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AM J HOSP PALLIAT CARE published online 8 July 2013
DOI: 10.1177/1049909113494460

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What is This?
Factors Influencing the Implementation of Health Care Reform: An Examination of the Concurrent Care for Children Provision

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Abstract
In the wake of the 2013 Presidential reelection, states now face the reality of implementing the healthcare reform, including ACA section 2302 (Concurrent Care for Children). The purpose of our study was to examine the influence of economic, political, and legal factors on state implementation of ACA 2302. Using data from 2010 to 2012, our analysis revealed that for early implementers economic, political or legal factors did not influence implementation of ACA 2302. In 2011, states that were engaged in Medicaid cost containment efforts were more likely to implement ACA 2302 and in 2012, states experiencing a budgetary crisis were less likely to implement ACA 2302. Our findings suggest that state-level implementation of ACA 2302 may be an important bellwether for future healthcare reform implementations.

Keywords
current care for children, hospice care, health care reform, children, end of life, ACA 2302

In the wake of the 2013 reelection of President Barack Obama, states now face the reality of implementing the Patient Protection and Affordable Care Act (ACA) of 2010.\textsuperscript{1,2} Although many of the provisions will go into effect in 2013 and 2014, several of the health care reform provisions became law upon signing. The ACA section 2302 (Concurrent Care for Children) was enacted on March 23, 2010. This mandatory provision states that children enrolled in the Medicaid or Children’s Health Insurance Plan (CHIP) hospice benefit may receive care related to their terminal illness concurrently with hospice care.\textsuperscript{3} In other words, Section 2302 eliminates a hospice eligibility requirement that children must forego curative care upon being admitted to hospice.\textsuperscript{4} Curative care may include dialysis, chemotherapy, radiation, and transplant rejection medications. However, children must still be certified with a life expectancy of 6 months or less by an attending physician or nurse practitioner to obtain hospice care.\textsuperscript{5} The ACA 2302, therefore, provides an important modification to hospice eligibility for terminally ill children.

Implementing federally mandated policy at the state level can be complicated, and there are often economic, political, and legal factors that impact whether or not a state implements legislation.\textsuperscript{6} For example, states facing economic turmoil (eg, budgetary crisis, Medicaid cost containment) may be less likely to implement a Medicaid/CHIP provision that has the potential to increase costs by expanding coverage for terminally ill children.\textsuperscript{7-9} In addition, given the environment of political polarization, states that are governed by Republicans (eg, governors, legislatures) may be politically motivated to not implement a provision of health care reform that is so closely associated with democratic President Barack Obama.\textsuperscript{8,10-12} Finally, states may not want to set legal precedent by accepting a health care reform provision, so they may choose to not implement any section of the law.\textsuperscript{13,14} This interplay of economic, political, and legal factors may affect implementation of Concurrent Care for Children.

Few studies have examined the Concurrent Care for Children provision. Our earlier research explored the intended goals of ACA 2302 to improve access to pediatric end-of-life care and enhance quality of care for children while ensuring political feasibility.\textsuperscript{15} The analysis found that utilization of hospice care may be more acceptable and affordable for children and their families once the choice between curative and hospice care was eliminated. We also found that effectiveness and patient centeredness of end-of-life care may improve with the incorporation of evidence-based practices.

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in the delivery of care for terminally ill children. However, we suggested that there may be issues with care coordination and equity of care, especially for children not covered by ACA 2302 (eg, children on private insurance). From a policy perspective, it was hypothesized that state-level implementation of the provision would be generally straightforward because of states’ prior experience legislating federally mandated modifications to Medicaid and CHIP programs. Miller et al investigated case studies of clinical implementation of ACA 2302. They identified 5 types of challenges for implementing the law including knowledge of pediatric end-of-life care, opinions of pediatric end-of-life care, complexity of care coordination, reimbursement for durable medical equipment, and insurance complexities. They suggested that clinical implementation of Concurrent Care for Children may require the coordinated efforts of clinicians to effectively communicate and ensure that children are receiving concurrent care at end of their lives. Overall, the aforementioned research suggests that there are opportunities and challenges to ACA 2302 implementation. There was no research, however, that investigated the association between economic, political, and economic factors and state-level implementation of Concurrent Care for Children.

Knowledge of the factors that influence the implementation of ACA 2302 has significant policy relevance. The Concurrent Care for Children provision may be an important bellwether for future health care reform legislation. Understanding the economic, political, and legal factors may assist policy makers at the federal and state levels in easing the implementation of complicated provisions such as health care exchanges with new or modified legislation. Likewise, identifying factors that have no impact may diffuse tensions at the state level around implementing upcoming provisions. The findings of a study examining ACA 2302 can also inform the actions of the states to fully implement Concurrent Care for Children. Therefore, the purpose of this study was to examine the influence of economic, political, and legal factors on the implementation of ACA 2302 at the state level.

Model and Hypotheses

Figure 1 depicts the conceptual model of ACA 2302 implementation as a function of economic, political, and legal factors. Economic factors relate to the broad economy of the state. State budgetary crisis status was included in our model because states in financial crisis often focus on managing their budget problems and do not focus on new programs or program enhancements that the state must deliver. States that implement cost-containment strategies are generally not interested in adding to a program that they are cutting. Thus, Medicaid cuts was included in our model. Political factors relate to the politics of governing a state. Governor party and legislature party were included in the model because Republican governors and legislatures may be motivated in a politically charged environment, such as prior to the presidential election, to thwart health care reform initiatives that were initiated by a democratic president. Legal factors are the government policies and administrative practices present in state government. States that have prior experience with implementing pediatric end-of-life legislation may be motivated to implement federally mandated changes, especially if the new law is perceived as improving access and quality of pediatric end-of-life care, so pediatric legislation was included in the model. Although the Supreme Court upheld the health care reform law on June 28, 2012, ACA lawsuit was included because states that were engaged in the federal lawsuit against health care reform prior to the Supreme Court decision may not want to set precedent by accepting a health care reform provision. States that have Certificate of Need (CON) laws, such as hospice CON, may have the infrastructure to implement changes affecting state hospice providers, so CON was included in the model. Thus, our conceptual model emphasizes that economic, political, and legal factors are directly related to state implementation of ACA 2302. We hypothesize that:

Hypothesis 1: Economic factors (ie, budget crisis, Medicaid cuts) will be associated with state ACA 2302 implementation.
Hypothesis 2: Political factors (ie, governor party, legislature party) will be associated with state ACA 2302 implementation.
Hypothesis 3: Legal factors (ie, pediatric legislation, ACA lawsuit, certificate of need) will be associated with state ACA 2302 implementation.

Methods

Data Sources and Sample

Several publicly available data sources were used for this study (Table 1). State Medicaid documents from 2010 to 2012 including hospice provider announcements, informational letters, administrative rule change notices, provider bulletins, policy statements, and policy manuals were used to identify state-level implementation of ACA 2302. The Center on
Budget and Policy Priorities surveys was used to identify states in budget crisis. The Kaiser Family Foundation 50-State Medicaid Budget Survey for State provided data on 2010 to 2012 state-level Medicaid cost containment. The National Governor’s Association was the source of 2010 to 2012 political affiliation of state governors, and the National Conference of State Legislatures was the source of 2010 to 2012 state legislature political affiliation. Data on state-level experience with pediatric end-of-life legislation were obtained from the Children’s Hospice International. The 2010 to 2012 National Conference of State Legislatures report was the data source for state involvement in health care reform lawsuits and CON status.

This study used the population of 50 states. Individual analyses were conducted for each year of the study (ie, 2010, 2011, and 2012), and states were excluded from the analysis after they implemented ACA 2302. The institutional review board of the University of Tennessee, Knoxville, approved this study.

**Measures**

Table 1 also includes the study variables and definitions. Further explanation of the variables is discussed in the subsequent section.

**Dependent Variable.** The *ACA 2302 implementation* was defined as whether or not a state implemented the Concurrent Care for Children provision in a given year.

**Independent Variables.** A group of variables were composed based on economic factors. *Budget crisis* was operationalized as whether or not a state had an annual budget shortfall greater than 10%. A binary measure of *Medicaid cuts* was created based on whether or not the state implemented provider payment changes, pharmacy controls benefit reductions, eligibility cuts, changes to application and renewal, changed copayments, or modified long-term care programs within the state Medicaid program in a given year.

Another group of variables was developed for political factors. *Governor party* was operationalized as whether or not a state governor was affiliated with the Republican political party. *Legislature party* was defined as whether or not the state legislatures were controlled by Republicans.

A final group of variables captured legal factors. *Pediatric legislation* was defined as having past experience with pediatric end-of-life legislation in state law. This variable, derived from Children’s Hospice International, was measured as a yes/no response to the question of whether the state had prior legislative experience. Whether or not a state participated in a federal lawsuit against ACA was the measure of ACA lawsuit. The *CON* was defined as whether or not a state had a CON law.

**Data Analysis**

Our question of interest was whether there was a relationship between economic, political, and economic factors and ACA 2302 implementation. Descriptive statistics were obtained on all study variables. A linear probability model (LPM) was used to estimate the associations between factors and ACA 2302 implementation. Separate regression models were specified for each year of the study. The LPM regression analyses are presented as unstandardized coefficients with Huber-White standard errors. All analyses were conducted using Stata 11.0 software (Statacorp LP, College Station, Texas).

**Results**

Figure 2 displays the map of ACA 2302 implementation among the states. From 2010 to 2012, we identified 31 of 50 states that
implemented ACA 2302. In 2010, 9 states implemented the Concurrent Care for Children provision. These included Alabama, Arizona, Hawaii, Maine, Massachusetts, Missouri, Oklahoma, Texas, and Wisconsin. In 2011, 14 states implemented ACA 2302 including California, Delaware, Idaho, Iowa, Kansas, Maryland, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, Oregon, and Washington. The 8 states that implemented ACA 2302 in 2012 were Arkansas, Illinois, Indiana, Kentucky, South Carolina, Utah, Vermont, and West Virginia.

Characteristics of the states studied are shown in Table 2. Over the time frame of the study, our sample decreased each year conditional on prior year implementation of ACA 2302. It was common for states to experience budgetary crisis in years 2010 (74%) and 2011 (68.3%), which diminished in the 2012 (18.5%) sample. The percentage of states that made cuts in Medicaid also decreased from 2010 (90.0%) to 2012 (85.2%). A majority of remaining states in the 2012 sample had Republican governors (63%) and Republican controlled legislatures (55.6%). States’ experience with prior pediatric end-of-life legislation remained relatively stable through the years (24.0%, 26.8%, and 25.9%, respectively). At the beginning of the study, 42% of the states participated in the lawsuit against ACA; however, by 2012 over half (55.6%) of the remaining sample were suing the federal government. Finally, most states in each year of the study had CON laws (72.0%, 70.7%, and 66.7%, respectively).

The results of the regression analyses estimating the associations between economic, political, and legal factors and ACA 2302 implementation are shown in Table 3. Economic factors were significantly related to implementation of ACA 2302.
In 2011, conditional on states not implementing in 2010, states that were engaged in cost-containment efforts within their Medicaid programs were more likely to implement ACA 2302 compared to states that were not cutting Medicaid costs ($\beta = .01, P < .01$). However, in 2012, conditional on not implementing in 2011, states experiencing a budgetary crisis were less likely to implement ACA 2302 compared to states not in budget crisis ($\beta = -.38, P < .05$). There was no association between political and legal factors and state implementation of ACA 2302 in any year of the study.

### Discussion

As one of the first studies to examine the implementation of health care reform at the state level, the goal of our study was to understand the influence of economic, political, and legal factors on implementation of Concurrent Care for Children (ACA 2302). Based on our descriptive analysis, we found that over a 3-year period the highest proportion of states implementing ACA 2302 were in the south and the lowest proportion was in the western region of the United States. Our results are consistent with Medicaid enrollment figures for children in these areas. The states in the southern region of the United States have a substantial number of children on Medicaid, whereas the number of children enrolled in Medicaid among western states is relatively low. This evidence suggests that state implementation of ACA 2302 was generally congruent with the Medicaid population served.

Our descriptive findings also highlighted the economic and political situation of states at the end of the Great Recession (December 2007 to June 2009). Similar to other reports, we found that by 2012 the economy showed signs of improvement, while at the same time political shifts occurred in the states. It is interesting to speculate whether or not many of the changes in political leadership resulted from the poor economy of the state, which seemed to correct itself before the change in political leadership happened. Our data did not allow us to investigate this question; however, future research might explore further the link between the economy and the political elections during this volatile recessionary time.

The regression analysis revealed that for early implementers in 2010 there were no economic, political, or legal factors that affected whether a state implemented ACA 2302. The conventional wisdom that politics and the ACA lawsuits would prohibit states from implementing any portion of health care reform did not hold up. One reason may be that lawmakers did not want to be viewed by their constituents as acting against the interests of terminally ill children. Although many state government officials are interested in swaying public opinion against health care reform, politicians understand how to maneuver around politically sensitive issues. For those politicians interested in reelection, denying access to concurrent care for terminally ill children may not be a vote-getting action. An alternative explanation may relate to the states’ experience in legislating federally mandated modifications to Medicaid and CHIP programs. It is relatively common for states to receive annual Medicaid and CHIP program change notices. In this case, the Department of Health and Human Services not only issued a notice, but also included the actual Concurrent Care for Children policy language for the state Medicaid and CHIP plans. Thus, the states that implemented in 2010 may have just taken the new law that was given to them and simply implemented based on standard operating procedures.

In 2011, however, we found contrary to our expectations that political and legal factors continued to not influence state implementation and that states engaged in Medicaid cuts were more likely to implement the law. A possible explanation is that states may have viewed Concurrent Care for Children as cost neutral. The ACA 2302 does not require states to set up a program structure with personnel, forms, and infrastructure. Instead, the provision may be administered within a state’s current Medicaid and CHIP program, thereby adding no administrative expense. In addition, ACA 2302 may only add the cost of the hospice benefit to the overall expenditures of pediatric Medicaid and CHIP beneficiaries who typically have care that costs approximately US$80 000 during the last year of life.
The cost of hospice care is generally low compared to treating the child’s health condition in acute and primary care and is based on a fixed per-diem expense that the state Medicaid and CHIP programs pays. Therefore, Medicaid administrators may have considered the implementation of ACA 2302 to have relatively little impact on the state budget.

By 2012, our analysis showed that states experiencing budgetary crisis were less likely to implement ACA 2302. One reason for this finding may relate to federal funding. The American Recovery and Reinvestment Act of 2009 (ARRA) issued federal stimulus funds aimed at improving the economic situation of states in the wake of the Great Recession. Although ARRA was amended with the ARRA Enhanced Medicaid Match in 2010, states may not have felt the full loss of ARRA funds in their economies until 2012. In addition, many states received federal funding through the 2009 CHIP reauthorization act. Some states were able to expand coverage for children, but others were unable to provide their share of the funds. These funds may have created a fragile financial buffer for Medicaid and CHIP programs that, once gone, resulted in states making deep cuts and containment efforts, including not implementing ACA 2302. Future research studying the state economic environment and ACA implementation is warranted.

This study has several limitations. First, we used primary data sources to identify state implementation of ACA 2302, but states may not have made these records publicly available. Although we did a comprehensive search for state documents including follow-up phone calls to state Medicaid offices verifying whether or not they had made publicly available documents on ACA 2302, it is possible that a state implemented ACA 2302 and did not communicate. Second, this study was limited to 3 years. Experts in longitudinal research suggest that a minimum of 3 years is required to effectively examine change over time; however, others have recommended that a minimum of 6 years of data are needed after a baseline measurement to obtain statistically reliable results showing change. Nonetheless, our findings are based on the most currently available data. A final limitation is the potential for endogeneity that refers to an independent variable being included in the model that may be correlated with the error term. For example, whether or not a state experienced a budget crisis may be correlated with unobservables that affect implementation of ACA 2302. However, we performed the Durbin-Wu-Hausman test of endogeneity and found no endogeneity bias in our estimates.

Despite these limitations, our study of ACA 2302 implementation has relevant policy implications. The Concurrent Care for Children provision is an important bellwether for future health care reform implementations. Our findings that politics and lawsuits did not influence the implementation of ACA 2302 suggest the heated, political rhetoric of “Obama-care” may not have influenced implementation of a health care reform provision. In addition, our results on the effect of economic factors on implementation suggest that money mattered. The economic health and well-being of the state has a significant impact on whether or not states implemented even one of the smallest of health care reform provisions—Concurrent Care for Children. As lawmakers are confronted with the implementation of the upcoming health care reform provisions, they might find guidance from this analysis that state economic conditions require special attention before health care reform provisions are enacted. In other words, cleaning up a state’s financial house may ease the implementation of health care reform in the future.

In summary, our study is one of the first to explore the state-level factors related to implementing health care reform. In particular, our findings highlighted the insignificant role of party politics and lawsuits in ensuring terminally-ill children have access to quality end-of-life care. Our finding also reinforced the importance of the state economy in implementation of the Concurrent Care for Children provision of health care reform.

Acknowledgment

The authors specially thank Beth Schewe for her assistance with the manuscript.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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