program given its considerable growth and current roles in the state;
- establish an updated agency and administrative structure consistent with the program’s goals and strategies; and
- set the selection and retention of the best possible Medicaid director as a foremost priority in the administration of Medicaid, and establish the conditions for doing so by determining the appropriate role and compensation of the Medicaid director.

The many large-scale challenges and opportunities associated with state Medicaid programs—and the economic and societal value of a director who is able to effect spending or programmatic impact—indicate the value of high-caliber leaders comparable in talent and experience to those leading organizations with similar economic and social impact. Medicaid’s growing leadership position in state health policy enhances and complicates the Medicaid director’s formal role, compounding the program’s out-of-date organizational structures and pay scale. The mismatch between program challenges and expectations on the one hand, and the organizational structure of the program and the role and compensation of its directors on the other, is evident when these are compared with the governance of similarly scaled public and private organizations. Failure to address these structural defects in Medicaid governance and leadership could result in significant net costs to state and federal taxpayers.

Key Conclusions and Recommendations

There has been little research focused on leadership of Medicaid, the country's largest state-run program, representing a total of half a trillion dollars spent per year and responsible for one-tenth or more of future growth in federal spending.⁹⁵

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. The financial, programmatic, and health system impacts of policy choices and management at the state level reinforce the importance of effective organizational structures and capable leadership.

This report leads to the following conclusions related to these areas:

- 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 health care spending in a state.
- Medicaid programs have been steadily assigned new responsibilities as definitions of needy populations and needed services have grown. The program has grown to become the main 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 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 IT 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 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 one-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) and transportation are also classified as “centrally managed”
- ² Medicaid and CHIP Payment and Access Commission. (n.d.). *Medicaid's Share of State Budgets*. Washington, DC: Medicaid and CHIP Payment and Access Commission. (Accessed July 29, 2015: <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>.)
- 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 usgovernmentsspending.com (n.d.). (Accessed July 21, 2015: http://www.usgovernmentsspending.com/entitlement_spending.)
- ⁵ DeNavas-Walt C., Proctor B.D., Smith J.C. (2011). *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. Washington, DC: US Department of Commerce. (Accessed July 21, 2015: <http://www.census.gov/prod/2011pubs/p60-239.pdf>.)
- ⁶ For enrollment and federal spending projections and for total Medicaid spending, 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 total Medicaid spending, see note 5 above and also Centers for Medicare and Medicaid Services. (2014). *National Health Expenditure Historical and 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>.)

- ⁷ Medicaid's average rank among K-12 education, higher education, public assistance, corrections, and transportation rose from 1.7 to 1.4 between FY 2009 and FY 2013, prior to expansion in most states, and Medicaid's share of state spending grew in 37 states. See National Association of State Budget Officers. (2013). *State Expenditure Report: Examining Fiscal 2011-2013 State Spending*. Washington, DC: National Association of State Budget Officers. (Accessed July 21, 2015: <http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf>.)
- ⁸ Medicaid and CHIP Payment and Access Commission. (2014). *Report to the Congress on Medicaid and CHIP: June 2014*. Washington, DC: Medicaid and CHIP Payment and Access Commission. (Accessed July 21, 2015: https://www.macpac.gov/wp-content/uploads/2015/01/2014-06-13_MACPAC_Report.pdf.)
- ⁹ 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>.)
- ¹⁰ Author's conversations with state Medicaid directors; See also note 9 above.
- ¹¹ Medicaid and CHIP Payment and Access Commission. (2014). *MACStats: Medicaid and CHIP Program Statistics*. Washington, DC: Medicaid and CHIP Payment and Access Commission. (Accessed July 21, 2015: https://www.macpac.gov/wp-content/uploads/2015/01/2014_06_MACStats.pdf.)
- ¹² 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/>.)
- ¹³ For total Medicaid spending in 2013, 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 July 21, 2015: <http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html>.)
- ¹⁴ For data on health spending by type and source of funds, see CMS publication cited in note 6 above.

- ¹⁵ See CMS publication cited in note 6 above.
- ¹⁶ For data used in author's calculations of federal spending projections, see CBO publication cited in note 6 above; For data used in author's calculations of health expenditures, see CMS publication cited in note 6 above.
- ¹⁷ See note 8 above.
- ¹⁸ Average was 22.7% for FY 2013, the year before program expansion occurred in a majority of states. See NASBO publication cited in note 7 above.
- ¹⁹ Kaiser Family Foundation. (2014). *Kaiser State Health Facts: Status of State Action on the Medicaid Expansion Decision*. Washington, DC: Kaiser Family Foundation. (Accessed December 3, 2014: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.)
- ²⁰ For Medicaid spending in federal fiscal year 2012, see Kaiser Family Foundation. (n.d.). *Kaiser State Health Facts: Distribution of Medicaid Spending by Service*. Washington, DC: Kaiser Family Foundation. (Accessed July 21, 2015: <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/>.)
- ²¹ For spending data, see Kaiser Family Foundation. (n.d.). *Kaiser State Health Facts: Distribution of Medicaid Spending on Long Term Care*. Washington, DC: Kaiser Family Foundation. (Accessed July 21, 2015: <http://kff.org/medicaid/state-indicator/spending-on-long-term-care/>.); Percentages in text exclude, but Figure 3 includes, states reporting no spending on nursing facilities, as this is interpreted to be an indication that the states reimburse nursing facilities solely through managed care companies, not an indication that nursing homes are not reimbursed at all, since nursing home services are Medicaid's original and federally mandated benefit.
- ²² Kaiser Family Foundation. (2012). *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. (Accessed July 21, 2015: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf>.); For the complexities of family planning matching funds, see US Department of Health and Human Services. (2011). *Audit (A-07-10-04156): Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program*. Washington, DC: Office of Inspector General, US Department of Health and Human Services. (Accessed July 21, 2015: <https://oig.hhs.gov/oas/reports/region7/71004156.asp>.)
- ²³ Medicaid and CHIP Payment and Access Commission. (2012). *MACFacts: Key Findings on Medicaid and CHIP: Health Care Related Taxes in Medicaid*. Washington, DC: Medicaid and CHIP Payment and Access Commission. (Accessed July 21, 2015: https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-HealthCareRelated-TaxesInMedicaid_2012-08.pdf.)

- ²⁴ Author's experience and news reports, such as Frago C. (2013). Medicaid Audit Report Release Seen as Political. *Arkansas Democrat-Gazette*. (Accessed January 31, 2013: <http://www.arkansasonline.com/news/2013/jan/31/medicaid-audit-report-release-seen-politi-20130131/>.)
- ²⁵ 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>.)
- ²⁶ Young K., Rudowitz R., Rouhani S., Garfield R. (2015). *Medicaid Per Enrollee Spending: Variation Across States*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. (Accessed July 21, 2015: <http://files.kff.org/attachment/issue-brief-medicaid-per-enrollee-spending-variation-across-states-2>.)
- ²⁷ Shields M., Thompson B. (2011). *Kansas Announces Sweeping Medicaid Restructuring*. Washington, DC: Kaiser Health News. (Accessed July 21, 2015: <http://khn.org/news/kansas-medicaid-managed-care-brownback-kancare/>.)
- ²⁸ For author's experience, see Nielsen M.J., Allison A., Brunner S. (2007). *Testimony on Updates on Medicaid and Other KHPA Programs*. Topeka, KS: Kansas Health Policy Authority. (Accessed July 21, 2015: <http://www.kdheks.gov/hcf/legislative/download/2007Testimony/5-31-07Update-JointCommitteeonHealthPolicyOversight-AllisonFINAL.pdf>.)
- ²⁹ For Medicaid spending in each state in federal fiscal year 2012, see Kaiser publication cited in note 25 above.

- ³⁰ 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.
- ³¹ Center for Medicare and Medicaid Innovation. (2012). *State Innovation Models: Funding for Model Design and Testing Assistance*. Washington, DC: US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. (Accessed July 21, 2015: http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf.)
- ³² Centers for Medicare and Medicaid Services. (2015). *State Innovation Models Initiative: General Information*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed July 21, 2015: <http://innovation.cms.gov/initiatives/State-Innovations/index.html>.)
- ³³ Golden W., Thompson J.W., Motley M., Fendrick A.M., Mathis C., Chernew M. (2014). *Arkansas Payment Improvement Initiative: The First Year*. Health Affairs Blog. (Accessed July 21, 2015: <http://healthaffairs.org/blog/2014/08/25/arkansas-payment-improvement-initiative-the-first-year/#>.)
- ³⁴ Centers for Medicare and Medicaid Services. (2014). *State Innovation Models Initiative Round Two*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed July 21, 2015: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-12-16.html>.)
- ³⁵ Allison A. (2014). Arkansas's Alternative to Medicaid Expansion Raises Important Questions about How HHS Will Implement New ACA Waiver Authority in 2017. *Journal of Health Politics, Policy and Law*. 39(5):1089-1098.
- ³⁶ Thompson J.W., Wilson J.C., Allison A., Beebe M. (2014). Arkansas's Novel Approach to Expanding Health Care Coverage. *Journal of Health Politics, Policy and Law*. 39(6):1277-1288.
- ³⁷ Bachrach D., du Pont L., Lipson M. (2014). *Arkansas: A Leading Laboratory for Health Care Payment and Delivery System Reform*. Commonwealth Fund. (Accessed July 21, 2015: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/aug/1766_bachrach_arkansas_payment_reform_ib.pdf.)
- ³⁸ Medicaid and CHIP Payment and Access Commission. (2015). *Report to Congress on Medicaid and CHIP: March 2015*. Washington, DC: Medicaid and CHIP Payment and Access Commission. (Accessed July 21, 2015: <https://www.macpac.gov/wp-content/uploads/2015/03/March-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.)

- ³⁹ For Medicaid data, see CMS publication cited in note 13 above; 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/>)
- ⁴⁰ For recent and representative summaries of the literature, see Van den Steen E. (2010). Interpersonal Authority in a Theory of the Firm. *American Economic Review*. 100(1):466-490; Aghion P., Holden R. (2011). Incomplete Contracts and the Theory of the Firm: What Have We Learned over the Past 25 years? *Journal of Economic Perspectives*. 25(2):181-197.
- ⁴¹ Roberts J. (2004). *The Modern Firm: Organizational Design for Performance and Growth*. Oxford: Oxford University Press.
- ⁴² Author’s paraphrase of Roberts—see note 41 above.
- ⁴³ “Supports” include homemakers, home modifications, and other activities that support noninstitutional living.
- ⁴⁴ Just nine states spend less than 10% on community-based services. Community-based services defined by Kaiser include standard home health services, personal care, home- and community-based care for the functionally disabled elderly, and services provided under home- and community-based services waivers. For data, see Kaiser publication cited in note 21 above.
- ⁴⁵ Whittington J.W., Nolan K., Lewis N., Torres T. (2015). Pursuing the Triple Aim: The First 7 Years. *The Milbank Quarterly*. 93(2):263-300.
- ⁴⁶ There are three such NAMD surveys conducted in 2012, 2013 and 2014. The 2013 and 2014 surveys were both published in calendar year 2014. 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.)
- ⁴⁷ For data used in author’s calculations, see note 46 above.
- ⁴⁸ Author’s analysis of CMS Financial Management Report data includes national totals for all separately identified long-term care, behavioral health care, and services for the intellectually or developmentally disabled. See CMS publication cited in note 13 above.

- ⁴⁹ For Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports, see Kaiser Family Foundation. (2011). *Kaiser State Health Facts: Medicaid Spending by Enrollment Group*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Urban Institute. (Accessed July 21, 2015: <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.)
- ⁵⁰ 42 Code of Federal Regulations §431.10. (Accessed August 2, 2015: <http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-part431.pdf>.)
- ⁵¹ Henri Fayol's 14 key principles of management from his book *Administration industrielle et générale* published in 1916 are available in English. (Accessed July 29, 2015: <https://managementmania.com/en/henri-fayol/>.)
- ⁵² Communications with Jason Helgerson and Deborah Bachrach, current and former Medicaid directors for the state of New York. June 2015.
- ⁵³ Communication with Tom Betlach, Arizona Medicaid director. June 2015.
- ⁵⁴ Communication with Darin Gordon, TennCare director. June 2015.
- ⁵⁵ 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>.)
- ⁵⁶ 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.
- ⁵⁷ See note 8 above.
- ⁵⁸ Author's estimates are based on state Medicaid agency personnel counts from NAMD. For data used in estimates, see National Association of Medicaid Directors. (2012). *NAMD's 1st Annual Medicaid Operations Survey: 2012 Chart Book*. Washington, DC: National Association of Medicaid Directors. (Accessed July 21, 2015: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_mcdops_chartbook_final_102612.pdf.)
- ⁵⁹ 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.); See also note 46 above.

- ⁶⁰ See note 8 above.
- ⁶¹ Communication with Stephen Somers, Center for Health Care Strategies president and chief executive officer. June 2015.
- ⁶² Business Roundtable. (2012). *Principles of Corporate Governance: 2012*. Washington, DC: Business Roundtable. (Accessed July 21, 2015: http://businessroundtable.org/sites/default/files/BRT_Principles_of_Corporate_Governance_-2012_Formatted_Final.pdf.)
- ⁶³ Ibid.
- ⁶⁴ Ibid.
- ⁶⁵ Ibid.
- ⁶⁶ See note 46 above.
- ⁶⁷ Bebchuk L., Fried J. (2003). *Executive Compensation as an Agency Problem*. Harvard John M. Olin Center for Law, Economics, and Business. Discussion Paper No. 421; Weisbach M.S. (2007). Optimal Executive Compensation versus Managerial Power: A Review of Lucian Bebchuk and Jesse Fried's Pay Without Performance: The Unfulfilled Promise of Executive Compensation. *Journal of Economic Literature*. 45:419-428.
- ⁶⁸ Murphy K.J. (2013). "Executive Compensation: Where We Are, and How We Got There," in *Handbook of the Economics of Finance*, Volume 2, Part A, eds. Constantinides G.M., Harris M., and Stulz R.M., pp. 211-356. Oxford, UK: North Holland, Elsevier.
- ⁶⁹ Ibid.
- ⁷⁰ Ibid.
- ⁷¹ Conyon M.J. (2006). Executive Compensation and Incentives. *Academy of Management Perspectives*. 20(1):25-44.
- ⁷² See NAMD's second annual survey cited in note 59 above.
- ⁷³ Missing states are Alaska, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, Rhode Island, Washington, and Wyoming.
- ⁷⁴ Tervio M. (2008). The Difference That CEOs Make: An Assignment Model Approach. *American Economic Review*. 98(3):642-668.
- ⁷⁵ See NAMD's second annual survey cited in note 59 above.

- ⁷⁶ This does not imply that civil service pay structures do not also bind. In Arkansas, for example, the author was an at-will gubernatorial appointee in a job classed and compensated in the civil service structure.
- ⁷⁷ 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>.)
- ⁷⁸ Conference Board. (2014). *Chart of the Week: Departing CEO Tenure (2000-2013)*. New York, NY: Conference Board. (Accessed July 21, 2015: https://www.conference-board.org/retrievefile.cfm?filename=TCB_CW-0561.pdf&type=subsite.)
- ⁷⁹ Communications with NAMD staff. December 2014.
- ⁸⁰ Employee totals based on author's convenience search of available public information. For university budgets, see Newman J., O'Leary B. (2014). Executive Compensation at Public Colleges—Salary Survey. Last updated June 9, 2014. *Chronicle of Higher Education*.
- ⁸¹ Salary computations exclude universities reporting partial-year figures. For compensation information used in author's calculations, see *Chronicle's* survey cited in note 80 above.
- ⁸² This is dependent on whether former Ohio State University President Gordon Gee's \$6 million annual pay was included in the analysis.
- ⁸³ Tenures calculated as of June 30, 2013. For date of hire information used in author's calculations, see *Chronicle's* survey cited in note 80 above.
- ⁸⁴ For data used in author's analysis, see CMS publication cited in note 13 above.
- ⁸⁵ For source of 2011 enrollment, see Centers for Medicare and Medicaid Services. (2011). *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*. Washington, DC: Centers for Medicare and Medicaid Services. (Accessed July 21, 2015: <http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-medicaid-mc-enrollment-report.pdf>.)
- ⁸⁶ 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.

- ⁸⁷ For data used in author's analysis of state spending, see CMS publication cited in note 13 above; For nonprofit hospital revenues, see Punke H. (2014). 50 Top-Grossing Nonprofit Hospitals: 2014. *Becker's Hospital Review*. (Accessed July 21, 2015: <http://www.beckershospitalreview.com/lists/50-top-grossing-nonprofit-hospitals-2014.html>.)
- ⁸⁸ 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.
- ⁸⁹ Ibid.
- ⁹⁰ Herman B. (2013). Hospital and Health System Executive Compensation in 2013: 8 Trends to Monitor. *Becker's Hospital Review*. (Accessed July 21, 2015: <http://www.beckershospitalreview.com/compensation-issues/hospital-and-health-system-executive-compensation-in-2013-8-trends-to-monitor.html>.)
- ⁹¹ 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 80 above; For Medicaid director compensation data, see NAMD's second annual survey cited in Note 59 above; For Medicaid MCO CEO compensation data, see Note 86 above; For compensation data for CEOs of nonprofit hospitals, see Note 88 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/>.)
- ⁹² *Philadelphia Inquirer*. (2011). Compensation for Health System Executives. (Accessed July 21, 2015: <http://www.philly.com/philly/business/175896851.html>.)
- ⁹³ Inference assumes that for-profit hospital executives earn as much or more than nonprofit executives, and that hospital compensation did not fall between 2010 and 2014.
- ⁹⁴ See note 62 above.
- ⁹⁵ For data used in author's projection of at least half a trillion dollars in total computable medical assistance and administrative expenditures in FY 2015, see CMS publication cited in note 6 above; Author's projections also accommodate federal spending projections from the Congressional Budget Office. See CBO publication cited in note 6 above.

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