Milbank Memorial Fund

REPORT

State Policy Capacity and Leadership for Health Reform

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Acknowledgments

Message from the President

The passage of the Affordable Care Act (ACA) initiated a flurry of decisions and activities by state health policy leaders. Implementing policy changes required in the ACA, state leaders took on issues with significant policy and operational import: Would they implement a state-based health insurance exchange? Would they expand Medicaid eligibility? How would small-group and individual insurance laws need to be changed? What definition of essential health benefits would a state adopt?

The stakes were high. Public opinion was often divided. Timelines were tight. Technical complexity was very high. Poorly executed decision-making and implementation processes would have significant political, financial, and human costs.

The answers and actions of state health policy leaders varied significantly. But an examination of how decisions were made and implemented provides a unique opportunity to assess the resources needed and the processes used by decision makers.

In this report, Pierre-Gerlier Forest and W. David Helms synthesize those lessons. Using a combination of surveys and qualitative interviews with the people who did the work within the states, the authors identify the key capacities that are essential for good policymaking and implementation:

- Roles, mechanisms, and leadership
- Staff capacity
- Federal resources and assistance from other sources

In addition, the authors identify outstanding needs that remain for state health policymaking in four areas:

- Ongoing policy capacity deficits
- Working with stakeholders and politics
- Organizational frameworks
- Maintaining trust and leadership

The Reforming States Group (RSG), 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, commissioned this study, and RSG members reviewed its findings. The RSG is committed to health policy leadership informed by evidence, experience, and bipartisan dialogue. Although RSG members hail from states with very different strategies for ACA implementation, they recognized the opportunity—even the duty—to gather lessons from the ACA implementation process.

History is an instructive teacher for those who will listen. The ACA may have been the largest and most complex pieces of social policy legislation passed by Congress since Medicaid and Medicare, but it will not be the last. State leaders will develop and implement health policy regularly. Perhaps very soon they will be asked to implement another iteration of federal health care legislation that could give them even broader policymaking parameters. Regardless of the policy positions they take, executive and legislative branch state policymakers and those who work with them need to learn from experience about what is needed to make decisions that are right for their constituencies and how to implement those decisions effectively and efficiently. The stakes remain high. The people they serve deserve nothing less.

Christopher F. Koller
President, Milbank Memorial Fund

Introduction

The Case for Policy Capacity

Policies are no longer thought to succeed on their own merit. We know better now. Decades of observing policy design and policy implementation have given rise to a subtle and complex vision of the policy process, one in which factors such as leadership, resources, and public support combine over time to bring success or failure. We also now tend to pay more attention to what Aaron Wildavsky famously called "the complexity of joint action."[1] Policies are not the only forces shaping social, economic, or cultural realities. Moreover, any given policy must comport with the concurrent effect of all the other policies at play in all the relevant sectors.

Policymaking is usually a collective endeavor, mobilizing the knowledge, experience, and skills of many different people. Policy capacity, the combination of intangible resources backed by tangible assets such as political authority and financial resources, has been defined as:

> The sum of competencies, resources, and experience that governments and public agencies use to identify, formulate, implement, and evaluate solutions to public problems . . . . It touches on all stages of the policy process, from the strategic identification of a problem to the actual development of a policy, its formal adoption, its implementation, and even further, its evaluation and continuation or modification.[2]

Health reform requires extensive policy capacity. It is highly technical and, at the same time, deals with the most intimate matters in people's life, including issues of life and death. Major health reform usually requires adaptation to new administrative and organizational structures (such as health insurance exchanges), better information systems (such as were required for the new insurance exchanges), and new incentives (such as providing subsidies offered by the exchanges) to achieve the desired policy choice. Health reform can be the pretext for "venomous political debates" and power politics at its worst.[3] Yet it is also the expression of essential human values like compassion and solidarity. Health reform cannot succeed without the support of patients and the active participation of providers. In the end, fundamental beliefs and commitments, as well as economic and personal interests, usually find their way into the policy process.

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 (beginning at 100% and declining to 90% by 2020) and subsidies for health plans purchased in the individual exchange. It also provided substantial grants to states to plan, develop, and begin operating the new health exchange. The federal govern-

ment also supported states by providing policy direction and technical assistance. However, 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 exchange. This required the sum of competencies encompassed in our definition of policy capacity.

The Supreme Court decision in *National Federation of Independent Business v Sebelius* in 2012 made the Medicaid expansion optional, leaving states with a very contentious policy choice of whether and how to provide health coverage or services for low-income adults. Given this political and policy context, the ACA left states with multiple challenges. In the words of Christopher Koller, president of the Milbank Memorial Fund:

> Adequate skills and resources are of increasing concern for state health and human services officials. The Affordable Care Act continues to be implemented, Medicaid programs grow in size and complexity, state budgets tighten, and population health challenges remain. State leaders routinely tell me about the challenges of developing and maintaining high-quality staff given budget limitations, antiquated administrative rules, and public attitudes.[4]

Beginning in 2010 and continuing into 2016, states faced a particularly critical deficit in health policy capacity as they considered the policy choices and associated challenges with establishing health insurance exchanges, managing the expansion of Medicaid, and overseeing changes in the delivery and financing of health care. While the intensity of these changes has diminished somewhat over this period, this was clearly a most demanding time for state health 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.

This report delves into these issues. Working with a sample of states—large and small, red and blue, actively reformist or more circumspect—the research team interviewed state officials and legislators about their experiences developing and sustaining the capacity needed for policy transformation 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 understanding 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 next sections introduce the aim of the study, study design, and methodology. A section of findings presents 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.

Aim of the Study and Study Design

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.

The design of this project followed a strategy widely used in policy analysis for exploratory research. In effect, the project framework was deliberately oriented toward observations from those on the front line of state health reform, who were actually implementing the reform. The observations were captured in a series of in-depth, semi-structured interviews.

A thematic analysis of the results is presented in the following sections. Our interpretation is based, in part, on our past experience in health policy development and implementation and on our frequent interactions with seasoned policymakers over the duration of the project. We also benefited from the results of a literature review conducted by a team under Professor Jean-Louis Denis of the National School of Public Administration in Montreal, which was aimed at documenting the full conceptual background behind the notion of policy capacity.[2]

An important strategic research decision, made essentially to facilitate interstate comparisons, was to use the implementation of the ACA as the reference point for our observations. Even if the socio-political context of each state is unique, and even if, consequently, each state follows a different reform agenda, the issues and the timelines were sufficiently aligned during the observation period to impose a common frame of reference and a common language.

Obviously, because the ACA was an exceptional initiative, in terms of both reform opportunities and challenges, it is possible that the stress on existing policy structures reached an unprecedented level during the first years of implementation. Capacity was a central concern in all corners of the health system because it was tested to its limit in so many ways. Yet it is also possible that the situation in more "quiet" times is, in fact, even more difficult within some states than what we observed, either because of a lack of political attention or a mere lack of resources.

We conducted a total of 24 interviews, 18 with state executive agency officials and six with legislators from 10 states. The interviews followed a semi-structured approach based on a series of interview protocols. The protocols (see the Appendix) were modified slightly based on whether the interviewee was a legislator or executive agency official and whether the state elected not to expand Medicaid or implement a state-based or partnership exchange. Contextual information on every participating state, including health reform background, was collected prior to the interviews using public sources.

The interviews, which lasted approximately one hour each, were conducted by phone by the authors between March 2015 and August 2015. The interview protocol was developed by the study team and reviewed by a study committee with representatives from the Reforming States Group, a bipartisan, voluntary group of state health policy leaders from both the executive and legislative branches, which is supported by the Milbank Memorial Fund. The reliability of the interview strategy and the interview instrument were also tested with a small group of selected participants.

The interviews were audio-recorded for the purpose of preparing individual interview reports. (The recordings will be saved in an archive for three years from the conclusion of the research.) The report findings are based on themes that emerged from the interviews.

Methodology

To facilitate broad comparisons, the study used a purposive sample from across 10 states that would be representative of the following characteristics:

1. **Geographic distribution** across the four US census regions (e.g., Northeast, South, Midwest, and West)

2. **Political diversity** with a balance among the states where either the Democratic or Republican parties controlled both the governor's office and the legislature and states where this control was split between the Democratic and Republican parties

3. **State population** as a proxy for number of staff working on state health policy

4. **State economic capacity** as measured by gross domestic product (GDP) and a proxy for the capacity to fund health reforms

5. **Reforms implemented:**
   - State-based exchange and Medicaid expansion
   - Federally supported state-based exchange and Medicaid expansion
   - Partnership exchange and Medicaid expansion
   - Federally facilitated exchange and Medicaid expansion
   - Federally facilitated exchange without Medicaid expansion

Using the five attributes above, the final sample includes two states from the Northeast, three from the South, three from the Midwest, and two from the West. Based on 2014 population data, the sample has three "small," four "medium," and three "large" states. For GDP as a measure of state economic or taxable capacity, the sample contains three "low," two "medium low," three "medium high," and two "high" states. Table 1 shows the geographic, population size, and economic or taxable capacity of the sample states.

Table 1. Sample Characteristics

Geographic Data					
States	Population 2014 Estimate	Census Region	GDP (million) in 2014 ($)	GDP per Capita ($)	State GDP Level
Arkansas	2,966,369	South	110,746	37,334	low
Connecticut	3,596,677	Northeast	232,620	64,676	high
Illinois	12,880,580	Midwest	680,448	52,827	medium high
Kentucky	4,413,457	South	171,850	38,938	low
Michigan	9,909,877	Midwest	417,306	42,110	medium low
Minnesota	5,457,173	Midwest	288,145	52,801	medium high
New Mexico	2,085,572	West	83,592	40,081	medium low
New York	19,746,227	Northeast	1,279,921	64,818	high
Oregon	3,970,239	West	203,788	51,329	medium high
South Carolina	4,832,482	South	174,573	36,125	low

Abbreviation: GDP, gross domestic product.
Population and Census Region: Data from US Census Bureau.[5]
GDP: Data from Bureau of Economic Analysis.[6]

For political diversity, the sample consists of three Democratic states, three Republican states, and four states where the two parties split control of the governor's office and the houses of the state legislature. Table 2 shows the political party that controlled the governor's office and two houses of the state legislature from 2010 through 2015 in each of the sample states.

Table 2. Political Context

States	2010			2011			2012			2013			2014			2015		
	G[a]	S[b]	H	G	S	H	G	S	H	G	S	H	G	S	H	G	S	H
AR	D	D	D	D	D	D	D	D	D	D	R	R	D	R	R	R	R	R
CT	R	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
IL	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	R	D	D
KY	D	R	D	D	R	D	D	R	D	D	R	D	D	R	D	D	R	D
MI	D	R	D	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
MN	R	D	D	D	R	R	D	R	D	D	D	D	D	D	D	D	D	R
NM	D	D	D	R	D	D	R	D	D	R	D	D	R	D	D	R	D	R
NY	D	D	D	D	R	D	D	R	D	D	D	D	D	D	D	D	R	D
OR	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
SC	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R

Abbreviations: D, Democrat; G, Governor; H, House; R, Republican; S, Senate.
[a]Governor political affiliation data from National Governors Association. [7]
[b]State legislature major political affiliation data from National Conference of State Legislatures.[8]

As shown in Table 3, the sample contains three state-based exchanges, two federally supported state-based exchanges, two partnership exchanges, and one federally facilitated exchange. All the states in the sample had a significant reduction in the number of uninsured from 2013 to 2015; Arkansas and Kentucky had the most dramatic decline in the proportion of uninsured, from over 20% to 9.1% and 9.0%, respectively.

We sought to include two more states that did not expand Medicaid and had accepted the federally facilitated exchange. We were unable to arrange interviews in those states, even though we emphasized that our results would maintain the confidentiality of both the individual interviewed and the state. The two states we contacted were exploring options on how they might expand Medicaid, which may have made our interview request problematic.

Table 3. Health Reform

States	Type of Exchange[a]	Number of Individuals Selecting 2015 Exchange Plan[b]	Number of People Covered by Medicaid as of June 2015[a]	Net Change in Medicaid Enrollment from July-September 2013 to June 2015[a]	Percent of residents without health insurance, 2013[c] (%)	Percent of Residents Without Health Insurance, First Half of 2015[c] (%)
Arkansas	partnership	54,885	820,769	263,918	22.5	9.1
Connecticut	state-based	133,395	760,758	NA	12.3	5.0
Illinois	partnership	286,888	3,131,846	540,903	15.5	8.8
Kentucky	state-based	98,015	1,117,207	510,402	20.4	9.0
Michigan	partnership	299,750	2,308,258	396,249	12.5	8.5
Minnesota	state-based	128,519	1,008,993	135,953	9.5	4.6
New Mexico	federally supported state-based	43,054	711,541	253,863	20.2	13.1
New York	state-based	295,898	6,441,902	763,485	12.6	8.3
Oregon	federally supported state-based	90,345	1,051,967	425,611	19.4	8.8
South Carolina	federally facilitated	161,941	1,009,201	119,457	18.7	12.6

Abbreviations: NA, data not available

[a] Data from the Centers for Medicare & Medicaid Services.[9]

[b] Data from the Department of Health & Human Services.[10]

[c] Data from Gallup.[11]

Findings

I. Roles and Mechanisms

We began our interviews with executive agency officials and state legislators in the sample states regarding the roles these officials played in developing their state's position on expanding Medicaid and implementing a state-based exchange. In particular, we asked about the policy roles and mechanisms used or put in place at the beginning of the reform process. This section reviews the roles performed by each type of policymaker, the mechanisms used to develop and support the policy choice, and the critical role that leadership played across the policy development and implementation process.

Role of the Governor

Six sample states emphasized the critical role their governors played in overseeing and supporting health reform. When their state legislators failed to pass legislation to establish their state exchanges as an independent quasi-governmental agency, two governors issued executive orders, citing what they viewed as a federal legislative mandate.

One state official with a divided state legislature stated that "first and foremost, leadership came from our governor. He became even more convinced by the studies that demonstrated the effect of increased coverage on the state's health status." Another official from this same state observed that "we had a committed governor and a strong team. Our leadership was extremely adequate—what I would call 'over the top.'"

An official from another state noted that "we built our exchange from the governor on down … and we benefited from strong leadership support throughout the implementation process." A state that moved from one-party control to a split legislature reported that it moved its exchange into the governor's office to engender greater support and provide more political insulation. This same state noted that the governor's support for Medicaid expansion was critical and helped "bring along the agencies."

Role of the Legislature

The role of the legislature was influenced by whether the state had one-party control or control was split across the two parties. But even where there was divided control, states reported that regular briefings with legislative leaders was critical. Three states said that they held frequent briefings with legislative leaders. One of these states emphasized that when presenting to these leaders, "we didn't cite journal articles but rather provided syntheses of evidence—evidence in the form academics publish did not have any impact with legislators." Another state reported that it used a former legislator who was "instrumental [in] building our support with legislators."

A state with strong leaders in health policy benefited from having a long-serving legislator who had championed prior state reforms. Since the legislature trusted its legislators with experience in health reform, the "executive team could coordinate with a limited number of legislators; our strong working relationship with these legislative leaders was key." A legislative leader from a state with a part-time legislature noted that "we know each other and we work well together." A state where political control changed during the implementation of the ACA reforms reported that the prior exchange staff "hadn't built support with legislators so when the exchange went bad, they didn't have the relationships" needed to sustain support for this new mechanism.

The six state legislators in the sample reported that they played very different roles in the policy development process. Legislators in two states emphasized that their legislature's prior role in advancing health reform was instrumental in the state's decision to move forward with both the Medicaid expansion and the development of a state-based exchange.

One of these states reported that the work done in the two years prior to the passage of the ACA "enabled us to move quickly to adopt the ACA reforms." Another state had implemented an exchange structure in the 1990s and had previously authorized "universal access to health care," which meant that the governor had the authority to expand Medicaid and only needed to secure a budget bill to add new "eligibles" to their Medicaid roll. However, prior experience approaching health reform in a bipartisan manner did not affect a third state, which faced extensive political backlash against the ACA when the state's Republican leadership refused to appoint any representatives to the governor's commission or to "even hold hearings on the governor's bill."

Three of the legislators in the sample reported that their legislatures had a "hands off" approach to the ACA reforms. A legislator from one of these states reported that their "legislature was never asked to serve on a task force or committee assessing reform options." Another legislator reported that the legislature's "role was limited to advocacy" and that the representatives "have gotten used to not having a role in this administration in setting policy; our governor sees policy formulation as the governor's responsibility." A third legislator reported that their legislature "didn't take action on the proposal to establish a state-based exchange, believing that even if the state established its own exchange, the federal government would still be calling the shots." And if the "'feds' thought they could do this, we decided to just let them do it." On Medicaid, this legislator reported that their legislature "spoke" against the expansion because of concerns about what the state's responsibility would be after 2020 and "about whether the ACA would ultimately succeed. And we didn't want to do anything that wasn't required."

Role of the Core Executive Team

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 was critical. Five states reported that their core team had been together for a number of years and had worked together on prior state health reforms.

One of these state leaders summarized this prior experience as follows:

> The leadership of our core team was our greatest strength. This interdisciplinary team was able to draw upon its considerable expertise in state government. Our staff not only had the technical expertise, they had leadership qualities and they were passionate about what they were doing. They were willing to take risks, make decisions, and move forward quickly. This was especially acute for the exchange IT system where we had contingency plans and where the staff had to be willing to pull the trigger when needed.

States without this experience needed to establish new ways to build this capacity, such as interagency groups and regular meetings with executive agency staff to build the cross-agency support needed to implement the ACA reforms. Several states that didn't have

an effective working relationship between their insurance and Medicaid agencies stated that they had to take the time and effort to build that relationship. Having the governor's support was often seen as critical to getting these departments to work together.

Mechanisms for Policy Development and Implementation

Governors were involved in developing and building support for the policy choices made with respect to both Medicaid expansion and the insurance exchanges. In half of the 10 sample states, the governor's office directed the policy process. 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 composed of executive agency leaders
- Regional advisory committees and forums
- University-based policy center to provide strategy and analysis

States used executive agencies to implement Medicaid expansion, and most of those states that established a state-based exchange used a quasi-governmental agency. While state governments fund these quasi-governmental agencies, this mechanism was selected in order to provide more operational and political independence and to include political leaders and representatives from stakeholders and community organizations in its governance. This structure was used by three state-based exchanges and by one federally supported state-based exchange—a variation to the state-based option wherein the federal government allows the state to use the federal exchange technology (i.e., HealthCare.gov). The reasons most often given for using the quasi-governmental mechanism were the ability to recruit the expertise needed to manage and operate these structures and greater flexibility in hiring outside contractors to provide technical support for critical functions, including information technology (IT) and marketing.

Stakeholder groups also preferred having these new exchange mechanisms placed outside of state insurance departments to provide some separation between the entity running the exchange and the state agency regulating the insurance industry. Two other states originally planned to use a quasi-governmental agency but ultimately placed this function in an existing state agency. This was necessary in one state when it did not receive legislative authority to establish its state-based exchange as a quasi-governmental agency. In hindsight, those responsible for implementing this exchange noted that placing this function inside state government actually contributed to its initial success; officials didn't have to

devote time during the critical period to create the new structure. Having this function inside state government also facilitated the coordination of decisions affecting both Medicaid and the exchange. The second state shifted its exchange to an existing state agency to provide more governmental oversight of exchange operations after extensive and well-publicized problems with its launch.

Those states that established a quasi-governmental agency to implement an exchange were faced with the challenge of coordinating policy and especially IT policy between this entity and the state's Medicaid agency. As noted above, one state that used an existing state agency to implement its exchange within state government emphasized that this approach made coordination across these two functions much easier. To address the coordination issue when using the quasi-governmental entity for its exchange, another state created an executive steering committee comprising two staff members from the exchange, two staff from Medicaid, and two members from the state's consolidated IT agency. This cabinet committee is responsible for setting and establishing IT priorities, resolving competing interagency priority conflicts, and ensuring robust cross-agency communications.

Mechanisms to Develop Stakeholder Support

The sample states used a variety of approaches to build sustained support from key stakeholders, including regular meetings and establishing formal processes for the stakeholder involvement.

Several states used mechanisms such as creating an oversight council for its Medicaid reform, putting insurance agents onto a new navigator and agent board, and establishing a formal stakeholder process for its exchange. The state that established the formal stakeholder process noted that "while this started as a formal process, it has evolved into a new norm where stakeholders from all walks feel they can get into a room for consultation with the department's leadership."

A state that used regional advisory groups to elicit stakeholder input noted that our "upfront investment in reaching out to stakeholders certainly paid off for us as we encountered issues. They were willing to work with us on the resolution of these issues." Another state official observed that the state's "prior working relationship with stakeholders from industry and community groups on prior health reforms meant we had a basis for working together." The absence of prior stakeholder involvement was clearly felt in one state when its exchange encountered significant implementation issues. "Part of the reason things went bad for our exchange was because communication had stopped with the stakeholders. Things can really go bad if the stakeholder relationships are lost."

In summary, developing leadership structures that facilitate strong relationships with stakeholders and that sustain state reform capacity is essential. As one official cautioned, "don't overpromise and underdeliver" and when problems do arise, "work hard to address stakeholder concerns." Leadership and mechanisms to sustain state health reform capacity

become all the more critical as states encounter changes in political affiliation, staff turnover, and burnout of those staff members who led the initial implementation process.

II. Staff Capacity

We asked interviewees about their staff's capacity to meet the challenges of the reform process, both at the beginning of the process and as implementation progressed. We define staff capacity narrowly—as the skills and knowledge necessary to carry out the complex set of tasks in developing and implementing policies set forth in the ACA. We looked at how states developed this staff capacity in some of the key areas that states required in order to plan and implement ACA-related health reforms, including planning and analysis, managing operations, and working with outside vendors and legislative staff.

The Importance of Prior Experience

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. Several officials noted that senior staff had been together for a number of years and that they were "ready to take on the significant challenges" of building support for and carrying out the intricate steps involved in enrolling new Medicaid recipients and setting up an exchange structure.

In addition to having established working relationships with one another, state leaders noted that their prior experience developing major health policies was helpful. It helped to guide 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.

Planning and Analysis

Despite many states' history of expanding Medicaid and enacting insurance reforms for the small group and individual health insurance markets, the broader scope of the ACA reforms provided new planning and analytical challenges, not the least of which was confronting the considerable political backlash to Obamacare.

Many 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 policy reforms required.

Even states indicating that they had sufficient capacity to perform their policy development and implementation responsibilities indicated that they needed to supplement their staff's analytic capacity. One official noted that senior staff had "worked together for years; we had the health policy and research background to inform the policy decisions . . . but we lacked depth in our analytic staff." Not all states believed they had sufficient staff capacity. One official with prior experience in implementing state reforms observed that "you

never have enough capacity" and that state governments are generally "underresourced in terms of both policy knowledge and implementation experience."

The ACA required many states to pull staff from other positions in state government and secure outside technical expertise. Executive agency staff from a midsize state said that "they made a conscious decision to use existing staff, devoting most of the federal money to building the exchange IT and expanding Medicaid; we didn't go to the legislature to ask for more money since that would have been the kiss of death." Several officials noted that they "didn't have the specialists to do the transformation" of Medicaid enrollment systems and restructuring of their individual and small group insurance markets. A large state reported that "we had strong leadership and policy expertise, but we didn't have the critical staff to run operations."

Managing Operations

Executive officials were asked to describe how their staff capacity evolved as they moved from the planning and development phase to the operational phase. One state reported that it was able "to hire a strong staff with the needed expertise to build our new independent (quasi-governmental) state exchange." Leaders from the same state did note, however, that it found its staff capacity needed "to evolve as we moved from the start-up organization needed for launch to an operational organization which was required to meet basic business functions such as accounting for time and managing a fixed budget."

Officials from another state that faced restrictions on hiring new staff for Medicaid reported that they had to "change the culture and capacity of Medicaid staff" as they moved from fee-for-service payment to an agency-driven payment improvement. Officials noted that "staff had to take on new roles, be more creative, and assume more intellectually demanding tasks." To provide the needed expertise in payment reforms and IT, this state used outside contractors. "Even if we could hire new staff, we couldn't have paid the same salaries that these personnel can command in the private sector," officials said. In response to their staff capacity needs, a midsize state reported that, in addition to securing more resources from the federal government, they shifted staff to higher-priority tasks such as manual processing to deal with the backlog.

Officials from a state with considerable prior experience in health reform decided to build capacity inside an existing state office of health policy and research, which was supplemented by analytic and research capacity provided by a state university. On the "make versus buy" decision, "we redeployed staff where possible. While outside consultants could have helped, we didn't have the three-plus months required to go through an open procurement." This state official noted that while the federal government "put significant money into building state exchanges, they put zero into state capacity for . . . implementation of health system changes and evaluation."

Leaders from a large state noted that as its Medicaid expansion got underway they were able to hire 20 new staff in a large department with more than 2,000 employees in order to obtain the "broad range of skills needed to make a major transformation." The interviewee added that "when we faced a significant number of new enrollees, we were able to hire 200 more caseworkers and retrain and redeploy existing staff. It was amazing that what we couldn't do before the crisis, we were able to do once we got slammed with a deluge of new applications." A midsize state reported that as they moved into implementation of the Medicaid expansion, "our capacity needs 'changed radically' and, given what we had learned with the IT rollout for our exchange, we knew we needed to ramp up our IT support."

Working with Outside Vendors

Several state officials attributed their success in implementing exchange structures to their ability to work well with outside vendors. They used a "war room" to monitor their enrollment progress so they could quickly make adjustments as needed. They also believe that keeping the same team together as they moved from policy formulation and system design to implementation and making refinements was a "key to their success."

Officials from a state with considerable prior experience with health reform noted that its capacity evolved "a lot" as it moved into implementation. They reported that there is a difference when you "move from the ideal world of policy to the painful operational side and its IT issues." The force of timelines pushed this state "to buy outside when our preferred approach had been to build staff capacity." When forced to bring in outside expertise, this executive emphasized that "we didn't have the experience and expertise needed to select the best contractor, [which often] led us to go with a name firm." A legislator from this same state observed that while the executive agencies had "really good thinkers, we all underestimated the resources needed for implementation."

A small state with an independent exchange increased its staff by 36% to meet the increased workload as it moved forward with enrollment and preparation to launch its small group exchange. It also was able to add more Medicaid staff to handle enrollment increases that exceeded its projections. Another small state noted that they needed "more staff that could do analytics and use 'big data,' work with actuaries, and have better project management experience as was needed for IT projects."

As for the decision to either add staff or secure outside resources, a large state responded that it did both. For its exchange, this state added staff with expertise in small business insurance, IT systems, and marketing and outreach. It also relied heavily on specific expertise provided by the Robert Wood Johnson Foundation's State Health Reform Assistance Network (RWJ State Network) and a state foundation "to augment our staff capacity." This state learned a great deal from "the expertise provided by our engaged stakeholder process—not only did they verify issues, but they helped us identify solutions." The interviewee noted that "implementing our exchange was an immense challenge and we didn't realize the magnitude of the task until we were in the middle of implementation."

On Medicaid, this same state had a good working relationship with existing contractors and used them, noting that "while there are firms with all the IT experience in the universe, we needed firms that understood how the ACA exchanges and Medicaid would operate given our existing state systems." The challenge was to have the policy experts "mind meld with the contractors' programmers so we could move quickly." A project with this scale and tight timelines "gave us no choice—we had to make this happen." On the staff side, the executive found that "[we] couldn't just hire new staff and have them jump in and be productive, so we had to just get more out of [the] staff we had by moving to a 24-7 schedule." To keep staff from burning out too quickly, added the interviewee, "we held off going to a seven-day workweek until the last two months. We also had to make decisions about which functions were essential and which functions could be deferred." State officials found that "it is not so simple to just define the policy and then turn it over to those charged with implementation."

A number of state officials reported that they often faced a difficult and cumbersome state procurement process when they sought to supplement their staff capacity with the expertise and manpower needed to meet the challenges they faced implementing the ACA reforms. In addition, state leaders reported that their staff could have benefited from more experience and training in both project and vendor management.

Several officials noted that their state is now experiencing an extensive brain drain because many of the people who helped get their state through the implementation of the Medicaid expansion and the exchange are leaving state government. This was sometimes a result of a change in administrations, but it was also a result of burnout that comes from being in stressful staff positions with constant and often critical media attention.

Staff Capacity in the Legislative Branch

To the extent their role called for participation, legislators were, by definition, more involved in policy development than in implementation. Most of the legislators in our sample stated that they primarily rely on the staff available from their legislative research or counsel service. For some, this was considered adequate; for others, this limited support was viewed as insufficient. One legislator emphasized that he relies on the executive agency heads and staff for needed information and "if they don't have the expertise they need on staff, we expect them to go out to experts such as actuaries that are under contract to those agencies."

Several legislators noted that they supplement their state's limited staff support with policy and analytical resources from their state university. A few noted that they also use resources provided by the Council of State Governments, the National Conference of State Legislatures, and the Reforming States Group. Another legislator noted that in addition to the analytic support provided by staff in the legislature and state university, he relies "on constituency groups I am aligned with."

Some legislators also noted that they use their interim committees to delve more fully into assessing issues and to provide oversight of major health system changes. One of these legislators said this process enables them "to go around the state to elicit input directly from citizens; when we are in the state capitol, we mainly hear from the established interests and advocacy groups."

III. Federal Support and Assistance from Other Sources

We examined the importance of the financial support provided by the federal government for Medicaid expansion, related eligibility system improvements, and the development of a state-based exchange. We also looked at where the sample states got assistance from other sources, such as national foundations, national health policy and research centers, and state and local foundations and universities.

Federal Financial Assistance

The nine states in the sample that moved forward with Medicaid expansion emphasized how important the generous matching rate (beginning at 100% and declining to 90% by 2020) was to the 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 was seen as critical to their ability to take the significant step of providing coverage to those below and just above the poverty line. These states also emphasized the importance of the higher 90-10 matching rate to make much-needed improvements to their Medicaid eligibility systems.

A state legislator from one low-income state said that while they already had a high 70-30 matching rate for Medicaid, "it was hard to turn down the 100% federal money! I tell my colleagues from Southern states that turned down the federal money for Medicaid how much our state appreciates their subsidizing our coverage expansion." This funding is "providing significant impacts including expanding coverage, increasing the number of health care jobs, and reducing [emergency room] use as these newly insured get access to primary care."

Although dwarfed in size by the value of available federal funds for medical benefits, substantial federal grants were available to states to establish state-based exchanges, upgrade Medicaid IT systems, and help insurance commissioners establish rate review functions. Officials from states that established state-based exchanges reported that the funding was important and that "we got what we asked for" and "we can't complain about the money." We don't know whether states would have accepted a small matching requirement for these federal grants, but our interviewees emphasized that they would not have been able to develop an exchange without significant federal funding. For some states, the opportunity to maintain control and avoid having the "feds" run their exchange was also a strong incentive. Even states with strong Republican leadership were willing to consider the exchange mechanism because they understood that their small group and individual markets needed fundamental reform. A number of states eventually elected to accept the federally facilitated exchange option, believing that operating their own exchange mechanism would be

"too heavy a lift." And as political opposition to Obamacare increased, even the significant federal funding was an insufficient incentive to overcome the growing opposition to operating a state-based exchange.

Federal Communications, Oversight, and Technical Assistance

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 exchanges. One state official reported that "working with the staff at CCIIO was the hardest part of my job, but we did appreciate the money!"

While understanding the huge challenges CCIIO staff faced, another state official noted that not getting the regulations out when they were needed caused them to "have to spend additional funds to make changes." A different state official confirmed that the delay in issuing major regulations and the reluctance of federal staff "to discuss the policy under consideration until after the formal decisions were made inhibited discussions—this is insane when the construct is a federal-state partnership." A state official with extensive experience in leading state health reforms said that while the federal staff "did a pretty good job of working with us, their micromanaging and reporting requirements took up time and resources." One state official didn't mince words when he characterized the federal technical support as "weak, disjointed, and bureaucratically heavy. They were uncoordinated and under close political supervision."

Several states observed that the policy of "no wrong door" was laudable, but achieving the goal of automatically redirecting enrollment applications submitted to either Medicaid or the exchange to the appropriate location was not so easy to implement. These states complained that the CCIIO did not appreciate the difficulty states faced in implementing this policy goal on such a short timeline. On the other hand, states working on innovative approaches to Medicaid expansion had a positive view of the federal Center for Medicaid and CHIP Services (CMCS) senior staff. These same states found the technical assistance provided through CMCS calls with states to be valuable, especially in facilitating learning from one other.

Assistance from National, State, and Local Foundations

State leaders acknowledged the intellectual support and guidance they received from national foundations, and they tapped these resources as needed. States in the sample that participated in the RWJ State Network gave high marks to the help they received from experts in the network. One experienced state official said the RWJ State Network "was a brilliant idea that enabled us to have the right people at the table to give the right assistance—this was a godsend." Another state health director said, "my staff gives five stars to RWJ. What we got from the other foundations was too broad; what we needed was the on-the-ground assistance."

The Reforming States Group also received high marks from a number of states. A Midwest state legislator said, "The Reforming States Group was good because it brings together executive and legislative representatives and facilitates 'very refreshing conversations.'" A Northeast state official reported that the Reforming States Group "was my most significant source of support both for the expertise and also for the opportunity to network with fellow state leaders. This peer-directed network is really valued by the states."

States also used policy briefs, research reports, and status reports on the progress of state implementation prepared by national foundations such as the Commonwealth Fund and the Kaiser Family Foundation. In addition to the national foundations, several states reported that they received valuable assistance from the National Association of Insurance Commissioners and the National Academy for State Health Policy. What states most valued from these groups was the opportunity to learn from other states through workshops, webinars, and policy briefs. However, states were sometimes frustrated by the lack of coordination across multiple sources of assistance, as well as the time required to respond to many requests to provide information about the status of their state's implementation of ACA reforms.

Several states have established an ongoing relationship with a state university to provide policy, research, and technical support to support their strategic and analytic needs.

One Northeast state established what they characterized as an "applied university-Medicaid partnership" modeled after the relationship between the University of Massachusetts Medical School and that state's Medicaid program. Under this state's adaptation of the model, the university funds a core team of academics to work with the Medicaid medical director on specific issues such as best standards for making decisions about what should be covered. While the Medicaid program provides limited seed money for specific projects, the state university supports the core team with approximately 25 staff. This state also has a long-standing partnership with a university-based center on aging to provide strategic planning for long-term care services and to evaluate existing projects and programs.

For a number of years, one Southern state has relied on its health policy center to provide strategic guidance, research, and analytic support. This center predates the ACA and has had independent hiring authority. The director of this program reported that state agency directors are "too consumed with program management, and that our center is able to be more strategic." While other states have independent health policy centers, he noted that his state's center "is unique in that we do frontline legislative advocacy and lobbying work." Another official from this same state said that while the state had a strong policy team, "we didn't have depth in our analytic capacity; to meet our need for increased analytic support, we turned to our university health policy center."

A Southern state used its state university to conduct an independent study to provide the governor with the "due diligence he requested on whether Medicaid expansion would be beneficial to [the] state."

The governor reported that he found "the findings from our study to be very helpful." The state executive staff said that it was "critical to have an outside university do the fore-casting on enrollment." An official from the Midwest said that they turned to their state university to do a study assessing whether the state had the capacity to serve the newly insured. This university used "its existing survey mechanism to quickly survey physicians and hospitals in the state to assess whether providers would accept these clients." This survey provided "concrete data points to validate that the state did have the capacity to serve new enrollees." This state also used a new collaborative that linked state "researchers to decision makers in government, the provider community, and business" to undertake an independent evaluation of this state's innovative Medicaid expansion. Yet another state emphasized the importance of its long-standing relationship with a state university's data and analytic center for analysis of its Medicaid data.

In yet another example, several states turned to their state universities to train navigators to assist potential enrollees in their exchange. One official stated that "we kept waiting for the CCIIO navigator training program to come out but when it hadn't, we decided to do our own training. We signed an interagency agreement with a state university's public health program to do our entire training program for navigators, and they were one of our greatest partners."

A state foundation was cited by another state for the critical role it played in convening stakeholders on issues. The foundation's independence was seen as critical. The state foundation also assisted in developing a prototype for an online shopping experience for the exchange. In summary, states in our sample acknowledged that they wouldn't have had the financial capacity to undertake the ACA reforms without the significant funding provided by the federal government. State leaders most valued high-level, just-in-time, and on-the-ground technical expertise provided by national and state foundations and associations. They especially valued the facilitated opportunities for state leaders to share experiences and learn from their peers.

Our respondents also acknowledged the challenges posed by political opposition to the ACA reforms and its tight timelines. However, given the critical roles that both the federal and state governments play in the health arena, many state officials wished their federal counterparts had a greater appreciation of the important role that states play in the federal system—and more acceptance of states as equal partners in implementing programs where both levels of government play important and interdependent 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.

Deficits of Policy Capacity

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 supplemental staff with the skills required to implement the policy options.

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 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."

In some cases, states identified and recruited people with prior experience in program or project management in other agencies. In one small state, for example, "expertise came from multiple agencies including the lieutenant governor's office, comptroller, Medicaid, public health, and the insurance department." Importantly, the demand for "strong operational staff" remains a major preoccupation of state executives at this time. As mentioned by someone coming from a large state with an apparent wealth of human resources, "It is critical to have the policy right, but moving policy into operations is an even bigger task." An interviewee for that state said, "We require a fundamental transformation in our staff capabilities; we have considerable experience on how to pay providers for fee for service, for example, but now we need to develop capacity for the state and health insurers to successfully construct value-based payment agreements." Or, in the words of an interviewee from a midsize state, "We need staff that provide practical experience to answer the challenges as they emerge."

A critical aspect of operational experience is the relationships between the state and the contractors used at different stages of policy development and implementation. An official

from a large state said, "Our state has learned that you need to have staff embedded in the call centers reviewing scripts and the questions and issues emerging [in order] to address them in real time; you can't just issue the contract and walk away." 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.

It is not surprising that states are anxious to get access to the evidence that good data can provide. A small state's executive said, "We need to use real facts, good data to make evidence-based policy; it is so easy to use anecdotal stories." In some states, the question is still how to access the data. "We must have transparent data; getting the state to approve all-payer claims was key to providing evidence for our reforms." In most of the sample states, however, health leaders are more concerned about making the best use of the existing data. Another state commented on its interest in using data for "comparative effectiveness" studies to assess new drugs and medical devices and to provide an evidence base to inform communication with constituents. More generally, however, as a leader from a small state remarked, data are needed mostly "to manage and to improve a program like Medicaid."

A midsize state's executive suggested that "the ACA has shifted the state's perspective from making the proper policy choice to the practical reality of implementation" where additional staff and technical support are needed. Yet this new orientation has not made policy analysis obsolete. "The Medicaid program still needs analytical capacity for program monitoring and evaluation such as some states have, to look at demographic changes, utilization patterns, and the effectiveness of various cost control measures."

One is tempted to say that health policy analysis is partly expertise and partly a state of mind. "It is critical to understand," said an executive from a large state, "that health reform is not a one-time event. We need to start with core staff that has good technical skills with relevant experience and are willing to take on the reforms; there has to be energy and passion for the reforms." A small state interviewee, however, was ready to be more prescriptive: "We need the following competencies: economic analysis, data analysis, policy analysis, and evaluation."

Stakeholders and the Politics of Reform

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. In the words of an official from a large state, "We need more effective stakeholder support and commitment to change, not only through the initial policy formulation but all the way through the implementation." Second, it suggests that some arguments can be heard despite the partisan divide, because they are based "on a dispassionate review of the data and sound research." In another state, an interviewee remarked, "We must keep this out of the partisan model."

Various stakeholder groups were mentioned in the interviews, with a special and unsurprising focus on the insurance industry. For example, an official from a large state remarked, "State leaders need a healthy relationship and understanding of the insurance industry, including the agents and brokers, if they want to get things done." In that vein, one state leader noted that "we must encourage states to use coalitions and/or commissions to expand the government's reach, both to bring in expertise and to build support for the adoption of the recommended proposal."

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. Moreover, it is a way to make sure state leaders won't find themselves "with blinders on," as one leader from a small state insisted. Coalition building also supposes that participants listen to suggestions and actively engage with the community. "You can't just sit back and wait for them to bring you issues; you need to engage them early on because they will have good ideas and will be more supportive."

The same uplifting tone doesn't prevail when the discussion turns to partisanship and its impact on health reform. An official from a midsize state remarked that "we first need to work through the political impasse and get past health care being such a contentious issue." In a small state, the hope was for "tools to get politics out of the conversation." One positive suggestion was to establish "nonpartisan forums," such as a bipartisan commission or an equivalent.

Successful Organizational Framework

What model or structure would best serve future health reform efforts at the state level? The answer provided by study interviewees is nuanced and complex. Their first thought was to preserve a "core staff." For example, an executive from a midsize state suggested the following:

> Have staff with the capacity to assess the population and the specific needs that would be impacted by the proposed reform. The core staff should include the department heads from all relevant agencies with their top staff. For the state health area as currently organized, this would be approximately 10 staff with five agency directors and five of their top staff. Don't disband after you determine the policy, but have them involved as you move through the implementation process. You may need to change the composition, but continue the core team even if you have to bring in replacements as staff resign and move on. You need to have two to three people who have the institutional memory.

As an official from a large state reminded us, "No one size fits all. Make capacity where necessary—to reassign staff, restructure agencies to foster better cross-functional relationships, and bring staff up that weren't in leadership positions were all [approaches] used in our state to supplement capacity." Some states still need to figure out where core capacity should be located. In states with limited resources, it appears that the "Medicaid department" is still the most desired option. In a small state, an executive made a vibrant

plea for the establishment of an "overall czar of health reform," or even better, "a strategic planning office" staffed by "a core group of 10 to 20 people that don't have day-to-day responsibilities to guide new program development."

As mentioned earlier, states 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. In smaller states in the sample, where there is a real need for "objective research," this is a prevalent model. Yet in the larger states with analytical capacity inside government, partnerships are still used to access specialized expertise. Partners can be key stakeholders like health insurance, hospital, and provider associations.

Regardless of the specific organizational frameworks established to develop and implement health policy, states interviewed valued independent, unbiased guidance. All the states in the sample underlined how important it is to receive "independent help," especially from national organizations like the RWJ State Network or the Reforming States Group. Another aspect of the support received from national organizations is the possibility to "sit people in a room and let [them] talk, while the experts just shut up." Networking with other states and learning from one another are critical to improving policy awareness and capacity. In fact, interstate learning is perceived as a more important source of sound policy advice than outsourcing to consulting firms and vendors. As someone from a midsize state said, "We outsource only when we need to supplement limited staff capacity."

Trust and Leadership

This section wouldn't be complete without including two underlying themes that were mentioned in most participants' answers: trust and leadership. Both executive 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.

Leadership in health care reform inevitably requires making difficult decisions that in turn require the acceptance of the policy choice by both senior officials and the broader community. Leadership in this context permeates the culture of a state carrying out major health system reforms. A state that demonstrates its leadership in health reform will attract other states interested in considering this policy change. And when a state gives "structure and status [to the reform opportunity], it may also attract capable people seeking positions with the potential to impact change," said a leader from a Western state.

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).

Managing change in a contested political context is never easy. In all but a few states, health reform faced major roadblocks that were only overcome because decision makers did not shy away from controversial initiatives or because seasoned executives had the ability to build critical consensus. The most apt metaphor is probably that politics acts as a filter for policy change. Sometimes, it looks like nothing can pass through the political filter—innovation is rejected by the political forces present in the state without much debate. Yet most of time, politics force policy entrepreneurs to adjust their projects to fit what is feasible at a given time and within a given distribution of power and authority.

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 policymakers to use as they embark on new health reform initiatives. A reminder of what will be needed, this checklist can be used before launch of a new initiative or during the plan development and implementation phase. It can also be helpful in making mid-course assessments or corrections. We found that "capacity" in the eyes of state officials had 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. Without the authority that comes from a governor's support and engagement, state health reform cannot go very far. In some cases, the governor's influence affects the process more than anything else—he or she decides on the approach and the calendar. In other cases, the governor's influence affects the substance: how far, how deep, and how quickly the changes will proceed. In many cases, of course, the governor impacts both the process and the substance—mainly because he or she has the political capacity to develop initiatives and build consensus for them.

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). In the US federal system, state policy resources are also directly impacted by the behavior of other jurisdictions, institutions, and individuals.

In the case of the ACA, the federal government made an extensive array of financial resources available to states for insurance exchange development and implementation, commercial insurance rate review, and Medicaid eligibility and enrollment systems. While extensive and crucial, the financial resources needed to be complemented by other resources; money cannot buy experience, guidance, and networks for learning.

The federal government also provided technical assistance and opportunities for states to network, but states reported that assistance sometimes came with an insufficient understanding and appreciation of the important role states play in the federal system. Without the support of third-sector organizations, states would have lacked needed technical expertise and the ability to upgrade their staff skills. They also would have missed the opportunity to learn from their peers in other states and to benchmark their progress based on what other similar states were achieving.

These financial and technical assistance resources are best managed by competent state staff who are fluent in the workings of the health care sector. States relied on individuals and partnerships to help build this internal fluency, taking advantage of the expertise of individuals, especially those from the insurance and health care industries. While not a substitute for staff expertise or paid technical assistance, the counsel of these individuals—provided informally and through advisory committees in a spirit of community service—helped states to know what they didn't know and to prioritize their needs.

3. Management Core—Beyond the governor and the availability of resources, the existence of a cadre of policy leaders with years of experience in managing state reforms is a critical policy capacity. 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. This essential knowledge doesn't need to be acquired in the state where the executive is currently active—although it helps, of course. However, such policymaking and implementation expertise always supposes a direct familiarity with the legal, economic, and demographic realities that constrain state capacity. While this doesn't mean "a team of all-stars" is essential, it does require a group of managers on board who are seasoned, pragmatic, and cooperative with one another. Capacity depends in part on the collective ability and emotional maturity to engage in the "relational work" necessary to build trust with various stakeholders to the process.

Good relations are not enough, however. Policy implementation requires proposals and decisions by this management core about structures and staff. As noted earlier, major health reform usually requires adaptation to new administrative and organizational structures, better information systems, and new incentives (such as providing subsidies offered by these exchanges) in order to achieve the desired policy choice.

The ACA, for example, provided direct incentives for states to create new structures to administer health insurance exchanges with their requirements for systems to market health plans and determine eligibility for subsidies. Some states in our sample followed that path, with a degree of success along the way, while others used existing agencies or departments to perform these functions, and still others opted for a federally facilitated insurance exchange. Four of the sample states elected to establish new structures to operate their exchange, with three opting to develop a new quasi-governmental agency for their state-based exchange and one using this structure for its federally supported state-based exchange. The wisdom and appropriateness of senior management recommendations as to whether and how to build a state-based exchange will be tested over time.

The study confirmed that while states with limited resources had to tailor their management core to the financial resources and technical expertise available, it also established that these limitations could be overcome.

Health leaders with policy knowledge and experience can be attracted to any state administration, provided that they will be entrusted with the resources and authority to oversee the reform agenda. Political leadership is often said to be about vision and communication, but it also manifests itself in the ability to attract and retain senior talent.

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 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. Our interviews found these tasks are often neglected in the policy development process or outsourced and poorly managed. If the appropriate questions are not asked and analyzed, and the findings are not communicated in effective ways, not only are policies at risk of being poorly developed and implemented, but the trust of critical stakeholders is also eroded, lessening the ultimate efficacy of the policy process.

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.

As we saw in our analysis of states' insurance exchange decisions, whether a new implementation structure is established or an existing structure is repurposed, states had to first decide on the staff to operate this structure. In examining the work of implementation, we found most states opted to move existing staff to new roles and missions, adding a very limited number of newly recruited qualified personnel. However, the limits of this approach are evident. The capacity of yesterday is not always suited to the needs of today. Even with the right structures and in states with a sizeable bureaucracy, the capacity of a state still can be short on necessary skills and resources. The most dedicated employee may not possess the knowledge and the skills to cope with the highly technical requirements of structuring and regulating the new individual and small group health insurance markets and of overseeing the marketing and enrollment of new enrollees for both the exchange and Medicaid. Few people in states' bureaucracies were well versed in information systems for project development and management, a set of competencies that is more often associated with private sector entrepreneurship than with a highly regulated public sector environment.

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.

If capacity cannot be "made" internally, then it must be "bought." The interviewees, however, also revealed deficiencies in state contracting and procurement procedures and the lack of staff with skill and experience in negotiating and overseeing major contracts with outside vendors. Procurement processes that are complex and lengthy presented states with overwhelming challenges, especially when staff are not adequately prepared. It is a well-known paradox: proper use of external expertise requires some in-house capacity, if only to set expectations at the right level.

Indeed, the report found many challenges that result from excessively rigid state hiring and contracting rules that affected the launch of a number of state exchanges. This led to, among other things, hiring outside vendors of insufficient quality who were then poorly managed. Once more, the political and ideological context matters a lot: steadily declining trust in government and steady gains in state elections by officials who distrust and denigrate government and its bureaucracies do not set an attractive stage for the sudden onset of major new requirements such as what states experienced with the extensive ACA-related tasks and their tight timelines.

State implementation capacity also depends on federal implementation capacity—it is hard for the states to develop and deploy capacity in a context in which the federal government asks too much too soon, sets unreasonable standards of performance, wastes states' time by not issuing regulations on a timely schedule, and requires reporting requirements that are too arduous. While the federal government did provide useful technical assistance and opportunities for states to network, states reported that the federal technical assistance often came with an insufficient understanding and appreciation of the important role states play in our federal system.

In a discussion with state health leaders that followed a presentation of our preliminary results, one official remarked that state health policy should appear as a "fantastic and exciting" opportunity to introduce real change in this country. This report identified problems and concerns that will only be resolved with better capacity, from policy expertise "upstream" to operations and logistics management "downstream." Yet the fundamental elements required for positive public action may already be in place, thanks to the dedication, tenacity, and competence of state health leaders, working within the particular political context—or "filter"—of their state.

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.

Appendix: Interview Protocols

Protocol A

Questions for states that implemented a state-based or partnership exchange and/or Medicaid expansion

1. Reflecting back over xxxx's (name of state) experience with the implementation of the ACA, what roles were assigned to members of the governor's staff and to key executive agencies?

   Probe:
   - Please identify your state's key actors and characterize the roles they played.

2. How would you assess the state's initial capacity (eg, staff, policy experience, financial resources) to meet the challenges posed by the significant new responsibilities your state confronted with the implementation of the ACA?

   Probes:
   - What specific capacities were you satisfied with and what would you have liked strengthened?
   - Were these capacities located within the state bureaucracy? If so, can you briefly describe how the team/teams was/were organized and what kind of resources you could initially count on?
   - Prior to the adoption of the ACA, did you have working relationships with health care experts or consultants outside the state bureaucracy?

3. Reflecting back over your experience with xxxx's (name of state) experience with the implementation of the Affordable Care Act, how would you assess the evolution of the state's capacity since 2010?

   Probes:
   - How did your needs change as you moved from the policy analysis and options assessment stage to sustaining your state's momentum throughout the implementation process?
   - When you needed to strengthen your capacity and capabilities, how did you balance the need to add staff versus the need to bring in outside expertise (ie, the make or buy option)? How did pressing implementation timelines influence this decision?

4. Again, reflecting back about your experience, how would you assess the leadership capabilities of the state's core health reform team?

   Probes:
   - How effective was your core team in building the support among key stakeholders?

- How effective was your core team in sustaining the support of these leaders as they moved into the detail of implementing your exchange (if state-based exchange) and the Medicaid expansion (if implemented)?

- What role did the governor's office play in leading this effort? Did the governor establish an interagency working group to coordinate decision making and provide overall direction for the implementation process? If so, how were conflicts among agency leaders resolved? How many participants were on this committee?

- What role did key legislative leaders play? How did you cultivate their involvement and support?

- Were there other important leaders? From health sector actors? From policy center and university actors? From the media?

- What specific approaches/mechanisms were used to build and sustain support among legislators and the key stakeholders? Did the governor establish a commission or advisory group composed of agency leaders, legislators, and stakeholders? If so, how many participants were in this group?

5. How would you assess the financial support and technical assistance your state received from:

    a. Federal government agencies, such as the CCIIO, Center for Medicaid and CHIP Services, Center for Medicare and Medicaid Innovation, and Assistant Secretary for Planning and Evaluation

    b. National foundation-supported technical assistance as provided by the RWJ State Network, Commonwealth Fund, Kaiser Family Foundation, Milbank Memorial Fund's Reforming States Group, etc.

    c. National health policy and research groups and think tanks such as the National Academy for State Health Policy, Urban Institute, Brookings Institution, Heritage Foundation, etc.

    d. Universities, notably state and state-based universities, and state foundations and policy institutes

    e. Private consulting firms

6. As you think ahead to future health reform challenges your state will face, what recommendations do you have for the types of core skills and capacity the state should have to support major health reforms?

    Probes:
    - Recognizing the inherent limitations states face in the number and types of staff that can be hired to support major health reform initiatives, how many staff with which key skills should constitute the critical core capacity? Where should it be located (i.e., governor's office, executive agency)?

- How can/should this core capacity be sustained over time as the initiative moves through the policymaking, implementation, and evaluation stages?

- What approaches and mechanisms would you recommend to ramp up your state's core capacity to meet a major reform initiative being implemented by your state's executive leaders such as might be required for major delivery system changes, cost containment measures, and lifestyle and health promotion initiatives? How would such an expansion of the state's policy capacity be executed and funded (eg, hiring new staff, redeployment of existing staff, and contracting with policy, research, and implementation firms)?

Protocol B

Questions for states that didn't implement a state-based or partnership exchange or Medicaid expansion

1. Reflecting back over xxxx's (name of state) experience with decision making surrounding the implementation of the ACA, what roles were assigned to members of the governor's staff and to key executive agencies?

   Probes:

   - Did the state accept a federal planning grant?

   - Please identify your state's key actors and characterize the roles they played in the initial planning process.

2. How would you assess the state's initial capacity (e.g., staff, policy experience, financial resources) to meet the challenges posed by the new responsibilities your state confronted with the implementation of the ACA?

   a. For performing functions associated with the federally facilitated exchange such as health plan certification, rate review, and assistance with enrollment?

   b. For any increased enrollment for the existing eligibles?

   Probes:

   - What specific capacities were you satisfied with and what would you have liked strengthened?

   - Were these capacities located within the state bureaucracy? If so, can you briefly describe how the team/teams was/were organized and what kind of resources you could initially count on?

   - Prior to the adoption of the ACA, did you have working relationships with health care experts or consultants outside the state bureaucracy?

3. Reflecting back over your experience with xxxx's (name of state) experience with the implementation of the Affordable Care Act, did the state make any changes to its health policy capacity since 2010?

   Probe:

• As you assessed options, did you strengthen your health policy capacity and capabilities? Did you balance the need to add staff or bring in outside experts?

4. Again, reflecting back about your experience, how would you assess the leadership capabilities of the state's core health reform team?

   Probes:

   • How effective was your core team in assessing options; working with key stakeholders?

   • What role did the governor's office play in leading this effort? Did the governor establish an interagency working group to coordinate decision making and provide overall direction for the implementation process? If so, how were conflicts among agency leaders resolved? How many participants were on this committee?

   • What role did key legislative leaders play? How did you cultivate their involvement and support?

   • Were there other important leaders? From health sector actors? From policy center and university actors? From the media?

   • What specific approaches/mechanisms were used to build and sustain support among legislators and the key stakeholders? Did the governor establish a commission or advisory group composed of agency leaders, legislators, and stakeholders? If so, how many participants were in this group?

5. How would you assess the financial support and technical assistance your state received from:

   a. Federal government agencies such as the CCIIO, Center for Medicaid and CHIP Services, Center for Medicare and Medicaid Innovation, and Assistant Secretary for Planning and Evaluation

   b. National foundation-supported technical assistance as provided by the RWJ State Network, Commonwealth Fund, Kaiser Family Foundation, Milbank Memorial Fund's Reforming States Group, etc.

   c. National health policy and research groups and think tanks such as the National Academy for State Health Policy, Urban Institute, Brookings Institution, Heritage Foundation, etc.

   d. Universities, notably state and state-based universities, and state foundations and policy institutes

   e. Private consulting firms

6. As you think ahead to future health reform challenges your state will face, what recommendations do you have for the types of core skills and capacity the state should have to support major health reforms?

   Probes:

   - Recognizing the inherent limitations states face in the number and types of staff that can be hired to support major health reform initiatives, how many staff with which key skills should constitute the critical core capacity? Where should it be located (ie, governor's office, executive agency)?

   - How can/should this core capacity be sustained over time as the initiative moves through the policymaking, implementation, and evaluation stages?

   - What approaches and mechanisms would you recommend to ramp up your state's core capacity to meet a major reform initiative being implemented by your state's executive leaders such as might be required for major delivery system changes, cost containment measures, and lifestyle and health promotion initiatives? How would such an expansion of the state's policy capacity be executed and funded (e.g., hiring new staff, redeployment of existing staff, and contracting with policy, research, and implementation firms)?

Protocol C

Questions for legislators in states that implemented a state-based or partnership exchange and/or Medicaid expansion

1. Reflecting back on xxxx's (name of state) experience with the implementation of the ACA, what role did the state legislature play in determining whether to establish a state exchange and whether to expand Medicaid?

   Probes:

   - Which committees in the state legislature were given this responsibility? What role did these committees play in reviewing and approving new proposed policies and legislation?

   - Did the governor establish a commission or study committee to assess options and, if so, were members of the legislature asked to serve on these?

   - When you sought expertise to advise the legislature, where did you turn for this advice? State universities, national policy organizations (e.g. Brookings Institution, Heritage Foundation, American Legislative Exchange Council, consultants)?

2. How would you assess the state's capacity (e.g. staff, policy experience, financial resources) to meet the challenges posed by the significant new responsibilities your state confronted with the implementation of the ACA?

Probes:

- Which agencies played the lead role in implementing the ACA?
- How would you describe the relationship between the governor's staff assigned to lead implementation of the ACA and legislative leaders?

3. Reflecting back about your state's experience, how would you assess the leadership capabilities of the state's executive agency's core health reform team?

Probes:

- What were their strengths?
- What additional capabilities were needed; what capabilities would you have liked to see strengthened?

4. How would you assess the leadership provided by the legislature?

Probes:

- Where would you have liked the legislature to play a greater role?
- What specific approaches/mechanisms would you now recommend that would have enabled the legislature to play a more effective role?

5. How would you assess the financial support your state received from the federal government?

Probes:

- What role did the legislature play in overseeing how these federal funds were used?
- Could your state have made the progress it has made without the significant infusion of federal funds?

6. As you think ahead to future health reform challenges your state will face, what recommendations do you have for the types of core skills and capacity the state should have to support major health reforms?

Probes:

- Recognizing the inherent limitations states face in the number and types of staff that can be hired to support major health reform initiatives, how many staff with which key skills should constitute the critical core capacity? Where should it be located (i.e., governor's office, executive agency)?
- Should the state legislature have a small dedicated staff that monitors and advises legislators on state health policy?

- What approaches and mechanisms would you recommend to ramp up your state's core capacity to meet a major reform initiative being implemented in your state? Such reforms could be either initiated by the state or as a result of new national legislation. Possible approaches include:

  o Expand the state's core health policy capacity by hiring new staff and/or redeploying existing staff

  o Use state universities/policy centers to supplement state policy capacity

  o Contract with national health policy/research centers for policy guidance and with private firms to undertake technical tasks such as a new IT system

- How should the state fund such expansions of its core capacity?

Notes

1. Pressman JL, Wildavsky A. *Implementation*. 3rd ed. Oakland, CA: University of California Press; 1984.

2. Forest PG, Denis JL, Brown LD, Helms D. Health reform requires policy capacity. *Int J Health Policy Manag.* 2015;4(5):265-266. http://www.ijhpm.com/pd-f_3012_691405b1882a813c18c5886e710b6b26.html. Accessed January 17, 2017.

3. Britnell M. *In Search of the Perfect Health System*. Basingstoke, UK: Palgrave Macmillan; 2015.

4. Koller CF. Learning Chinese. Milbank Memorial Fund: The View from Here blog. www.milbank.org/the-view-from-here/learning-chinese. Published August 1, 2014. Accessed November 10, 2016.

5. QuickFacts. US Census Bureau website. https://www.census.gov/quickfacts/ Accessed January 12, 2017.

6. Bureau of Economic Analysis. Broad Growth Across States in 2014 [news release]. http://www.bea.gov/newsreleases/regional/gdp_state/2015/pdf/gsp0615.pdf. Washington, DC: US Department of Commerce; June 10, 2015. Accessed December 1, 2016.

7. Governors. National Governors Association website. www.nga.org/cms/governors. Accessed December 1, 2016.

8. National Conference of State Legislatures. 2014 Sate and Legislative Partisan Composition. www.ncsl.org/documents/statevote/legiscontrol_2014.pdf. Denver, CO: National Conference of State Legislatures; June 9, 2014. Accessed December 1, 2016.

9. Centers for Medicare & Medicaid Services. Medicaid & CHIP: June 2015 monthly applications, eligibility determinations and enrollment report. https://www.medicaid.gov/medicaid/program-information/downloads/june-2015-enroll-ment-report.pdf. Published August 31, 2015. Accessed November 10, 2016.

10. Department of Health & Human Services. ASPE Issue Brief. Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report. aspe.hhs.gov/sites/default/files/pdf/33826/ib_2015jan_enrollment.pdf. Published January 27, 2015. Accessed November 10, 2016.

11. Witters D. In US, uninsured rates continue to drop in most states. Gallup website. www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx. Published August 10, 2015. Accessed November 10, 2016.

Correction: April 20, 2017

An earlier version of this report cited the wrong political party affiliated with the Arkansas Senate in 2013 and 2014. It was Republican, not Democrat.

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About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Reforming States Group

The Reforming States Group (RSG) is a nonpartisan, voluntary group of state health policy leaders from both the executive and legislative branches who, with a small group of international colleagues, gather regularly to share information, develop professional networks, and commission joint projects—all while using the best available evidence and experience to improve population health. Supported by the Milbank Memorial Fund since 1992, the RSG brings together policymakers who usually do not meet together outside their states, to share information they cannot obtain anywhere else.

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