Process Learning and the Implementation of Medicaid Reform

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As the implementation of health care reform proceeds in the face of ongoing political conflict, variations in state decisions are shaping important aspects of its pace and scope. This article investigates five potential explanations for state implementation of the Medicaid expansion—state party control, economic affluence, the trajectory of established policy, state administrative capacity, and the process of learning from intergovernmental bargaining. Our analysis of fifty states finds, not surprisingly, that party control of government influences state decisions. We also find, however, several additional and striking influences on states—namely, the trajectory of established policy for vulnerable populations and, of particular importance, state learning about the process of intergovernmental bargaining.

Political maneuvering over health care reform continues as it has been steadily implemented in Washington and in states across the country following the Supreme Court's affirmation of the Affordable Care Act of 2010 (ACA) and President Barack Obama's 2012 reelection. Republican efforts to repeal the ACA in Washington and to blunt it in states are sowing some confusion among consumers but not stopping the wheels of implementation (Ario and Jacobs 2012; Jacobs 2014). Following the surge in enrollment in late 2013 and early 2014, the Congressional Budget Office (2014) reported that thirty eight million more Americans will be covered by 2018 through health insurance exchanges and the expanded Medicaid and the child health insurance programs than they would have without the ACA.

The pace and scope of health reform is, however, varying across states. The ACA's expansion of access to medical care rests on two programs: the establishment of health insurance exchanges for individuals and small businesses without coverage and the expansion of Medicaid to all individuals below 138 percent of the federal poverty line. The exchanges will be established throughout the country; with the federal government establishing exchanges in states that decide not to act.

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The greatest differences across states will emerge with regard to Medicaid reform as some states exercise their option not to proceed. The Supreme Court's ruling in June 2012 upheld the constitutionality of the ACA and its exchanges but made the Medicaid expansion optional and, specifically, barred Washington from using the threat of withholding existing funding as a stick to pressure state compliance. While the federal government cannot cut funding, the ACA is offering states generous carrots—it will pay 100 percent of the costs from 2014 to 2016 and then transition to cover 90 percent of the costs by 2020 as well as a generous portion of administrative expenses. The fiscal weight on state budgets of funding the ''uncompensated care'' of the uninsured can now be considerably lightened. Although fiscal carrots are inducing some states to expand Medicaid, about half the states are not yet moving ahead with reform.

The ACA's reform of Medicaid raises an important question for health reform as well as the nature of intergovernmental relations: What is influencing state decisions to implement the Medicaid expansion? Of course political party is a major explanation—states where Republicans enjoy all or some levers of power are tending not to proceed while Democratic controlled states are generally implementing the expansion more rapidly and thoroughly. As important as political party looms, it is not sufficient as evident from the variations in progress among Democratic and Republican states.

This article argues that state experiences with intergovernmental bargaining—what we call ''process learning''—is a critical factor in influencing the degree of state progress on Medicaid reform, raising broader issues about intergovernmental relations. In the broad field of federalism, most analysis focuses on comparative state analysis and on the one-way relationship of the national government to the states or vice-a-versa. Often neglected is how state bargaining interactions with Washington produce an understanding of new federal programs not as final offers but rather as opening bids in negotiations to widen discretion to fit their contexts. We argue that state decisions to implement ACA's expansion of Medicaid are, in part, a function of familiarity with the federal government: state experience negotiating and working with the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (DHHS) builds up the skill and confidence to treat interactions with the national government as a dynamic balancing of national regulations and state preferences. States with more experience interacting with CMS over Medicaid changes are expected to make particular progress implementing ACA's expansions because they have learned the skills and appropriately modulated expectations to effectively bargain with Washington. Conversely, states with less of a track record interacting with CMS are more likely to view federal rules relating to the ACA as fixed rather than negotiable and, as a result, make less progress implementing the optional Medicaid expansions.

We study one of the two cornerstones of the ACA—Medicaid expansion. Unlike the health insurance exchanges that have a national government fallback option, state decisions dictate whether this component of reform proceeds; it is also an arena of state experimentation in interaction with the federal government. Understanding why states adopt Medicaid expansion is important to both the course of health reform and the nature of vertical federalism.

This article begins by situating state decisions on Medicaid expansion within scholarly debates over federalism and intergovernmental relations before discussing our data and analyses.

State Learning About Intergovernmental Relations

The New Deal's expansion substantially expanded relations between state and national governments. Rather than fading with the growth of the federal government, intergovernmental relations are becoming more important as waivers are more widely used in health care, education, and other policy areas. Health reform fits into this contemporary pattern; the Supreme Court's ACA ruling reinforces and expands the importance of state relations with Washington.

Research on intergovernmental relations has generated two bodies of studies—those on downward and upward vertical federalism. Downward federalism is the national government's use of strong, clear mandates and a mix of rewards and punishments to drive state action on policies as diverse as health care, education, and environmental protection (Roh and Haider-Markel 2003; Allen, Pettus, and Haider-Markel 2004; Karch 2006; Nugent 2009). Activity by the national government and Congress not only impacts policy outputs but also stimulates political reactions including the mobilization of interest groups (Baumgartner, Gray, and Lowery 2009).

Upward federalism traces back to the notion of states as "laboratories of democracy," which generate ideas and policy innovations that "rise" up to drive national policy making (Brandeis 1932). Although widely heralded, research generally points to the limited scope of direct state influence on the development of specific Washington policies (Weissert and Scheller 2008: 171; Robertson 2012: 173–75; Thompson 2012).

Much of the discussion of intergovernmental relations focuses on tracing the "pendulum" swings between upward and downward federalism. For instance, Robertson (2012) traces the seesawing of authority to the federal level in the 1930s, back toward the states in the 1970s and 1980s before the surge of nationalization in K-12 education and health care in the early twenty-first century.

Less attention, however, has been devoted to the dynamic nature of intergovernmental relations and, specifically, to how state learning from their experience of bargaining with Washington can influence their receptivity to new

federal policies. The most commonly studied form of intergovernmental learning concentrates on "*policy learning*." Policy learning occurs both in horizontal federalism (i.e. states or cities study evidence to identify successful policy adoptions by counterparts)[1] and in vertical federalism where the national government follows state policies that work (Weissert and Scheller 2008). The key feature in both forms of policy learning is that past experiences and policies influence future action. The limitation with the "policy learning" concept is that it neglects state experiences, skills, and expectations about the opportunities and constraints of the process of intergovernmental relations.

In contrast, "process learning" results from the knowledge and experience that states pick up from bargaining and negotiating with Washington. Building on past research, we argue that states and, specifically, gubernatorial administrations that are the primary state contact with Washington learn through the iterative sequence of the intergovernmental process—the national government's initial activity, the state requests for modifications or exemptions, and Washington's subsequent requests for revisions and then approval.[2] The gain is mutual: federal agencies can induce participation and innovation from governors and cabinet members that might otherwise resist or refuse new programs; state leaders can reap greater latitude to shape national policy to their circumstances. State executive leaders that engage in the intergovernmental bargaining process tend both to develop expectations that federal agency implementation of laws are somewhat malleable (rather than rigidly fixed) and to pick up skillful strategic tools—from lobbying Congress or the executive branch to coalition building with legislators and organized groups who can pressure government officials (Ingram 1977; Nugent 2009). In addition to positive inducements that flow from bargaining, state leaders also witness the costs of inaction—missed opportunities from not modifying new mandates, the politically damaging criticism from organized stakeholders, and internal pressure from disgruntled program officials.

The "process learning" of governors and their cabinets from their past relations with the national government is especially likely with regard to federal health policy and Medicaid because of repeated, routinized, and long-standing intergovernmental interactions. Medicaid's federal administrator—the CMS—operates a process for states to seek waivers to experiment with Medicaid; this produces (from certain states) a large and steady stream of requests backed up by lobbying of Congress, DHHS, and the White House, which in turn results in a string of federal requests for modifications and then approvals (Thompson and Burke 2007, 2009). The back-and-forth between Washington and the states over the amending of Medicaid through waivers (as authorized through Section 1115 of the Social Security Act) created a process in which bargaining and mutual accommodations (including reinterpretations of what Congress passed into law) became the "norm" (Kim and Jennings 2012; Shelly 2013). State submission of requests for Section 1115 waivers

are often preceded and then followed by extensive and time-consuming negotiations with the federal government, not infrequently taking several years to obtain approval. Gubernatorial administrations with experience pursuing Section 1115 waivers learn both skills for influencing the federal government's program evaluation and its decision making across the executive and legislative branches as well as modulated expectations—the opportunities for greater flexibility and the limits to what CMS will accept (Thompson and Burke 2007; Weissert and Weissert 2008). Pursuing waivers not only deliver wider policy latitude but also equip governors and their cabinets with stronger "skills as administrators, innovators, and constructive critics of federal programs" (Nugent 2009: 175).[3]

In short, there is a need to fill out research on federalism and, especially, its vertical dimension by exploring further the bargaining process between levels of government and the learning it generates for governors and their cabinets. Our analysis considers the impact of this "process learning" on state policy decisions—along with competing potential influences—in the particular context of varying state decisions to implement the ACA's Medicaid expansion.

Nested Federalism: Explaining Medicaid Expansion

Vertical federalism is guided by a host of factors. State relations with the federal government are shaped by political, policy, economic, and administrative circumstances. We argue that the experience of state leaders negotiating with Washington needs to be considered as well.

Partisanship and State Policy Making

A common account of vertical federalism is that state adoption of federal programs is a function of the national government's provision of funding and latitude. As Gormley (2006) puts it, "[t]he more money the federal government makes available to the states [and the fewer mandates], the happier the states tend to be" (525; also Allen, Pettus, and Haider-Markel 2004; Karch 2006).

While money and institutional latitude are certainly attractive features for states, the political salience of the program is a conditioning factor. Programs that become highly visible in polarized party disputes are conditions that will entirely override or significantly offset the financial and institutional attractions of a new federal program (Deering and Shelly 2009; Layman et al. 2010; Doan and McFarlane 2012; Sylvester 2014).

The impact of partisanship is amply evident in state decision making on the implementation of the ACA's Medicaid expansion. On the one hand, the financial incentives are exceptional. Washington covers all the costs of expansion for the first three years and, afterward, continues to cover an unusually large portion of Medicaid costs. On average, the federal government pays 57 percent of Medicaid's

costs to states (Kaiser Family Foundation 2012b); the ACA offers to cover all costs for the first three years and then 96 percent of administrative and benefit costs as well as to reduce state funding for "uncompensated care" of the uninsured whose treatments will be covered by the new program (Angeles 2010; Kaiser Family Foundation 2010; Conlan and Posner 2011; Bachrach and Jacobs 2012). In addition, the adoption of the Medicaid expansion is not mandated; it is an option. On the other hand, the sharp partisan divide during the passage of the ACA in 2010 (no Republicans voted for its passage) has persisted afterward at not only the national level in Congress but also in states (Francis and Francis 2010; Oberlander 2011; Jones, Bradley, and Oberlander 2012; Jacobs and Callaghan 2013; Rigby and Haselswerdt 2013). Most of the states controlled by Democrats—like Connecticut, Maryland, and Minnesota—adopted the expansions of Medicaid while the majority of Republican controlled states are refusing to implement it.[4] (18 of 30 Republican governors are opposing the reform while all of their Democratic counterparts are supporting it.)

The mediating effects of partisanship on state evaluation of the ACA's financial and institutional features are, however, not uniform (Jacobs and Callaghan 2013). The most striking cases are the Republican states like Arizona, Iowa, New Mexico, and North Dakota that departed from their Party's national position and implemented reform. Conservative favorite, Jan Brewer (Republican Governor of Arizona), bullied the state legislature's more conservative Tea Party members into adopting it by insisting that "It's pro-life, it's saving lives, its creating jobs, it is saving hospitals . . . I don't know how you can get more conservative than that" (quoted in Santos 2013).

The nuance of partisanship extends to which branch of government is controlled, especially in the case of Republican control. While Republican legislators elected by ideologically homogenous districts with the support of the Tea Party and other conservative activists have steadfastly opposed ACA implementation, a number of Republican governors have taken a more pragmatic approach to support Medicaid expansion in response to their broad political constituents (including hospitals and other aspects of the health care system) and statewide institutional responsibilities including the budget (Skocpol and Williamson 2012). This has generated, at times, disparate political interests as illustrated in Arizona where the Republican Governor favored reform and the GOP legislature opposed it. Of course, Democratic governors facing Republican legislatures (as in Virginia) consistently hit deadlock, though not uniformly (as in Arkansas).

The Influence of Established Policy

The scope and nature of each state's existing programs for low-income individuals may be a second factor influencing state evaluations of the ACA's invitation to

expand it. Studies of American political development and policies ranging from education to Social Security and assistance for the poor show that established policy creates "self-reinforcing or positive feedback[s]" that perpetuate and often lead to the expansion of programs (Skocpol 1992; Pierson 2000; Campbell 2003; Mettler and Soss 2004; Orren and Skowronek 2004). This body of research suggests that state decisions about the ACA's Medicaid expansion will be driven by prior state policies related to Medicaid eligibility and benefits for the poor and the uninsured as well as the State Children's Health Insurance Program (SCHIP), which targets uninsured children in families with incomes that are modest but too much to be eligible for Medicaid. Those states with strong and established SCHIP and Medicaid programs may be uniquely positioned to leverage existing programs for low-income individuals to meet the current needs through ACA implementation.

The Role of Economic Context

State economic circumstances are a third influence on state policymaking that might impact state adoption of the ACA's Medicaid expansion. State economic circumstances have a clear history of influencing state policy decisions. Most past research suggests that affluent states are more innovative and receptive to developing new federal initiatives (Welch and Thompson 1980; Davies and Derthick 1997: 229–31; Rigby and Haselswerdt 2013). Supporters of health reform however, expected a different dynamic: they suggested that the ACA's unusually generous federal financing package would be "too good" for less affluent states to pass up (Bachrach and Jacobs 2012). According to this second account, Medicaid reform would be more common in less (as opposed to more) affluent states who were emerging from the economic collapse of 2009 and hungry for federal dollars to add to its Medicaid coffers.

Institutional Capacity and Policy Change

Administrative capacity in states is another potential influence on its decisions regarding ACA implementation. According to research by organizational economists and institutionally oriented political scientists, policies that create administrative capacity (like Medicaid) foster durable and expanding development along the same path (Skocpol and Ikenberry 1983; Skocpol 1992; Pierson 2000). States with greater administrative capacity have the tools needed to effectively design, adopt, and implement programs and, in turn, boost the confidence of politicians that program expansions or alterations can be implemented without issue. Administrative capacity has been shown to be especially relevant in state health policy making. For example, Holahan et al. (1998) demonstrate its utility for determining eligibility, processing enrollments, assuring payments, and monitoring

the quality of care; Gold, Sparer, and Chu (1996) show that states with stronger administrative capacity had more effective procedures and resources to enroll Medicaid recipients. One of the implications of this research is that the capacity and confidence of states in tackling health policy is impacted by administrative resources in a broad swath of areas like insurance regulation, coverage expansion, and cost control.

The Importance of Intergovernmental Interactions

Party control, policy trajectories, economic affluence, and administrative capacity are important and familiar influences on state policy adoption; learning the process of intergovernmental bargaining may also play an important role in state decision-making. States with experience bargaining with CMS on Section 1115 waiver requests may be more receptive (than those without interaction) to pursue the ACA's Medicaid expansion because governors and their senior policy makers have learned that they can tailor it, to some extent, to unique state circumstances while capitalizing on the new resources. These interactions take place between the federal government and the governor and cabinet officials, which puts a premium on the learning that occurs under the current administration in terms of influencing Medicaid expansion decisions.

Hypotheses

We will examine six hypotheses to explain state variation in Medicaid expansion.

- *Legislative Partisanship*: Republican-controlled legislatures will be strongly opposed to expanding Medicaid and exhibit minimal implementation progress; conversely, Democratic legislatures will coincide with more progress.
- *Gubernatorial Partisanship*: Republican governors will mildly support Medicaid expansion owing to their state-wide considerations; Democratic governors will strongly support Medicaid expansion.
- *Policy Trajectory*: States with a history of creating more generous SCHIP and Medicaid programs will make more progress in implementing the ACA's Medicaid reform.
- *State Economic Circumstances*: More affluent states are more likely to accept federal funds and to implement reform while less affluent states will feel constrained from expanding Medicaid by their difficulty to pay even modest additional costs.
- Administrative Capacity: States with more administrative skill and capacity in managing health insurance markets and coverage will be further along in implementing Medicaid reform than states with lower administrative capacity.

- *Process Learning*: More extensive state "process learning" about intergovernmental bargaining (as measured through the presence of a Section 1115 waiver request) will be associated with greater progress in achieving reform.

Data and Analysis

We have collected the data and constructed six independent variables to examine our key hypotheses for state Medicaid expansion across fifty states. Our hypotheses—and our variables—represent leading explanations for Medicaid expansion and health reform as well as our effort to develop a parsimonious model.

Relative State Progress Expanding Medicaid

Developing a measure of relative state progress expanding Medicaid (our dependent variable) is a particular challenge. Most efforts to track state decision-making rely on trichotomous measures that record whether states are moving forward with reform, not moving forward with reform, or are currently debating the topic.[5] The Kaiser Family Foundation, for example, uses this approach and reports that as of March 26, 2014, twenty-six states are moving forward with reform, nineteen are not moving forward with reform, and five are openly debating the issue.[6] The limit of this approach is that it omits data on relative state progress—the progress of states in planning for the expansion but not formally enacting them as well as those that have enacted them but lagged in developing the necessary infrastructure.

Unfortunately, the extensive work generating measures of Medicaid development prior to the ACA's passage is not well-suited to studying its initial implementation. Relative state adoption of the ACA is not adequately captured by past measures of the generosity of Medicaid benefits (Buchanan, Cappelleri, and Ohsfeldt 1991; Moffit, Ribar, and Wilhelm 1998), the dimensions of Medicaid's political dynamics (Grogan 1994, 1999), and other approaches. Rigby and Haselswerdt (2013) develop a new measure to track ACA implementation (focusing on insurance exchange adoption by states) based on the differences among states in the length of time taken to enact reform; but this approach neglects the content of reform.

We develop an alternative measure of state implementation of ACA's Medicaid extension that focuses on relative state progress in moving through five stages of development toward greater compliance with federal requirements. The stages do not necessarily represent a temporal sequence as states may vary the order of their action; our stages measure state progress in tackling increasingly important steps—from obtaining funds for planning to full legislative action. The first stage is state application for at least one "Level One" federal grant to finance planning for implementation. The application process for obtaining these grants requires a

concerted effort from state government to detail how it will use federal funds to comply with the ACA. Data for the grants are compiled by the federal government.[7]

While a federal planning grant indicates a general intent to prepare for reform and identify options, the second level is more important and moves toward actual state approval of the Medicaid expansion—the Governor's public announcement of support for the reform. Gubernatorial support for reform is a necessary (though not sufficient) step; the executive branch takes the initiative for planning and the state's chief executive must sign (as oppose to veto) enacted legislation to authorize the expansion. Because governors tend to focus on the ACA's attractive financial and institutional terms as well as the broad pressure behind reform from stakeholders in the health care system, their support has been more forthcoming and vocal than the legislature's. A number of governors were supportive of Medicaid expansion but stymied by legislators (e.g., Florida, Missouri and Montana). Gubernatorial support is tracked through public statements in State of the State addresses, press releases, and other speeches in conjunction with the monitoring by Kaiser Health Facts and The Advisory Board.

The next level of relative state progress accounts for those states who are currently seeking approval from the federal government to implement a Medicaid reform alternative to the ACA (Indiana and Pennsylvania) as well as two states (Wisconsin and Utah) that received waivers to revise their existing Medicaid programs without adopting the ACA reform. All states in this category have made the decision to implement some form of Medicaid reform without adopting the original model stipulated by the ACA and CMS.

The fourth step toward greater federal compliance is federal approval to implement a state's distinctive approach to ACA Medicaid expansion. Although these states are not implementing Medicaid reform as it was originally designed to be implemented, they have worked with the federal government to develop specific solutions that are tailored to the particularized circumstances of the state while meeting the basic coverage requirements of the ACA legislation. Three states have reached this status to this point: Arkansas, Iowa, and Michigan.[8]

The fifth and highest level of state implementation is its adoption of Medicaid expansion as expressly stipulated under the ACA in order to comply fully with its requirements. (See Supplementary Appendix for detailed information on each dimension of our Medicaid expansion measure.)

Our measure of state Medicaid expansion, which is presented in figure 1, reveals substantial variation among states. The relative progress of states in achieving the five stages of implementation ranges from zero if no state progress is evident to five for the implementation of Medicaid reform that fully complies with ACA requirements. Our measure reflects developments as of January 2014 and therefore should be considered interim findings. Some states (such

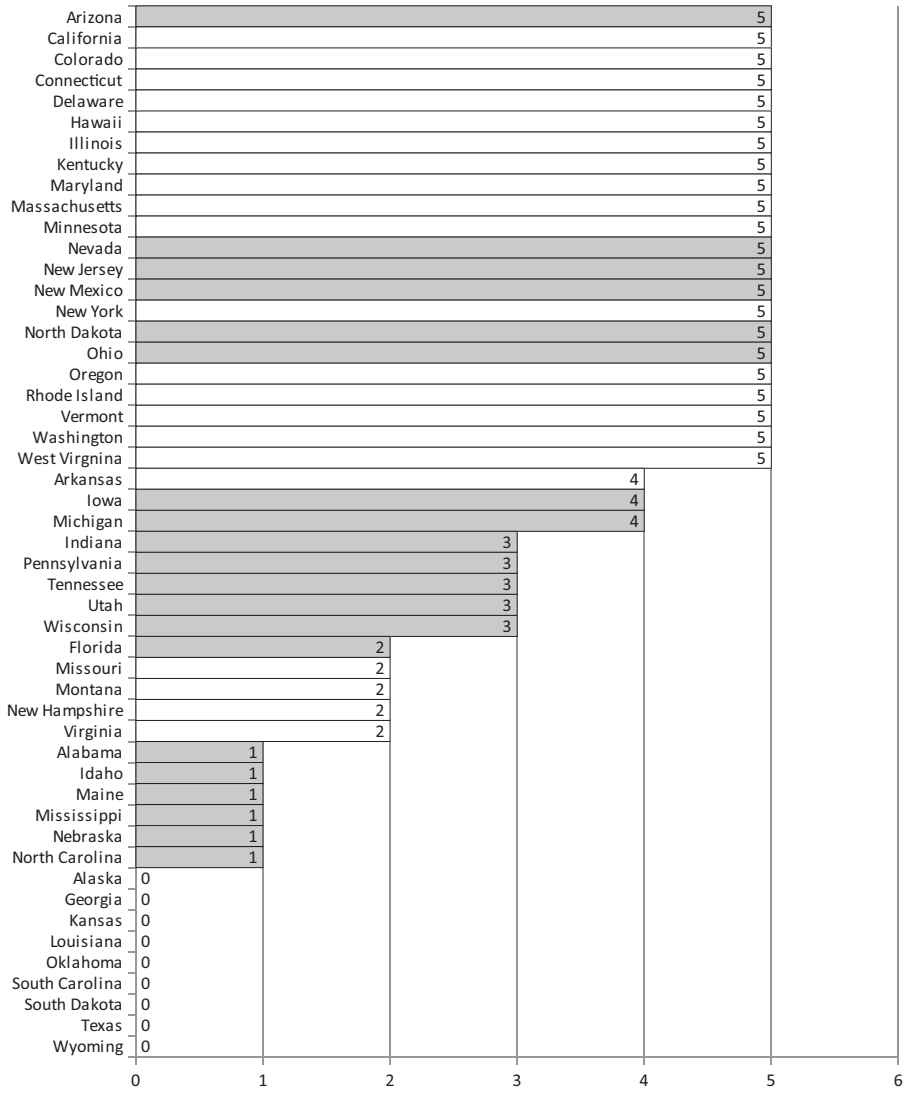

Figure 1 Medicaid reform development.

as Indiana and Pennsylvania) are currently negotiating with CMS for a waiver to implement reform alternatives and could change categories. Additionally, states that to this point have held back on Medicaid reform could move forward with implementation as other states succeed with reform (including some Republican states) and there are grounds to consider "imitating" them (Karch 2006).

The general pattern in figure 1 suggests that state progress tracks with partisanship: Medicaid expansion is furthest along in the Democratic-controlled states of California, Colorado, Massachusetts, and Minnesota and lags most in the Republican states of Texas, South Carolina, and Louisiana. There are also some signs that Republican states are approving Medicaid expansion or are taking steps toward its adoption. It is unclear, however, whether these initial dents at the state level in the otherwise rigid wall of Republican opposition are sufficiently robust to reveal empirical patterns beyond partisanship.

Independent Variables to Explain State Medicaid Reform

We construct six independent variables to explain state variation in Medicaid reform. The first is "process learning" by states, which is captured with a dummy variable for whether or not a state has proposed a Section 1115 Medicaid waiver under their current governor using information collected by CMS and supplemented by information gathered by Kaiser Health Facts (Kaiser Family Foundation 2012a; Waivers 2013).[9] While our process learning variable might conceivably be measured by federally approved waivers, our approach captures a wider range of state experience gleamed from the interactions of the Governor and his Cabinet officials with the federal government (Ingram 1977).[10] Focusing on all waiver applications also allows us to include data on states with pending applications—a fuller indicator of state intentions.[11] As we are ultimately interested in capturing the process of new learning through bargaining, our measure excludes waiver renewals, which are more routinized and often less salient or demanding of high-level gubernatorial attention.

Our interest in process learning receives initial support. There is a modest and positive bivariate correlation between process learning and Medicaid reform progress (Pearson $r = 0.37$, $p < 0.01$). Of course, this correlation does not take into account other potential influences on state decisions.

The next two variables measure the distinctive motivations of political party control of the state legislature and governor's office. The first is a dummy variable for whether or not a state has a Republican governor and the second is a three-point variable capturing either full, partial, or no Republican control of the state legislature. These measures allow us to gauge the significance of Republican governors backing health reform in the face of legislative opposition from members of their Party—as has been the case in Florida and Virginia. Previous research has also used split-party measures (Ferguson 2003; Medoff, Denis, and Stephens 2011; Miller and Blanding 2012; Rigby and Haselswerdt 2013). Bivariate analysis suggests that both variables are negative and significant correlates of implementation progress (Governor Pearson $r = -0.56$, $p < 0.01$; Legislature Pearson $r = -0.68$, $p < 0.01$). This is a bit surprising: while GOP legislatures were expected to oppose

the ACA, Republican governors were expected to support Medicaid expansion due to their responsiveness to state-wide considerations related to fiscal issues and medical providers.

The next variable accounts for the economic circumstances of states based on per capita income. This measure uses population data from the 2010 Census and state-level personal income data that is averaged over all four quarters of 2010, which is provided by the Bureau of Economic Analysis (Bureau of Economic Analysis 2013).[12] Bivariate analysis suggests a modest, positive relationship between economic affluence and Medicaid reform implementation (Pearson $r = 0.28$; $p < 0.05$). This suggests that affluence—rather than a weak economy (as some health reformers predicted)—is associated with implementation.

The fifth independent variable is the trajectory of established Medicaid and SCHIP policy. We developed an additive scale to measure the existence and generosity of state programs toward key groups: pregnant women, working parents, the medically needy, childless adults, and to children. Each group is scored on a zero to two scale with higher scores representing more generous benefits; a composite measure was created by combining these results.[13] The scale's focus on program generosity shares the orientation of earlier Medicaid studies (Buchanan, Cappelleri, and Ohsfeldt 1991; Grogan 1994; Cohen and Cunningham 1995; Moffitt, Ribar, and Wilhelm 1998; Yelowitz 1998; Grogan 1999) and tracks variation in existing program generosity from the lowest generosity in Nevada and Utah to the highest generosity in Connecticut and New York. As expected, state decisions to move toward adopting the ACA's Medicaid expansions are highly correlated with the generosity of past policy decisions to widen access (Pearson $r = 0.59$; $p < 0.01$).

Our final explanatory variable is state administrative capacity. Measuring state administrative capacity in the area of health policy is daunting; past analysis offers no clearly defined measure, with most tailored to narrowly drawn research questions. Our measure is a cumulative measure of both the capacity of states in a common area of responsibility (insurance oversight) as well as more specific capabilities related to aiding the poor and vulnerable such as opening high-risk pools to the medically needy. This measure is described in detail in the Supplementary Appendix; and its values correspond with expected variations in state capacity—from the weak resources of Alabama and the greater capabilities in Maryland, Massachusetts, and Connecticut.[14] Bivariate analysis shows—as expected—a positive correlation between state administrative capacity and Medicaid reform progress (Pearson $r = 0.33$; $p < 0.05$).

Explaining Relative State Expansion of Medicaid

Our multivariate analysis examines the impact on state Medicaid expansion by six potentially significant influences—state party control of the governor's office, state

party control of the legislature, economic affluence, established policy trajectory, administrative capacity, and process learning through waiver requests. We use ordinary least squares (OLS) regression because the dependent variable is measured along six points.[15] Our diagnostic analyses did not detect multicollinearity as a significant problem (Arceneaux and Huber 2007).[16]

Table 1 confirms the partisan patterning of health reform that was evident in figure 1 while also revealing interesting differences across the legislative and executive branches. The presence of a Republican legislature is a negative and highly significant predictor of reform implementation; this is consistent with the previous accounts that stressed its steadfast opposition to the ACA. The presence of a Republican governor suggests a more nuanced affect: it was a negative and only marginally significant predictor of reform. Together, the two party control effects support the party control expectation: the stronger the Democratic control over state government, the more progress the state makes in implementing Medicaid reforms. Nonetheless, Republican governors exert a weaker effect than Republican legislatures.

Table 1 Process learning influences Medicaid reform (The dependent variable is each state's progress stage of Medicaid expansion)

Variables	Model 1
Republican Leg.	–1.626***
	(0.673)
Republican Gov.	–1.036*
	(0.549)
Affluence	–0.00005
	(0.00004)
Process learning	0.712*
	(0.419)
Policy trajectory	0.253**
	(0.122)
Administrative capacity	–0.045
	(0.081)
Constant	5.774***
	(2.039)
Observations	50
R^2	0.576
Adj. R^2	0.517

Standard errors in parentheses. ***$p<0.01$, **$p<0.05$, *$p<0.10$.
Note. OLS regression was used for this analysis.

Although partisanship is clearly important, the variation in Medicaid progress by Republican states suggests that other factors may be at play—a pattern that is confirmed by our analysis. After controlling for party control, established policy trajectory and process learning are also significant predictors of reform progress.[17] The positive and significant result for policy trajectory shows that the existing generosity of state programs plays a crucial role in determining the degree of state progress adopting the ACA's Medicaid reforms. Echoing past research on Medicaid, where you finish depends on where you start—existing Medicaid policy engenders positive feedbacks that allow for easier program expansion (Campbell 2003; Mettler and Soss 2004). Neither state affluence nor administrative capacity registered as significant effects.

Our most theoretically striking finding is the process learning effect. Table 1 shows that the governor's experience in proposing a Medicaid waiver to CMS does contribute to state Medicaid expansion. (Reduced models that excluded variables that failed to reach statistical significance in table 1 find that the p value for the process learning improved and reached the 0.07 level.)[18] The finding for process learning is consistent with our earlier expectation that a state's waiver proposal triggers a process of interaction that advances its understanding of CMS and skills in navigating the bureaucracy, which in turn fuels its development of a newly expanded Medicaid program in not only Democratically controlled states of California and Minnesota but also states with GOP leaders such as Pennsylvania and Arizona.

Discussion and Implications

State adoption of new Medicaid expansions called for under the ACA is influenced by which political party controls the executive and, especially, the legislative branches of state government. Although our findings for partisanship were consistent with previous research, our analysis did not confirm influences identified by prior studies. State affluence and administrative capacity were—as we reported earlier—correlated with Medicaid reform, but both dropped out as significant effects in our multivariate analysis. States that are richer and possess more robust administrative capacity like Connecticut and New York are Democratic states; poorer states with weaker administrative capacity like Alabama and Mississippi are Republican strongholds. The insignificant results for economic affluence and administrative capacity are at odds with previous research on financial incentives as a driver of vertical federalism (Allen, Pettus, and Haider-Markel 2004; Gormley 2006; Karch 2006) and on institutional resources (Skocpol and Ikenberry 1983; Gold, Sparer, and Chu 1996; Holahan et al. 1998).

As important as party remains in the early phrase of ACA implementation, there appears to be other dynamics at work (Jacobs and Callaghan 2013). This article

finds evidence that the established trajectory of Medicaid and SCHIP policy and the learning generated by entering the process of applying for a health reform waiver influenced state adoption of Medicaid expansion. The process learning effect is theoretically noteworthy, highlighting that state experience with intergovernmental relations and negotiating with federal agencies can produce skills and expectations that facilitate state and federal receptivity to negotiation and mutual accommodation.

While the learning effect points to an influence on "upward federalism" when states evaluate federal policies, these findings stem from a form of dynamic, two-way vertical federalism. State requests for 1115 Medicaid waivers—and other mechanisms for requesting flexibility—trigger back-and-forth consultations and negotiations with mutual benefits. Federal agencies (as in the case of ACA) find the bargaining useful as a way to induce state participation while states welcome opportunities to gain greater leeway than was outlined in the original law. States who gain experience from requesting waivers have reason to view the ACA's original design of Medicaid as an opening bid in subsequent negotiations rather than as a "take-it-or-leave-it" order to states. Strikingly, states adopting the new Medicaid expansions engaged in extensive informal consultations with federal officials and trusted intermediaries to identify areas of flexibility as well as formal waiver requests to negotiate still greater latitude (as in the case of Arkansas) (Jacobs and Ario 2012).

Conclusion

States are center stage in the implementation of the ACA and, specifically, the expansion of Medicaid. The stakes are high; the states that have rejected the Medicaid expansion have left over five million Americans without its benefits, fueling severe health and financial consequences (Dickman et al. 2014). Our analysis addresses the crucial question of what drives state decisions to adopt the ACA's Medicaid program. Our findings confirm that partisan control—especially, Republican legislative majorities—influence Medicaid expansion. We also find, however, that the established trajectory of existing Medicaid and SCHIP policies matter and, of particular interest, state learning from waiver requests exert significant influences on states decisions. These results identify crucial influences on future Medicaid policy and underscore an important dimension of intergovernmental relations—bargaining and subsequent process learning.

Our findings may have an important implication for the course of state adoption of health reform. Party control is an important factor in state implementation of the ACA but it should be treated as a constraint rather than an unmovable barrier. The Medicaid expansions by Republican governors in Arizona, New Jersey, and elsewhere point to influences that counteract party. Nonetheless, we are analyzing Medicaid expansion as it unfolds in real time, justifying some

caution. Relationships among particular variables may change as more states with different political circumstances adopt Medicaid expansion and additional factors gain greater traction.

Even if the constellation of particular variables that explain Medicaid expansion vary, this article's findings are consistent with prior research on state policy adoption that questions mono-causal explanations (Karch 2006). Over time, more Republican governors may find the pull of party less influential as they are increasingly cross-pressured by a variety of factors—from the pull of establish policy trajectories to process learning and the lobbying of organized stakeholders and public interest groups.

Supplementary Data

Supplementary data can be found at www.publius.oxfordjournals.org.

Notes

1 Shipan and Volden (2008); Kile (2005); Berry and Berry (1990); Glick and Hays (1991); Gray (1973); Mooney (2001); Mooney and Lee (1995, 2000); Walker (1969).

2 Governors decide whether to pursue waivers and to negotiate with the federal government in what can be high-profile, politically charged, or budgetarily significant initiatives. This is especially true with high-profile issues like implementation of the ACA. While a longer state history might build a deeper learning within the civil service, the experience of governors with waivers is the decisive factor in whether to negotiate with Washington.

3 The process learning that results from state interactions with the federal government over waiver requests is primarily driven by internal pressures from stakeholders, budgets (including the uncompensated care of hospitals that public funds finance), and administrators. While the Governor's party influences the governor's disposition to pursue Medicaid expansion (as we demonstrate below), the effects of their waiver experiences—along with past research—exert specific influences on them. Tangible state circumstances—as opposed to the Governor's general dispositions or "worldview" – inform state waiver requests (Thompson and Burke 2009).

4 "Controlled by" refers to full Democratic and full Republican control of both branches of government in each state.

5 Dichotomous measures that exclude the currently debating category are also quite common.

6 http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#.

7 The data for grants can be found here: http://www.cms.gov/cciio/resources/marketplace-grants/index.html.

8 In these three states, CMS accepted their modifications of the ACA's expansion of Medicaid; Wisconsin and Utah took a different path—they revised their existing Medicaid programs but did not decide to adopt the ACA expansion and therefore did not seek a waiver to modify it.

9 Our focus on Section 1115 waivers follows past research on intergovernmental bargaining and state Medicaid policy (Thompson and Burke 2007).

10 A broader measure could have been used to capture waiver interactions prior to the current administration as a way to account for institutional memory among civil servants. Because governors gave extraordinary attention to ACA implementation owing to its budgetary and political implications, we chose to focus on waiver requests by the sitting governor and on the process learning within a given administration.

11 We analyze state waiver requests from Medicaid in order to study the learning of governors and their senior staff regarding Medicaid expansion. They also learn from waivers on education, environmental, and other policies but the public salience, political stakes, and budgetary significance of Medicaid expansion makes it distinctive.

12 Similar results were found for alternative variable specifications and, particularly, when we used second quarter income data.

13 For variables where variation existed in whether or not benefits were provided at all, scoring was determined based on the extent of benefits provided (2 points: full Medicaid benefits; 1 point: some benefits; 0 points: no benefits). For variables where all states provided benefits, percentages were used and the group scores were determined based on which third of the distribution a state fell into. More detailed information can be found in the Supplementary Appendix.

14 There is a strong degree of face validity with this measure: states considered to have high administrative capacity (MA/CT) receive scores well ahead of states considered to have low administrative capacity (AL) (Gold, Sparer, and Chu 1996).

15 Although the data are technically ordinal in nature, we opted to use OLS given the construction of our dependent variable (there are a number of scale points and they are continuously ordered and regularly spaced) and the simplicity of explanation provided by OLS. In addition, OLS and ordinal logistic regression produce similar patterns of results for the discussion of our results.

16 We tested for multicollinearity given its prevalence in the comparative state research and the correlation among some of our independent variables. Although a certain degree of multicollinearity is unavoidable with the type of variables we examined, the tolerance and variance inflation factor for our model suggests that the intercorrelations between our variables are not problematic.

17 The interaction of our two party variables are neither substantively nor empirically significant. As we explained earlier, the legislative and executive branches systematically tend to differ on health reform in terms of its electoral and policy implications. For instance, Tea Party legislators are beholden to one set of political activists and to narrow policy objectives while Republican governors tend to focus on the broader electorate and on balancing the state's budget and maintaining hospitals weighed down by uncompensated care. In addition, our statistical tests for interactions between the two party variations were statistically insignificant.

18 The statistical significance for policy learning improved to $p < 0.088$ when administrative capacity was excluded from the model in table 1; it improved to $p < 0.07$ when both administrative capacity and affluence were removed.

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