

The Politics and Policy of Health Reform
**Expanding Medicaid Access
without Expanding Medicaid:
Why Did Some Nonexpansion States
Continue the Primary Care Fee Bump?**

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Abstract Six states that have rejected the Patient Protection and Affordable Care Act's (ACA) Medicaid expansion nonetheless extended the primary care "fee bump," by which the federal government increased Medicaid fees for primary care services up to 100 percent of Medicare fees during 2013–14. We conducted semistructured interviews with leaders in five of these states, as well as in three comparison states, to examine why they would continue a provision of the ACA that moderately expands access at significant state expense while rejecting the expansion and its large federal match, focusing on relevant economic, political, and procedural factors. We found that fee bump extension proposals were more successful where they were dissociated from major national policy debates, actionable with the input of relatively few stakeholder entities, and well aligned with preexisting policy-making structures and decision trends. Republican proposals to cap or reduce federal funding for Medicaid, if enacted, would compel states to contain program costs. In this context, states' established decision-making processes for updating Medicaid fee schedules, which we elucidate in this study, may shape the future of the Medicaid program.

Keywords Medicaid, access to care, state policy making

In the wake of the Affordable Care Act (ACA), states faced two key policy decisions regarding Medicaid, with the potential to expand access to care for low-income and underserved populations. First, the 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius* (132 S. Ct. 2566) made expanding eligibility criteria to include childless adults and other individuals with incomes below 138 percent of the federal poverty level optional for states. The federal government has promised to

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Table 1 State Decisions on Medicaid Expansion and the Primary Care “Fee Bump”

Continuing Fee Bump	Medicaid	
	Nonexpansion States	Medicaid Expansion States
No	FL, ID, KS, LA, ^a MO, NC, OK, SD, TN, TX, VA, WI, WY	AZ, AR, CA, IL, IN, KY, MA, MN, NH, NJ, NY, ND, OH, OR, PA, RI, UT, ^b VT, WA, WV
Yes	AL, GA, ^{c,d} ME, ^c MS, NE, ^c SC ^{c,e}	AK, CO, CT, ^{c,e} DE, ^c DC, HI, ^c IA, MD, MI, ^c MT, NV, ^c NM

Source: MACPAC 2015: chap. 8; Tollen 2015; and Kaiser Family Foundation 2015

^aMedicaid expansion took place in July 2016, after the authors’ analysis was completed.

^bExpansion under discussion.

^cFees continued in 2015 above pre-fee bump levels but less than 100% of Medicare levels.

^dFees not increased until 2015 legislative session.

^eFees elevated for provider classifications other than primary care physicians, as defined in the Affordable Care Act.

pay 100 percent of these new beneficiaries’ costs for the first three years, with the maximum state contribution phasing up to 10 percent. Nineteen states have resisted expanding Medicaid, declining a significant opportunity to expand coverage and improve access through a demand-side policy (Kaiser Family Foundation 2015).

Second, states could choose whether to extend the ACA’s primary care “fee bump.” The fee bump, which raised Medicaid fees for primary care services up to 100 percent of Medicare fee levels, was intended to incentivize primary care physicians (PCPs) to accept Medicaid patients. This supply-side-oriented provision for improving access was considered particularly important in light of expectations that Medicaid enrollment would grow dramatically as states expanded Medicaid eligibility (Sommers, Swartz, and Epstein 2011). Congress increased reimbursement levels only for 2013 and 2014, the period when it was expected Medicaid expansions would go into effect. The expiration of the fee increase in January 2015 pressured state policy makers to maintain the increase at significant state expense, lest fees fall to their pre-2013 levels (Wilk and Jones 2014).

Seventeen states and the District of Columbia elected to extend the fee bump—fully or partially—into 2015. As shown in table 1, eleven of these states plus the District of Columbia also expanded Medicaid. But six states (Alabama, Georgia, Maine, Mississippi, Nebraska, and South Carolina) extended the fee bump despite rejecting Medicaid expansion.

These decisions present two paradoxes. Without a Medicaid expansion, the principal motivation for the fee bump—to incentivize providers to care for the surging number of new Medicaid enrollees—was undercut in these

states. And in an era of tight state budgets (Pew Charitable Trusts 2016), these states rejected an ACA provision through which they could draw down millions of federal-match dollars but renewed another ACA provision that would require spending additional state funds.

In this article we examine why several states extended the Medicaid fee bump even though they rejected Medicaid expansion and explore how these two decisions were made at the state level. These apparent contradictions highlight the difficulties of achieving policy goals in health care, such as expanding access to care for vulnerable populations, in the face of political discord surrounding the ACA. Through this examination, we also illuminate key features of the state-level policy decision-making processes that are likely to play increasingly large roles in health policy more broadly under the Trump administration.

Scholars have examined why states have adopted or rejected parts of the ACA over which they have some discretion, including health insurance exchanges (Rigby and Haselswerdt 2013; Jones, Bradley, and Oberlander 2014; Béland, Rocco, and Waddan 2016), essential health benefits (Bagley and Levy 2014), health insurance rate review (Fulton et al. 2015; Béland, Rocco, and Waddan 2016), and Medicaid expansion (Jacobs and Callaghan 2013; Jones, Singer, and Ayanian 2014; Béland, Rocco, and Waddan 2016). Not surprisingly, they find Republican-led states more likely to reject major components of the ACA and Democratic-led states more likely to adopt them. However, they have also demonstrated that the politics of implementing the ACA are playing out in different, complex ways for different policies.

To our knowledge, no study has systematically examined how states approached the expiration of the ACA's fee bump. Similarly, we know of no study that documents the processes by which states set Medicaid reimbursement rates. Currently these processes are largely opaque, though they may significantly influence the effectiveness of state Medicaid programs.

Wilk and Jones (2014) identify the dearth of evidence and timing challenges state policy makers faced when deciding whether to extend the fee bump. Important federal guidance was not released until November 1, 2012 (CMS 2012), just two months before the policy was to go into effect. Consequently, most states were playing catch-up and did not fully implement the fee bump until late 2013. This meant that evidence about its effect on physicians' Medicaid participation levels was severely limited by mid-2014, when states were setting reimbursement levels for 2015, after the fee bump would expire.

Evidence concerning the importance of Medicaid reimbursement rates as a driver of access to primary care services for the poor is also substantially

equivocal. Several studies suggest that fee increases have small to moderate effects on PCPs' Medicaid participation levels (Berman et al. 2002; Coburn, Long, and Marquis 1999; Fanning and de Alteriis 1993; Gray, Vandergrift, and McAllister 2015; Perloff, Kletke, and Fossett 1995; Perloff et al. 1997; Wilk 2013; Zuckerman et al. 2004), and emerging studies on the effects of the fee bump itself are similarly mixed (Crawford and McGinnis 2014; Decker 2016; MACPAC 2015: chap. 8; Mulcahy et al. 2016; Polsky et al. 2015). Other factors such as delays in payment, administrative burden, and perceptions of patient difficulty might be equally or more consequential (Cunningham and Nichols 2005; Cunningham and O'Malley 2009; Davidson 1982; GAO 2011; Hadley 1979; Long 2013; Spaulding 2015; Wilk 2013).

States' decisions to extend the Medicaid fee bump's elevated reimbursement rates or allow them to fall back to 2012 levels merit investigation as a uniquely paradoxical case study within the contentious and dynamic policy environment surrounding ACA implementation. We use quantitative and qualitative methods to explore states' decisions on extending the fee bump, relying on work by Béland, Rocco, and Waddan (2016) to organize our analysis. They understand state decisions about implementing the ACA as significantly driven by three factors: public sentiment, institutional fragmentation, and policy legacies. Public sentiment is important in that the extent to which the public opposes the ACA purportedly affects how strongly policies associated with it are resisted. The level of institutional fragmentation—the number of stakeholders involved in a debate, the extent of their competing interests, and the power distribution among them—influences the difficulty level of policy making. Finally, policy legacies, the preexisting pathways for policy making in the state, shape how new debates play out. We conclude by discussing implications for contemporary state health care policy making.

Methods

We began by examining statistical correlations between select quantifiable state-level factors and states' decisions about extending the fee bump across all states. Specifically, we identified the states that did and did not extend the fee bump into 2015 and stratified them by select contextual factors potentially relevant to both decisions, including rates of PCP participation in Medicaid in 2011 (Decker 2012), FY 2015 federal medical assistance percentages (FMAP) (ASPE 2013), Medicaid-to-Medicare ratios of average fee-for-service primary care fees in 2009 (Zuckerman and

Goin 2012), Medicaid managed care enrollment fractions in 2011 (CMS 2011), and party control of state legislatures and governorships in 2014 (NCSL 2016).

Of particular interest, the FMAP and pre-ACA Medicaid-to-Medicare ratios determined how much it would cost a state to keep fees elevated. Similarly, the cost projections for continuing the fee bump in states with greater managed care enrollment fractions might appear to be smaller, and so the proposals would be more attractive, because the cost of the fee bump would be obscured when passed through managed care organizations' capitation rates (versus when paid directly to PCPs).

We also used an interpretive comparative case study approach to better understand factors that influenced states' decisions concerning Medicaid expansion and extending the fee bump (Kaarbo and Beasley 1999). Between September 2015 and January 2016, we conducted semistructured interviews with key informants in five of the six states that opted out of Medicaid expansion but extended the fee bump: Georgia, Maine, Mississippi, Nebraska, and South Carolina. We declined to conduct interviews in the sixth state meeting these criteria—Alabama—because it strongly matched other states in our study along key dimensions and, we believed, was unlikely to yield substantially new information. We also identified three comparison states with demographics and political dynamics similar to these five but that took a different approach with respect to the two Medicaid decisions. We compared New Hampshire to Maine; Kansas to Nebraska; and North Carolina to Georgia, Mississippi, and South Carolina.

We interviewed legislators, Medicaid officials, and key personnel at state provider organizations and Medicaid managed care organizations in our case and comparison states. In total, we conducted twenty-nine interviews, interviewing between three and five stakeholders in each state. Interviewees agreed to participate with the condition that we kept their identity private. Therefore, we report our key findings in general terms, except insofar as relevant details are public knowledge.

Results

Descriptive Analysis

Our quantitative findings (table 2) are divided into three categories: all states, states that expanded Medicaid, and states that did not expand Medicaid. Among all states, the proportions of Medicaid expansion states (12 of 32, 38 percent) and nonexpansion states (6 of 19, 32 percent) extending the fee bump were comparable. States with a Medicaid-to-

Table 2 States Extending the Primary Care Fee Bump into 2015: All States, Medicaid Expansion States, and Medicaid Nonexpansion States

Characteristic	States Extending Fee Bump [<i>n</i> (%)]		<i>p</i> < <i>t</i>
	With Characteristic	Without Characteristic	
All states			
Any	18 (33%, <i>N</i> = 51)	—	—
Medicaid expansion	12 (38%, <i>N</i> = 32)	6 (32%, <i>N</i> = 19)	0.67
FMAP ≥60%	10 (38%, <i>N</i> = 26)	8 (32%, <i>N</i> = 25)	0.63
Medicaid-to-Medicare primary care fee ratio ≥0.81 in 2009	6 (50%, <i>N</i> = 12)	12 (31%, <i>N</i> = 39)	0.25
Medicaid managed care enrollment ≥85% in 2011	9 (47%, <i>N</i> = 19)	9 (28%, <i>N</i> = 32)	0.18
≥70% of PCPs accept new Medicaid patients in 2011	12 (38%, <i>N</i> = 32)	6 (32%, <i>N</i> = 19)	0.67
Medicaid expansion states			
FMAP ≥60%	5 (38%, <i>N</i> = 13)	7 (37%, <i>N</i> = 19)	0.93
Medicaid-to-Medicare primary care fee ratio ≥0.81 in 2009	4 (67%, <i>N</i> = 6)	8 (31%, <i>N</i> = 26)	0.14
Medicaid managed care enrollment ≥85% in 2011	5 (50%, <i>N</i> = 10)	7 (32%, <i>N</i> = 22)	0.34
≥70% of PCPs accept new Medicaid patients in 2011	8 (36%, <i>N</i> = 22)	4 (40%, <i>N</i> = 10)	0.85
Medicaid nonexpansion states			
FMAP ≥60%	5 (42%, <i>N</i> = 11)	1 (13%, <i>N</i> = 8)	0.10
Medicaid-to-Medicare primary care fee ratio ≥0.81 in 2009	0 (0%, <i>N</i> = 6)	6 (46%, <i>N</i> = 13)	0.01
Medicaid managed care enrollment ≥85% in 2011	4 (44%, <i>N</i> = 9)	2 (20%, <i>N</i> = 10)	0.26
≥70% of PCPs accept new Medicaid patients in 2011	4 (40%, <i>N</i> = 10)	2 (22%, <i>N</i> = 9)	0.40

Source: Authors' analysis of data compiled from Kaiser Family Foundation 2015, Tollen 2015, Decker 2012, ASPE 2014, Zuckerman and Goin 2012, and CMS 2011

Notes: All analyses include the District of Columbia. FMAP=federal medical assistance percentage; PCP=primary care physician.

Medicare fee ratio greater than 0.81 in 2009 were more likely to extend the fee bump (6 of 12, 50 percent) than were states with a lower ratio (12 of 39, 31 percent). Similarly, states with greater Medicaid managed care enrollment (9 of 19, 47 percent) were more likely to extend the fee bump than their counterparts (9 of 32, 28 percent).

These trends do not differ markedly within the subsample of Medicaid expansion states. However, our results for nonexpansion states are different. Those with higher FMAs (5 of 11, 42 percent) were more likely than states with lower FMAs (1 of 8, 13 percent) to extend the fee bump. Interestingly, nonexpansion states with higher Medicaid-to-Medicare fee ratios (0 of 6, 0 percent) were substantially less likely to extend the fee bump than those with lower fee ratios (6 of 13, 46 percent).

Additionally, nonexpansion states that extended the fee bump had a partisan composition similar to that of states that rejected both the expansion and the fee bump (fig. 1). Eleven of the thirteen states (85 percent) that rejected both were controlled entirely by Republicans in 2014, compared to 80 percent (4 of 5; we exclude Nebraska because it has a nonpartisan unicameral legislature) of nonexpansion states extending the fee bump. No nonexpansion state that extended the fee bump had a Democratic governor in 2014.

Broadly, our descriptive analysis shows that nonexpansion states that extended the fee bump looked different from expansion states that extended the fee bump in terms of FMAP rates and Medicaid-to-Medicare fee ratios, and they looked similar to all nonexpansion states in terms of partisan composition.

Qualitative Analysis

Public Sentiment

The debate over expanding Medicaid was intense, high profile, and polarizing in every state we examined. Because a fee bump extension, like Medicaid expansion, could rightfully have been framed as an endorsement of a key ACA provision, advocates of maintaining increased Medicaid fees were presented with a dilemma. While the expiration of the ACA's fee increase provided a unique opportunity to propose increasing reimbursement rates, openly connecting the fee bump to the reform could make their efforts vulnerable to anti-ACA sentiment. There was a risk that conservative legislators and Tea Party advocates focused on other issues would mobilize against the fee bump if a linkage between the ACA and the fee bump in public proceedings attracted more public attention.

We found that supporters of the fee bump often strategically avoided framing their proposals as driven by the ACA, and deliberations about extending the fee bump mostly happened out of the public eye. In Georgia, proponents of extending the fee bump mentioned its connection to the ACA

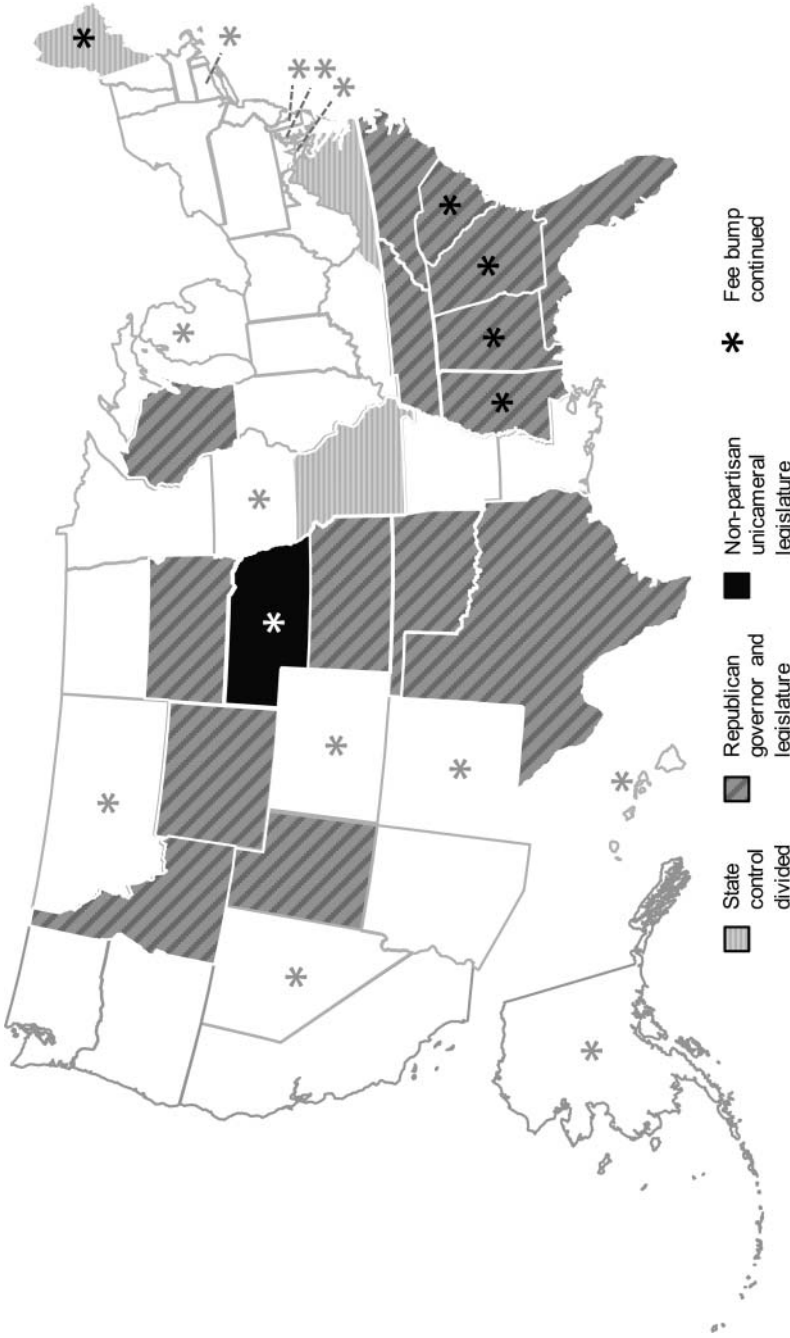


Figure 1 Nonexpansion States' Partisan Composition and Decisions on the Primary Care "Fee Bump" (2014)

Source: MACPAC 2015; chap. 8; Tollen 2015; and NCSL 2016

Note: Medicaid expansion is currently under discussion in Utah. Nebraska is excluded from descriptive analyses of partisan composition because its unicameral legislature is officially nonpartisan.

Medicaid expansion took place in July 2016, after authors' analysis was completed.

in their failed 2014 proposals but removed these references from their successful proposal during the 2015 legislative session. In other states, policy makers had been largely unaware of the connection to the ACA. In Nebraska, for example, interviewees recalled that Medicaid expansion debates were tightly linked to the ACA, but the fee bump was a separate discussion.

The successful fee bump extension proposals in Maine, Mississippi, and South Carolina also excluded ACA mentions. In these states and in Nebraska, interviewees reported that fee bump extension advocates moved their proposals forward smoothly as part of the routine legislative processes by which Medicaid fee schedules are updated annually. South Carolina advocates framed the policy as increasing access and prevention, which even opened the door for enhancing reimbursement levels for obstetricians, gynecologists, and generalist psychiatrists in addition to PCPs.

The difference in public awareness of the two debates also affected how policy makers and advocates interpreted cost estimates for each policy proposal. While cost was identified as a principal consideration for both proposals, Medicaid expansion cost (or savings) estimates were especially large in magnitude. These estimates often indicated that by expanding Medicaid states would draw down substantial sums of money, particularly given the program's large federal match. However, several interviewees recalled that state leaders vehemently opposed Medicaid expansions even when presented with this evidence; interviewees often linked this reasoning to ideological opposition to the ACA overall.

Leaders opposed to expansion would often point to the Medicaid expansion proposal's projected direct costs—as much as \$5 billion over ten years in a larger state. Moreover, many state leaders anticipated additional costs, as they did not trust the federal government to follow through with its commitment to fund at least 90 percent of Medicaid expansion populations' costs over the next decade. (Recent uncertainty over the ACA's future suggests their concern may have been warranted—not because their opponents abdicated on promises, but because their allies are keen on cutting the program.)

Advocates of the fee bump did not have the advantage of being able to claim large financial benefits to the state. Raising reimbursement levels would cost the state money, with the federal government covering only the portion of these increased fees determined by established FMAP rates. The prospect of advocating for a fee bump extension using a cost-based argument was particularly daunting in some states, like Kansas and North Carolina, where the sentiment was widespread that Medicaid was a “broken

program” in need of reform and any such investment would be “throwing good money after bad.”

In some states, including New Hampshire, fee bump advocates considered uniting the Medicaid expansion and fee bump extension proposals and their associated debates but ultimately decided against it. New Hampshire had little money to spend, as it does not draw revenue from sales or income taxes. Consequently, advocates sought to offset the costs of increasing primary care fees as part of negotiations over Medicaid expansion, given that Medicaid expansion was projected to have a net-positive budget impact. However, they allowed the fee bump proposal to fall away when the Medicaid expansion debate became more contentious, not wanting to risk tainting the fee bump proposal with the tensions over expansion or to further complicate already heated deliberations. One advocate recalled, “Ultimately, the debate over expansion became so big that the discussion of PCP fee levels was a distraction. There was no traction and no vehicle for funding.”

On the other hand, although our Nebraska interviewees reported that Medicaid expansions and the fee bump were not debated one versus the other, their decisions to reject Medicaid expansion and to extend the fee bump were both informed by assessments of state costs. As one advocate observed, the legislature had viewed the cost trade-offs for Medicaid expansion with the perspective of “we can’t do that,” while they had viewed the potential of the fee bump to improve Medicaid services and access as “a big bang for the buck.”

Institutional Fragmentation

The degree to which institutional fragmentation was present in the Medicaid expansion and fee bump extension debates varied. In all states we examined, the Medicaid expansion debate included many vocal stakeholders: the governor, the legislature, Medicaid agencies, physicians’ advocacy groups, patients’ advocacy groups, hospital groups, and think tanks. The fee bump discussions, by contrast, typically included only a few of these groups: state legislators or the governor’s office, the Medicaid agency, and provider groups. The involvement of other entities was rare.

The fee bump debate proceedings routinely mirrored the relatively simple, rote process of updating Medicaid physician fee schedules. In this process, the Medicaid agency provides an initial budget proposal, which may be adjusted through consultation with the governor’s office. The legislature then receives the administration’s budget proposal, which in

some cases includes line items for elements such as Medicaid rates, but in other cases aggregates budget items together at a higher level. The legislature uses the administration's proposal as a starting point for developing the state's budget. Leaders in both branches of government receive input from provider groups along the way.

Importantly, this process varied across states in terms of the extent of the input and direction the Medicaid agency received from the legislature or governor's office. In some cases, there was heavy involvement before the initial proposal was submitted. Informants in North Carolina and Kansas, which ultimately did not extend the fee bump, indicated that the legislature had instructed the Medicaid agency not to include a fee bump extension in its budget proposal. An advocate in North Carolina, for example, recalled that the legislature had informed the state Medicaid agency that any proposal to extend the fee bump would be "a nonstarter."

On the other hand, some legislatures gave Medicaid leaders greater discretion to shift money to physician fees if they considered it a high priority and were willing to divert money from other places. For example, an advocate in New Hampshire explained, "The final reimbursement level is incredibly removed from the legislature." Consistent with previous findings in related Medicaid policy-making contexts (Grogan 1994), fee bump extension proposals were more successful in states where informants indicated Medicaid agencies had retained greater authority in setting physician payment rates (e.g., Mississippi) or where Medicaid agencies and legislatures shared authority (e.g., South Carolina).

Legislators in Georgia, Maine, and South Carolina exerted some control over the costs of fee bump extension proposals by extending the fee bump only partially. These states passed budgets setting primary care fee levels between their 2012 (pre-fee bump) levels and Medicare levels. In one case, Georgia declined to pass a fee bump extension by January 1, 2015, in part because of its estimated costs and in part out of hopes the federal government would itself fund the fee bump extension. During the 2015 legislative session, however, a compromise was reached by which Medicaid fees would be raised to 90 percent of Medicare levels; this law's projected costs of \$21 million were significantly less than the \$65 million estimated for a full fee bump extension.

In some states, such as Nebraska, we received conflicting information about how much leeway Medicaid leaders there had. This suggests that the role of key players and the level of autonomy for the executive branch are not always cut-and-dried. The ultimate balance may largely depend on the particular people involved, the issue at hand, the extent to which an agency

tries to push the envelope, and how firm the legislature and governor are in enforcing boundaries.

Interest groups—principally state provider advocacy organizations—were also actively involved in this process, lobbying governors, agencies, and legislatures in support of fee bump extension proposals. In some states interviewees representing organizations that supported both Medicaid expansion and the fee bump indicated they would have been happy to win at least one of these battles. In other states, provider groups were divided internally over Medicaid expansion but unanimously supportive of the fee bump and so chose to lobby hard for the fee bump only. Moreover, in Kansas, provider organizations opted not to expend political capital in either debate, believing the proposals would fail because of the tumultuous climate around health reform. A stakeholder reported, “It was a rough year [for providers], and they were trying to keep a low profile.”

Interviewees in all states suggested that managed care organizations did not play a meaningful role in deliberations about the fee bump, and our informants within these organizations expressed indifference as to whether the provision would be extended.

Policy Legacies

Policy legacies, or path dependence, in Medicaid fee setting also affected how states decided whether or not to extend the fee bump. It was easier to initiate discussions of raising fees for primary care services in states where the legislature had approved slight increases in physicians’ fees each year routinely (e.g., Mississippi, Nebraska). By contrast, it was more difficult to propose extending the fee bump in states with extended histories of flat or declining Medicaid fee levels (e.g., Georgia, North Carolina, Kansas). In Georgia, for example, the state’s Medicaid agency did not include a fee bump extension in its 2015 budget proposal; rather, it waited for pertinent requests from the governor’s budget office before offering information about the fee bump.

Budgetary flexibility, significantly the result of myriad policy choices over many years, was a necessary condition for deliberations on extending the fee bump to proceed. In New Hampshire and Kansas, for example, low tax revenues and tight state budgets precluded meaningful discussion of any cost-increasing initiatives to improve access to care for low-income groups. And in North Carolina, Medicaid budgets were strictly managed (pending substantive efforts to reform the program overall); consequently, any increase in fees for primary care services would have to be offset by

corresponding decreases in fees for specialty care or other services—a divisive proposition.

By contrast, one interviewee intimated that Nebraska had passed the fee bump extension because the legislature determined the state had the financial means to sustain the increases over time. In states like Nebraska with sufficient budgetary flexibility for the fee bump debate to proceed, the cost estimates presented for Medicaid fee bump extension proposals—between \$4 million and \$65 million per year—were demonstrably lower than what could be projected for Medicaid expansions (in direct costs alone). Interviewees highlighted that the reasons these fee bump cost estimates were low included relatively high Medicaid fees paid for primary care services historically (as in Mississippi and North Carolina) or relatively small state contributions for fee increases in light of high FMAP rates (as in Mississippi and South Carolina), consistent with findings from our descriptive analysis.

Policy legacies also affected the influence of key interest groups in some states. Unique established characteristics of primary care practices in some states worked against their professional associations' lobbying efforts. For example, 90 percent of PCPs in New Hampshire are employed by hospitals. This increased the role of hospitals in fee bump deliberations but also gave the state greater leverage to resist increases: legislators knew very few hospital-affiliated providers would stop accepting Medicaid patients if fee levels were not increased.

Discussion

The rationales for states enacting both Medicaid expansions and fee bump extensions, seeking to improve access to care by multiple means, and for states enacting neither—total ACA aversion—seem straightforward. However, the rationales for states enacting one provision and not the other are less apparent. In this study we investigated why some nonexpansion states elected to extend the fee bump into 2015, focusing on economic, political, and procedural factors that may have influenced how states have pursued and enacted ACA-related policies.

A few themes emerged concerning the role of public sentiment and debate salience in these states. First, it is possible for states to advance goals consistent with those of key ACA provisions, even if it means avoiding mentioning the ACA altogether in the face of strong opposition to the law; instead, fee bump extension advocates framed these proposals as advancing causes of access and prevention or as part of the typical, annual

processes of updating Medicaid's fee schedules. By contrast, Medicaid expansion proposals' linkages to the ACA were inextricable. The feasibility of this strategy likely depends on the nature of the policy in question: it will be more difficult for high-visibility redistributive policies to move forward in this way than for low-visibility distributive policies.

Our results also showed that, in most cases, both expansion and non-expansion states were more likely to extend the fee bump where the direct financial costs of doing so were lower. This reflection of lawmakers' cost sensitivity may also be helpful for understanding why states with greater managed care enrollment were more likely to extend the fee bump. Projected costs for fee bump extension proposals in these states might appear to be smaller, and so the proposals would be more attractive, with larger shares of the fee bump's increased payouts obscured as part of managed care organizations' capitation rates (vs. when paid directly to PCPs in a fee-for-service Medicaid program).

The role of interest groups in the legislative process may explain an unexpected finding that, among nonexpansion states, fee bump extensions were more common where historical fees were lower. In states that rejected Medicaid expansion—to the disappointment of provider organizations advocating strongly for it—and also paid relatively low primary care fees in Medicaid, policy makers may have considered extending the fee bump, even partially, as a way to appease providers.

States' decisions about the fee bump were also influenced by the number and inclinations of involved stakeholders, heterogeneous Medicaid fee-setting processes, and whether state legislatures and governor's offices tended to follow the lead of their state Medicaid agencies regarding budget proposals and fee schedule updates. Compared to the Medicaid expansion debates, decisions regarding the fee bump were limited to a few key stakeholders commonly involved in making similar decisions. The varying levels of attention from the public and interest groups are partly explained by the differences in the nature of the policies. Debates over redistributive policies, such as Medicaid eligibility, attract more attention than do fights over regulatory issues, such as reimbursement levels.

Finally, we found that several preexisting state-specific policies, such as FMAP levels, pre-ACA fee levels, and Medicaid managed care enrollment rates, were associated with states' decisions regarding the fee bump. Other policy legacies, such as established flexibility in state budgets and an established pattern of regular fee increases in some states, also played a role.

Our study has several limitations. First, our study focuses on the experiences of eight states. Our inferences may not generalize elsewhere, particularly to states that expanded Medicaid. Second, many of our findings

concern the relationships between state legislatures and Medicaid agencies. Because of the unique qualities of Medicaid programs (e.g., the size of Medicaid's footprint in state budgets), our findings may not generalize to policy-making efforts involving other public health agencies or programs. Moreover, we are not privy to the nature and content of all communications among key stakeholders, and thus our understanding of the relationships among them is necessarily incomplete. Our informants' reflections on these dynamics may have been imprecise (e.g., due to imperfect recall) or influenced by the outcomes of the ensuing legislative processes. Moreover, we were unable to determine whether the insights of individuals who declined to participate in this study would have significantly affected our conclusions. Finally, we could not identify a causal relationship between key variables and state decisions about the fee bump. The small cell sizes and cross-sectional nature of the data used in our descriptive analyses likewise could not support such inferences.

Moving forward, the Trump administration's and Congress's actions regarding the ACA, Medicaid, Medicare, and other health-related policies are likely to reshape the terms of public policy debates on health. If the new president's unpopularity transfers to the legislation he signs—or if the laws are unpopular in their own right—our findings about how health policy advocates advanced their agendas during ACA implementation may also transfer: proposals may be more successful if dissociated from major national policy debates, actionable with the input of relatively few stakeholder entities, and well aligned with preexisting policy-making structures and decision trends.

Of course, Congress could end states' debates concerning the future of the fee bump by funding a nationwide extension of the provision. Hope of federal action to extend the fee bump was virtually nonexistent among our interviewees, reflecting Congress's general inaction on this issue. Rather, Republican leaders' proposals to cap or reduce funding for Medicaid would, if enacted, reinforce states' prominent role in shaping the Medicaid program as they take action to contain costs. State leaders have limited tools to manage their Medicaid budgets: eligibility, benefits, and reimbursement rates. Consequently, if many states desire to maintain levels of coverage and benefits in their Medicaid programs, they may resort to lowering fees still further below what Medicare and private insurers pay. How far fee levels would fall would be determined significantly by states' established decision-making processes for updating Medicaid fee schedules. Thus, a refined understanding of these processes and the political and institutional factors that influence them is important for anticipating the future of the Medicaid program.

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