



The  
Reforming  
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Group

## EXECUTIVE SUMMARY

# State Policy Capacity and Leadership for Health Reform

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Policies are no longer thought to succeed on their own merit. Decades of observing policy design and policy implementation have given rise to a more complex vision of the policy process, one in which factors such as leadership, resources, and public support combine over time to bring about success or failure.

Policymaking is usually a collective endeavor, mobilizing the knowledge, experience, and skills of many different people, both inside and outside of government. Policy capacity is the combination of intangible resources backed by tangible assets such as political authority and financial resources, which are required to develop, adopt, implement, evaluate, and adapt policies. Health reform, with its unique combination of conceptual, economic, ethical, and political challenges, obviously requires extensive policy capacity.

The Patient Protection and Affordable Care Act (ACA) of 2010 brought sweeping changes to the US health care system. Some changes took effect immediately, while others had a longer timeline, including strategies to restructure the delivery system to provide higher quality, less costly care. The federal government provided a very high matching rate for Medicaid expansion and subsidies for health plans purchased in the individual marketplace. It also gave substantial grants to states to plan, develop, and begin operating the new health marketplaces. The federal government supported states by providing policy direction and technical assistance. Even with this extensive financial and technical support, states had to enact the necessary laws and regulations to implement the broad policy prescriptions embodied in the ACA, especially whether to expand Medicaid and establish a state health insurance marketplace. This required the sum of competencies encompassed in our definition of policy capacity.

Caught between a demanding federal mandate and their own fiscal and sociopolitical realities, states were expected to effectively design, implement, and assess ambitious and complex reforms. Even states with large bureaucracies and a tradition of policy innovation could not be expected to possess all the needed professional expertise, the human and financial resources, and the institutional infrastructure required for this extraordinary situation. Smaller states were, of course, often in a more constrained resource position, even taking into account their advantage of having closer personal relationships with major stakeholders.

The study was commissioned by the Reforming States Group, a bipartisan, voluntary group of state health policy leaders from both the executive and legislative branches, which has been supported by the Milbank Memorial Fund since 1992. The aim of the study was to understand how policy capacity was defined and managed by state health leaders in different political environments during the implementation of the ACA. Working with a sample of states—large and small, red and blue, actively reformist or more circumspect, etc.—the research team interviewed 18 state executive agency officials and six legislators from 10 states about their experiences developing and sustaining the capacity needed for major transformations in health care. These in-depth interviews provided us with unique insights into the challenges arising from the implementation of the ACA—and a fresh understand-

ing of the states' commitment to the reform process. Analysis of these interviews reveals that despite many challenges, the states were able to engage in the change process while putting their own brand on reform.

The report findings present a synthesis of the interviews according to several major themes:

- the policy roles and mechanisms in place at the beginning of the reform process and the contribution of leadership to the reform process;
- the state of policy capacity at that same moment and its evolution through the reform period;
- the financial and technical resources for policy development and implementation and the utility of the support received; and
- the most pressing needs for the future.

A general conclusion follows these findings.

## Findings

### I. Roles, Mechanisms, and Leadership

Governors, legislatures, and core executive teams all played a role in bringing about reform.

The importance of executive leadership in health reform cannot be overstated. Repeatedly, the role of governors and their immediate staff was identified in the interviews as a crucial variable. Without the authority that comes from a governor's clear and constant engagement and support, state health reform cannot go very far. Another factor of progress and success resides in the existence of a cadre of policy leaders with years of experience at the state level. Behind some of the most well-developed reforms, it is possible to trace the influence of a person (or a team) with exceptional understanding of and experience in how state policy is formulated and implemented.

Legislators played a limited role in the reform implementation process, although in a few cases, their experience and length of tenure made a difference at the policy formulation stage. Even if legislators are not always themselves advocates, their close relationships with stakeholders provided necessary avenues for the transfer of information and expertise.

Virtually all of the sample states reported that the primary responsibility for interpreting and implementing the ACA fell upon a small group of executive branch officials—and that the experience and leadership of this core staff were critical.

Trust and leadership were the two characteristics mentioned in most participants' answers. Both agency and legislative officials emphasized the importance of building relationships with fellow agency staff and legislators over a number of years. This trust proved invaluable, both in making critical policy choices and throughout the implementation process. In

fact, health officials from two of the 10 sample states insisted that without “trust between the governor’s staff, state agency directors, and key legislators,” reform attempts could not have succeeded. Trust requires transparency, accountability, and commitment. Trust builds leadership—and leadership cannot exist without trust.

In half of the 10 sample states, the governor’s office directed the policy process and, in the other half, the governor delegated the policy design to the executive agencies, providing political support as needed.

The principal mechanisms—commissions, task forces, committees, and centers that were used to develop and coordinate the policy design and to oversee the implementation process—included:

- Bipartisan commission comprising political leaders and key stakeholders
- Study committee comprising agency directors and major stakeholders
- Task force comprising executive agency leaders
- Regional advisory committees and forums
- University-based policy center to provide strategy and analysis

## II. Staff Capacity

Many of the sample states have a long history of expanding Medicaid and enacting insurance reforms for the small group and individual health insurance markets.

In addition to having established working relationships with one another, state leaders noted that their prior experience developing major health policies played a critical role. It assisted with guiding decisions about whether to have the policy process run by the governor’s office or delegated to specific state agencies. It also influenced decisions about whether to use an independent commission with representation from legislative leaders and the major stakeholders and/or an executive agency task force with representation from the major state agencies responsible for Medicaid and regulating health insurance markets.

We also looked at how states developed staff capacity in some of the key areas that states required in order to plan and implement ACA-related health reforms—planning and analysis, managing operations, and working with outside vendors and legislative staff.

Most states indicated that they had sufficient capacity to do the planning and policy analysis required to make decisions about expanding Medicaid and implementing a state-based exchange, but they needed to secure additional staff and outside expertise to implement the significant changes these reforms required. A few states, however, indicated that there is never enough staff capacity at the state level.

Staff members subject to demanding new tasks and processes were often exposed to professional stress and burnout. Capacity, where it exists, is vulnerable to human resources management deficiencies such as insufficient compensation, limited career support, and exhausting work schedules. Staff recruitment and retention are always challenging, but more so in a political environment in which public employees do not always feel properly valued.

Recruiting new staff, even in modest numbers, was not easy, especially given salary limitations and cumbersome state recruitment processes. Finding and retaining people with the proper experience in operations management, which is at the core of implementing the ACA policy changes, was even more difficult—especially in the emerging policy specialties related to the use of new information technology, data management, data mining, and analytics. In the ACA health reform context, demand exceeded supply. Contractors and other outside vendors were used to mitigate the major shortfalls in expertise, but the preferred approach in most states would have been to build staff capacity instead.

Another gap revealed in the interviews concerns the ability to negotiate and oversee contracts with outside vendors. Procurement processes are complex and lengthy and can lead to bad decisions, especially if the state lacks the expertise to oversee these contractors. It is a well-known paradox: proper use of external expertise requires some in-house capacity, if only to set the expectations at the right level and to ensure that this expertise fits the state's unique circumstances.

### III. Federal Support and Assistance from Other Sources

The nine states in the sample that moved forward with the ACA Medicaid expansion emphasized how important the generous matching rate was to their adoption of this reform. While some of these states had previously expanded eligibility for low-income adults, the opportunity to move to 138% of the federal poverty level at no immediate cost to the state was seen as critical to their being able to take this significant step in providing coverage to those below and just above the poverty line. These states also emphasized the importance of taking advantage of the higher 90-10 matching rate provided to enable states to make much-needed improvements to their Medicaid eligibility systems.

While the states greatly appreciated the federal financial support, they weren't as positive about the technical assistance they received. Many of the sample states were critical of the Center for Consumer Information and Insurance Oversight (CCIIO), the federal agency that oversaw the development of health insurance marketplaces. While understanding the huge challenges CCIIO staff faced, these states complained that the CCIIO did not always appreciate the difficulty states faced in implementing complex and controversial policy goals on such a short timeline. Conversely, states working on innovative approaches to Medicaid expansion had a positive view of the federal Center for Medicaid and CHIP Services senior staff.

States acknowledged the intellectual support and guidance they received from the national foundations and think tanks—and they tapped these resources as needed. States also valued the opportunity to learn from other states through workshops, webinars, and policy briefs. However, the lack of coordination across the multiple sources of this assistance was sometimes a source of frustration, as well as the time and resources required to respond to the many requests to provide information coming from various yet clearly overlapping research initiatives.

States that had established an ongoing relationship with a state university to provide policy, research, and technical support found the strategic and analytic support valuable. States also turned to their state universities to train staff and contractors as “navigators” to assist the public in enrolling in an exchange. State foundations were also cited for the critical role they played in convening stakeholders on critical issues, in addition to their research or information roles.

#### IV. Future Needs

All interviews concluded with open-ended questions about staff capacity needs for future national or state health reforms. Some of the current needs are still so pressing and some of the obstacles so important that the conversations focused more on present needs than on the future. These needs—both present and future—fall into four categories: (1) ongoing policy capacity deficits, (2) working with stakeholders and politics, (3) organizational frameworks, and (4) maintaining trust and leadership.

Implementing the ACA exposed deficits of state policy capacity in three areas:

1. Even when states were well equipped to recognize situations that require action and undertake the policy analysis of proposed changes, they needed to supplement their staff with the skills required to implement their policy choices.
2. Once policies were implemented, states acknowledged that they lacked sufficient capacity to manage program operations, including the ability to plan, organize, and supervise the delivery of programs or services.
3. Nearly all states in the sample faced problems with data access, analysis, and management; this challenge remains and will need to be addressed if health care reforms are to have the greatest impact.

What these issues have in common is a direct impact on successful implementation. As a longtime state health leader said, “We don’t need more experts coming in to tell us what the policy should be; we need senior experts to help us implement the policy choice we have selected—it is moving from policy to implementation that is critical.”

A critical aspect of operational experience is the relationships between the state and the contractors used at different stages of policy development and implementation. As we noted before, the need to develop capacity to oversee and manage contracts is one of the hard lessons learned during the first phases of reform implementation.

There is general demand for good and sound strategic advice to address the political aspects of health reform, as opposed to the more technical and managerial aspects. First, it means a capacity to get along well with the health sector's numerous and powerful stakeholders.

Various stakeholder groups were mentioned in the interviews, with a special and unsurprising focus on the insurance industry. The goal of a robust stakeholder process, as captured in the powerful formula used by an official from a midsize state, is to build an “advocacy community” that can take ownership and responsibility for the reform.

What model or structure would best serve future health reform efforts at the state level? The answer provided by the study informants is nuanced and complex. Their first thought was to preserve a “core staff.” Given the limitations of sustaining sufficient capacity, states recognize that they need to supplement their own bureaucratic capacity with stable partnerships with outside institutions. Some are independent research and strategic analysis units located in academic institutions, notably state universities. Regardless of the specific organizational frameworks established to develop and implement health policy, the state officials we interviewed emphasized the importance of independent, unbiased guidance.

## Conclusion

It is striking to note how much has been accomplished in a few years to bring real health reform to our sample states. Despite challenging political environments, health insurance markets were reformed, and Medicaid expansion occurred in many states, resulting in significant coverage increases. Some states imagined—and have begun to implement—bold transformation of how care is both delivered and paid for. Other states preferred to adopt incremental reforms, taking advantage of newly available financial resources and technical capabilities to pursue more modest but important expansions in health coverage. Finally, some other states limited themselves to careful adjustment of their existing health system, demonstrating that fiscal and programmatic prudence doesn't necessarily imply inaction (although that might have been the case in states beyond this study's reach).

All states in the study's sample demonstrated that they were able to develop and implement health reform that reflected their particular political choices and values. All showed creativity and initiative in variable proportions and sometimes with considerable challenges, but with an unquestionable sense of commitment to the public interest. Responsible managers secured the resources they needed to make things happen. Political leaders (in most cases) were ready to take charge of the process and to accept the accountability that came with it. Stakeholders rallied around the reform agenda and contributed a measure of success and expertise.

## A Capacity Checklist—What’s Needed for Health Care Reform

Based on our interviews with state leaders, we developed a capacity checklist for policy-makers to use as they embark on new health reform initiatives. A reminder of what will be needed, this checklist can be used before launch or while in the plan development and implementation phase and when beginning a mid-course assessment and any needed corrections. We found that “capacity” in the eyes of state officials has five overlapping, yet distinct, dimensions:

- 1. Leadership**—Capacity is only valuable if it is activated and sustained by executive and legislative officials who have adequate authority to lead and are willing to exercise their authority. The role of executive leadership in particular is the paramount policy capacity. Repeatedly, the role of governors and their most immediate staff was identified in the interviews as the most important component in developing and implementing policy.
- 2. External Resources**—The capacity to develop and implement policy is determined in large part by the additional resources available to accomplish the work, such as money, technical assistance, and forums (especially those that encourage peer-to-peer communication and learning). Within the US federal system, state policy resources are also directly impacted by the behavior of other jurisdictions, institutions, and individuals.
- 3. Management Core**—Beyond the governor and the availability of resources, another important policy capacity is the existence of a cadre of policy leaders with years of experience in managing state reforms. Sometimes states complemented their management core with staff from outside the health sector. A few also had federal experience at some point in their career. Yet behind most well-developed elements of any complex state health reform, it is possible to trace the influence of a person or several people with exceptional understanding of and experience in how state policy is formulated and implemented.
- 4. Analysis**—Capacity in developing and implementing comprehensive health policy reforms requires the ability to project the effects of proposed reforms and policy options on their implementation and to accurately evaluate whether new programs and structures are reaching their goals. One needs relevant data and information that can be put to use in an effective management information system, which is not easy to do in a short time, especially in states that have not already invested much in those systems. Analysis and information are also central to the proper evaluation of programs. Too often this is what comes immediately to mind in discussions of “capacity,” and while analysis and information are necessary, they must operate in the context of moving the policy choice through the complex stages of program development and implementation.



**5. Implementation**—Without a set of operational skills that get policies to work as they are supposed to in the real world, no policy process can be successful. Our analysis found that large segments of state health policy capacity, particularly its implementation, remain underdeveloped. Sometimes it is because of a lack of qualified personnel, sometimes because it is too difficult to invest in the future when the present is so demanding. Implementation capacity, even where it exists, is vulnerable to human resources management deficiencies such as insufficient compensation, limited career support, and exhausting work schedules. Staff recruitment and retention are difficult, more so in a political environment in which public employees do not always feel properly valued.

We conclude this study with real appreciation of what states have been able to accomplish as well as a heightened recognition of the limitations they face in achieving major health reform without always being able to count on substantial support from the federal government. States have often served as laboratories for national reform. Today states faced with opposition to Medicaid expansion have again been innovative in developing a new private option as an alternative way of serving this population. Other states can and will initiate important delivery system and payment reforms, as witnessed by New York's fundamental restructuring of its Medicaid delivery system through the Delivery System Reform Incentive Payment Program and Maryland's All-Payer Model for global hospital budgets. These initiatives demonstrate both the importance of state initiative and the critical role our federal government can provide through a policy framework and significant financial support.

Finally, this study has confirmed the influence of federalism on the development of American health policy. The activities described here were largely reactions to the opportunities, requirements, and constraints presented by federal action in the form of the ACA. While the states clearly play important roles in health policy, we should not assume that they can achieve major systemic reforms consistent with their political "filter" in isolation and, notably, without the active policy and financial support of the federal government.