

PHILANTHROPY, POLICY, AND POLITICS:  
POWER AND INFLUENCE OF HEALTH CARE NONPROFIT INTEREST  
GROUPS ON THE IMPLEMENTATION OF HEALTH CARE POLICY

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## **DEDICATION**

I dedicate my dissertation work to God for giving me a purpose, lifting me up throughout every step of my journey on this earth, and allowing me to serve others. To my parents for their sacrifices to give me a better future. To my wife and two daughters for their unconditional love, patience, and support. To the chair of my committee Dr. Dwight Burlingame for his leadership, knowledge, and wisdom. To my committee members Dr. Lehn Benjamin, Dr. Nir Menachemi, and Professor Sheila Kennedy for supporting and guiding me throughout my research. To the Lilly Family School of Philanthropy for the generous financial support. To all my professors, mentors past and present, and colleagues who inspired me to live for a purpose and advance the cause of justice, freedom, liberty, equality, and love for humanity.

Fady A. Qaddoura

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Nonprofit organizations that “speak for, act for, and look after the interests of their constituents when they interact with government are, by any definition of political science, interest groups.” Indiana’s recent implementation of the Healthy Indiana Plan 2.0 (HIP 2.0) under the Affordable Care Act (ACA) opened a window of opportunity to closely examine the role of nonprofits in shaping the implementation of health care policy. Existing literature on health and human service nonprofit organizations did not examine in depth the role and influence of nonprofits as interest groups in the implementation of public policy. This study examines a deeper research question that was not given adequate attention under existing studies with a special focus on the health care policy field: whose interest do nonprofit organizations advance when they attempt to influence the implementation of public policy? To answer this question, it is critical to understand why nonprofits engage in the public policy process (motivation and values), the policy actions that nonprofits make during the implementation of the policy (how?), and the method by which nonprofits address or mitigate conflicts and contradictions between organizational interest and constituents’ interest (whose interest do they advance?).

The main contribution of this study is that it sheds light on the implementation of the largest extension of domestic social welfare policy since the “War on Poverty” using Robert Alford’s theory of interest groups to examine the role of nonprofit organizations during the implementation of HIP 2.0 in Indiana. Given the complexity of the policy process, this study utilizes a qualitative methods approach to complement existing quantitative findings. Finally, this study provides a deeper examination of the relationships between nonprofits as actors

within a policy field, accounts for the complexity of the policy and political environment, analyzes whether or not dominant interest groups truly advance the interest of their constituents, and provides additional insights into how nonprofits mitigate and prioritize competing interests.

Dwight Burlingame, Ph.D., Chair

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## CHAPTER ONE: INTRODUCTION

Nonprofits deliver services on behalf of government and operate in sophisticated political and policy environments that affect their budgets, structure, mission, and constituents. In order for them to survive, nonprofits engage in the public policy process to protect their interest and produce favorable policy outcomes (Almog-Bar & Schmid, 2014; Berry & Arons, 2003). In light of the critical role nonprofits play in serving the needs of millions of Americans, it is important for nonprofit scholars to examine the political behavior of health care nonprofits and develop a deeper understanding of whose interest they advance (Berry & Arons, 2003). A closer examination of the values, motives, and methods will help us better understand the political behavior of nonprofits as interest groups during the implementation of public policy.

The question of whose interest must nonprofits advance is clear from a theoretical perspective: the interest of their constituents. From a legal perspective, and according to federal law and IRS Regulations, nonprofits are established to advance the best interest of their constituents or those who they serve. However, given the complex political and policy environments that nonprofits operate within, the answer becomes less clear (Hudson, 2004). In addition, nonprofit organizations are value driven and not profit driven. This is evident in the health care field via IRS rules and regulations under the Affordable Care Act (ACA) that mandate health care providers such as hospitals to complete a community health needs assessment once every three years, which is an indication that nonprofit hospitals have a social responsibility to address the needs of their constituents and communities. According to federal law and IRS rules, nonprofits are prohibited from advancing private interests and must exist to achieve "exempt purposes" including the relief of the poor, the distressed, or the underprivileged; advancement of education or science; erecting or maintaining public buildings, monuments, or works; lessening the burdens of government; lessening neighborhood tensions; eliminating prejudice and discrimination;

defending human and civil rights secured by law; and combating community deterioration and juvenile delinquency (IRS, 2017).

To successfully analyze why and how nonprofits engage in the implementation of health care policy, this study will utilize a micro-level analysis of internal decision making processes within a given organization and meso-level analysis that focuses on the relationship between interest, power, and health care policy. For the purposes of this study, power is defined as the ability or capacity of an organization to dominate a policy field and influence decisions made by other actors to impact policy outcomes. When these two levels of qualitative analysis converge they produce a more comprehensive understanding of the policy field, organizational actors, organizational conflicts based on values and interests, and the distribution of power between nonprofit interest groups. This analysis can be best framed using Robert R. Alford's theory of structural interests, which distinguishes between dominant, challenging, and repressed interest groups (Alford, 1975; Barker, 1996). According to Alford, institutions with dominant interest aim to maintain the status quo of a certain policy system to maximize their influence and benefits; challenging interest groups are less content with the status quo and envision the advancement of their interests through a structural and transactional change of a policy system; and repressed interest groups are the most impacted by the changes but are not well represented (Alford, 1975).

In his 1970 case study examination of embedded structural interest within the New York health care system and policy field, Alford described dominant interest groups as professional monopolizers, challenging interest groups as corporate rationalizers, and repressed interest groups as organizations representing the poor working class. For the purposes of his study, Alford further explained professional monopoly as an interest group category that encompasses medical researchers, physicians in private or group practice, salaried physicians, and professionals in other health care occupations.

Alford also explained corporate rationalizers as an interest group category that encompasses medical schools, public health agencies, insurance companies, hospitals, and health planning agencies. Nevertheless, Alford was not prescriptive about the type of institutions that occupy each category of structural interest; rather, he concluded that different types of groups could occupy different categories of structural interest at different times (Alford, 1975).

Due to the complex nature of the public policy process, nonprofits' engagement in and influence over the implementation of public policy can be better understood using a qualitative method to extract meaning from nonprofit leaders regarding their organizational interest and ability to influence the implementation of health care policy. In addition, the qualitative analysis aims to uncover how nonprofits prioritize and mitigate competing or contradictory interests between the organization's financial stability and the interest of constituents they serve. For example, the Indiana Hospital Association, which is a nonprofit organization that represents over one hundred seventy hospitals in Indiana, declares that one of their main policy goals is to increase reimbursement and financial stability for hospitals that they represent (Indiana Hospital Association, 2017). Other nonprofit organizations such as the United Way of Central Indiana advocate for the provision of affordable health care for working families. Therefore, different types of nonprofits may advance different types of interests based on their missions and motives.

While different types of nonprofits behave differently, this study is focused on examining the behaviors of Indiana's health and human service nonprofits as one system of organizations that is composed of multiple interest structures. This approach is more focused on the collective behavior rather than the individual behavior of nonprofits and is aligned with Robert Alford's methodological assumptions of his *New York City Health Agencies* study, which was concerned with "how a complex system of organizations handle a problem" rather than how individual nonprofits behave within a policy field (Alford, 1975, p. 19).

Similar to Alford's approach, the selection of nonprofits for this study was based on the researcher's professional judgement and knowledge of the role of Indiana's nonprofits in the health care policy field and delivery system. The selection criteria focused on nonprofits that interact with funding, regulating, and planning agencies (Alford, 1975).

The empirical materials of this study are derived from only few organizations judged to be key ones in the process of decision making. The angle of vision is thus influenced to some extent by the choice of organizations, since the specific documents available will inevitably represent the interests of the organizations which provide the point of entry or access into the system.

It is important to state that the political behavior and advocacy methods of 501-C-3, 501-C-4, and 501-C-6 nonprofits depend on many variables such as an organization's mission, role, scope of services offered, budgets, the impact of proposed policies, and the political calculus of benefits vs. harms resulting from taking a certain policy position on controversial policy proposals (Andrews & Edwards, 2004; Child, 2007; Donaldson & Shields, 2009; Kimberlin, 2010; Leroux & Goerdel, 2009; Yoshioka, 2012). According to Andrew and Edwards, 501-C-3s tend to be the least engaged in formal lobbying activities due to federal regulations that cap spending limits on lobbying activities (Andrews & Edwards, 2004). 501-C-4 and 501-C-6 nonprofits are legally permitted to engage in different types of advocacy strategies to influence public policy such as agency advocacy, legislative advocacy, legal advocacy, and community advocacy (Ezell, 2001; Mosley, 2011; Nicholson-Crotty, 2009; Wallack & Dorfman, 1996).

## **Policy Context: Indiana's Medicaid Expansion**

The Healthy Indiana Plan 2.0 (HIP 2.0) is Indiana's Medicaid expansion program under the ACA (CMS, 2017). HIP 2.0 was modeled after HIP 1.0, which was designed by former Governor Mitch Daniels' administration in 2007 and formally legislated in state law by the Indiana General Assembly with bi-partisan support (FSSA, 2016). The initial plan was designed based on a consumer-driven Medicaid model that was managed by Managed Care Organizations (MCOs) such as Anthem Blue Cross Blue Shield, MDwise, and Managed Health Services (FSSA, 2016).

The original design of HIP 1.0 included a high deductible health plan paired with Personal Wellness and Responsibility (POWER) account, which operated similarly to a Health Savings Account (HSA). The idea of personal monetary contribution towards one's own healthcare was meant to encourage participants in the HIP insurance plan to make better decisions regarding their physical and behavioral health; utilize healthcare services appropriately without over utilizing or underutilizing available services; and demand cost-conscious quality healthcare services. Officials from the state of Indiana cite the success of HIP 1.0 as the motive to design a new HIP plan that meets federal mandates to expand Medicaid without compromising the POWER account and consumer driven model (FSSA, 2016).

HIP 2.0 sought replacing traditional Medicaid, or what is also known as the Fee-For-Service model, for all non-disabled adults ages between 19 to 64 and expand HIP to those who fall below 138% of the Federal Poverty Level (FPL). HIP 2.0 augments the existing HIP 1.0 program by offering HIP 2.0 to individuals previously excluded from the program due to eligibility restrictions and enrollment caps that were designed to maintain budget neutrality. This expansion of HIP 1.0 targets an estimated 559,000 uninsured non-disabled adults ages 19 to 64 who earn an income under 138% FPL (FSSA, 2016). Consistent with the State's



original enabling legislation, HIP 2.0 promotes private employer based coverage over public assistance in several ways. First, the State implemented a new optional defined contribution premium assistance program, HIP Employer Benefit Link (HIP Link), designed to support individuals wishing to purchase their employer's sponsored health insurance.

Second, to promote private market family coverage, the State proposed an optional premium assistance program for children currently receiving benefits through the Children's Health Insurance Program (CHIP), whereby the State provided premium assistance to allow the children to be covered under their parents' employer-sponsored or Marketplace plan. Third, under HIP 2.0, members who consistently made required contributions to their POWER account maintained access to a new "HIP Plus" plan that included enhanced benefits such as dental and vision coverage. Members under 100% FPL who did not make monthly POWER account contributions were placed in the "HIP Basic" plan, a more limited benefit plan. The HIP Basic plan maintained essential benefits, but incorporated reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan, unlike HIP Plus, required co-payments for all services. Fourth, recognizing the strong tie between work and health, HIP 2.0 further promoted private market coverage and employment by introducing the HIP's Gateway to Work program. This program required HIP 2.0 participants be referred to the State's workforce training programs and work search resources to create opportunities for HIP members to connect with potential employers (FSSA, 2016).

Given the unique opportunity to closely examine the implementation of HIP 2.0, this study will examine whose interest did Indiana's nonprofit organizations advance when they attempted to influence the implementation of HIP 2.0?

To answer this question, a qualitative research methods was used to examine why nonprofits engage in the public policy process (motivation and values), the policy actions that nonprofits make during the implementation of the policy (how?), and the method by which nonprofits address or mitigate conflicts and contradictions between organizational interest and constituents' interest (whose interest do they advance?). Chapter one reviews existing literature on nonprofits political behavior as public interest groups, their engagement in the policy process, and their advocacy to influence health care policies. Chapter two explains the research method. Chapters three and four provide the data analysis and findings. The conclusion offers closing thoughts on the importance of this research and raises additional research questions that are more suitable for future research.

## CHAPTER TWO: LITERATURE REVIEW

Three main bodies of literature inform the main research question of this study: interest groups theory, public policy implementation, and advocacy by health and human service nonprofits. Interest groups literature provides the historical development of interest group theory, summarizes existing research on nonprofits as interest groups, and highlights research areas that either received significant attention or were not deeply examined. The public policy literature summarizes the different stages of the public policy process, the role of nonprofits in the implementation phase of the public policy process, the impact of nonprofit advocacy on policy outcomes, and the impact of the policy and political environment on nonprofits. Literature on advocacy by health and human service nonprofits summarizes research that focused on advocacy by health and human nonprofit organizations, definitions and theories of advocacy, tactics and strategies, funding, and effectiveness of advocacy. The three bodies of literature illustrate that existing research provides a rich theoretical and empirical understanding of nonprofit advocacy, the policy process, and the impact of nonprofit advocacy on policy outcomes and the political environment. It is worth noting that existing literature does not offer a deep examination of conflicts between nonprofits' organizational interest and the interest of those who they serve. This study examines the organizational values and motives, policy actions of nonprofits, and conflict of interest between organizational values and actions on one hand and the interests of those who they serve on the other.

While understanding the interests of patients or clients from their own perspective is critical, this study focused on examining the organizational perspective of nonprofits' interest vs. clients' interest rather than clients' perspective of whether or not they think their interest was advanced by nonprofits that serve them. Future research could examine the main research question of this study by interviewing clients and patients in addition to leaders of health and human service nonprofits.

## Interest Groups Theory in Political Science

American political scientists tend to agree that interest group theory originated from Madison's contributions to the federalist papers and was initially referred to as "countervailing power" or "balance of interests" theory (Maisel & Berry, 2010, p. 37). Madison was concerned that radical advocacy by one or several politically powerful groups to pursue selfish interests at the expense of the public good could create an authoritarian political system. Madison thought that extending the political system to allow greater participation by more groups would offset extreme shifts in governing and would mitigate risks associated with minority or majority tyranny (Berry & Wilcox, 2007). American political scientists tend also to agree that interest group theory was revived around 1908 and evolved over a period of few decades by going through four stages of theoretical development: group theory, pluralism, multiple elitist theory, and neo-pluralism. Arthur F. Bentley is recognized in the political science field as the pioneer scholar who helped advance James Madison's group theory (Bentley, 1908) and David Truman as the reviver of Bentley's work (Truman, 1951). Bentley's work emphasized that the governmental process is an interaction "between power and economic interest while the state and the law were reducible to representation of interest" (Maisel & Berry, 2010, p. 39); Truman on the other hand focused on social and political interest rather than economic interest as the main motive for political activity by interest groups (Maisel & Berry, 2010, p. 39).

Truman's group theory was prominent in the 1950s but was displaced in the 1960s by Robert A. Dahl's Pluralism Theory (Dahl, 1967; Dahl & Lindblom, 1953), which is a theory of power that focuses mainly on political parties and elections rather than public interest groups. Dahl's theory incorporated some components of sociologist C. Wright Mills' Power Elite Theory (Elwell, 2006) and emphasized that public policy is determined by interactions between interest groups, politicians, government officials, and political parties (Maisel & Berry, 2010). However, Dahl's argument was undermined by Mancur Olson Jr.'s

Collective Action Theory of Groups (Olson, 1965) and Theodor Lowi, Jr.'s Multiple Elite Theory (Lowi, 1965, 1968, 1969, 1974, 1976; Lowi & Ripley, 1973). Both Olson and Lowi theorized that powerful elite interest groups dominate different policy areas (McFarland, 1969, 1976, 2004).

Multiple elite theory dominated the field of political science as the prominent interest group theory until the end of the 1970s but was replaced by neo-pluralist theory during the 1980s and early 1990s (Berry, 2007). The theoretical foundation of neo-pluralist theory revolves around the idea that “countervailing power results from issue networks, advocacy coalitions, social movements, political patrons, and group entrepreneurs” (Maisel & Berry, 2010, p. 44; McFarland, 2004). Since the 1990s, interest group theory did not go through significant theoretical development; however, in the last decade, interest group theory received a renewed attention as a result of the scholarly work of B. Jones and Baumgartner on “politics of attention,” which is a theoretical framework in the political science field that is concerned with how the American political process works.

The politics of attention is mainly concerned with the way politicians process streams of information flowing from different entities within the American political system, prioritize which issues to focus on or ignore, and allocate attention to certain policy issues. Entities with ideological and self-interest motivations such as interest groups, media outlets, government agencies, and politicians process facts and information differently and allocate attention to certain policy issues in ways that serve their interests. This builds on the theory of “complex political systems” and overlaps with theoretical notions of public policy changes, political agenda setting, and issue framing (Maisel & Berry, 2010, p. 47).

## ***Nonprofits as Interest Groups***

Jeffery Berry's book *A Voice for Nonprofits* is considered one of the most prominent scholarly works on nonprofits as interests groups. In his book, Berry presents evidence from an empirical study that he conducted to measure the impact of tax laws on nonprofits' political participation. Berry argues in his book that tax deductibility and tax exemption laws deter 501-C-3 nonprofits from participating in the public policy making process, which in turn, "harms the most vulnerable populations, who are denied effective representation in the political system"(Berry & Arons, 2003, p. 4). In addition, Berry argues that the rapid growth of the nonprofit sector, the domination of health and human service nonprofits within the sector, the expansion of the welfare state while concurrently downsizing federal and state governments, and the increase in government-nonprofit subcontracting have transformed nonprofits from private charities to an arm of government, which complicates the public policy making process and creates a reciprocal impact on both sectors (Berry & Arons, 2003).

The core idea of Berry's book is that nonprofits are public interest groups and their engagement in political advocacy varies depending on their human and financial resources, level of interest in the political process, and level of risk associated with losing their tax exemption status if significant resources were spent on lobbying (Berry & Arons, 2003, p. 25). Berry argues that scholarly work on nonprofits' engagement in the public policy process is scarce (Berry, 1977; Berry & Arons, 2003), so he aspires to use his book to "push scholarship towards boarder understanding of nonprofit's role in public policymaking" by emphasizing how lack of engagement by nonprofits as lobbies "works against the interests of those people who have no one else to represent them" (Berry & Arons, 2003, p. 25).

Berry presents several critical ideas in his book that include the following: the study of interest groups is the study of how various constituencies are represented in the political process; government regulations affect entry of 501-C-3 nonprofits to the policy making process; nonprofits are considered interest groups because they represent constituencies with a variety of needs; and existing political science theories, such as elite theory and political opportunity theory, do not adequately explain the participation of nonprofits in policy making (Berry & Arons, 2003, pp. 29-34). In addition, Berry explains that government intentionally regulates the interest group market to control the influence of interest groups over the policies that govern them; to ensure government integrity and accountability; to preserve order among competing interests and interest groups; and to subsidize and promote unrepresented groups in the policy making process (Berry & Arons, 2003, pp. 35-36).

In addition to *A Voice for Nonprofits*, Berry published two valuable books, *The Interest Group Society* and *Lobbying for the People*. Both books aim to further advance understanding of interest groups. In *Lobbying for the People* Berry focuses on the structure, operations, and advocacy decision making process of public interest groups and he examines the conversion process by which public interest groups convert constituent preferences into political and policy agendas (Berry, 1977). Berry distinguishes between private and public interest groups in the following ways: (1) private interest groups are special interest groups that interact with the government to influence public policy outcomes to benefit their members only. Private interest groups can represent for-profit corporations or closed membership non-profit organizations (Berry, 1977, 1989). (2) Public interest groups are organizations that attempt to influence public policy outcomes so that the benefits may be enjoyed by the general population (Berry, 1977, 1989).

According to Berry's definition, the terms "private" and "public" are not used in the legal sense to differentiate between non-profit and for-profit organization based on their registration with the IRS; rather, the terms are used to distinguish between different constituency types that are represented by interest groups. In order to complete his study, Berry conducted 83 structured interviews, two case studies, and participant observations methods. Findings from Berry's study highlight the following: (1) Public interest groups contribute to the American political system by bringing new issues to the forefront of the political agenda; (2) through litigation, administrative intervention, and other tactics public interest groups perform a law enforcement function in obtaining new rulings or exacting compliance with old ones; (3) public interest groups educate the public, facilitate citizenship participation, and represent the policy preferences of their constituents; and that (4) government should not circumscribe the participation of public interest groups in the political process, especially public interest nonprofits that are registered with the IRS as 501-C-3 tax exempt organizations (Berry, 1977).

Berry's third book *The Interest Group Society* used a framework of traditional democratic theory to address macro level questions relating to the origins, proliferation, and impact of interest groups, both private and public, on American political parties and elections. Although Berry's book did not focus on nonprofits, his arguments provide a good framework for researchers in the philanthropic studies field to understand the political process in which nonprofits participate. Berry makes several important arguments in this book that revolve around the following ideas: (1) Interests and interest groups are not the same and should be distinguished from each other;(2) interest groups facilitate citizens' participation in the political process, help cultivate social capital, and improve the functioning of government by monitoring government programs and policies;



(3) interest groups are not political parties or social movements, although social movements are composed of many interest groups; (4) the public distrusts interest groups in general but still value organizations that represent them; (5) since the 1990s, politicians and lobbyists created and protected a revolving door between government, private sector, academia, and other institutions to influence public policies; and (6) interest groups intensified their involvement in elections since the 1990s with the hope of influencing election outcomes that are more favorable towards certain policy arenas (Berry & Wilcox, 2007).

Berry concludes his book with a call to reform campaign finance and lobbying laws to encourage and empower unrepresented groups to gain access to the political process and make their voices heard during critical phases of the policy decision making process. Similar to Berry, several academics and scholars published in recent years several books calling for reforming laws to curtail the corrupting role of money in politics and to address ethical issues arising from the revolving door between government and private interest groups (Lessig, 2011; Sachs, 2012).

Jeffery Berry's books *A Voice for Nonprofits* and *Lobbying for the People* are highly cited and respected publications; however, over the past two decades, a new generation of social scientists became more interested in understanding the role and impact of public interest groups on the American political and policy processes (Boris & Steuerle, 2006; Bryce, 2012; Grossmann, 2012; Hesseinius, 2007). Grossman's book *The Not-So-Special Interests: Interest Groups, Public Representation, And American Governance* focuses on two main research questions: who is represented? And whose voice is heard? Grossman uses "Behavioral Pluralism" theory to explain the relative representation of public groups, and "Institutionalized Pluralism" to explain why some organizations representing these groups are more successful than others.

Behavioral Pluralism “suggests that advocacy organizations represent the distinct interests and ideas of public groups in proportion to the civic and political capacity of those groups” (Grossmann, 2012, p. 8); and institutionalized pluralism “suggests that certain organizations become the presumed representatives of public groups in all types of media and all branches of government ... their structural attributes enable them to play these legitimized roles in public representation and policy deliberation” (Grossmann, 2012, p. 9). Grossman conducted an empirical study that covered 1600 advocacy organizations that are active in the Washington D.C. area and concluded that their legitimacy and effectiveness of representation depended on the civic and political capacity and characteristics of their organizations and constituencies (Grossmann, 2012).

Similar to Grossman, Anthony J. Nownes' book *Interest Groups in American Politics: Pressure and Power* explains the paradox of interest groups, what interest groups are, what they do, and what role they play in American politics. Although nonprofits are referenced extensively throughout his book, the author did not dedicate enough focus on the role of nonprofits as public interest groups in the political and policy process. Bryce's book *Players in the Public Policy Process: Nonprofits as Social Capital Agents* did a better job in examining nonprofit organizations as social capital assets and agents of public policy within a principal-agent framework. Bryce's interdisciplinary approach draws on economics, sociology, political science, and public choice theories to systematically develop the main argument of the book, which is that nonprofits are institutional forms of social capital (Bryce, 2012).

## **Nonprofits and the Public Policy Process**

Scholarly work tends to examine advocacy in a context that is framed by the political and policy environments that nonprofits operate within (Berger, 2011; Berry, 1977; Berry & Arons, 2003; Berry & Wilcox, 2007; Frumkin, 2002; Nicholson-Crotty, 2007, 2011; Schlozman, Verba, & Brady, 2012; Stone & Sandfort, 2009). This context portrays nonprofits as agents of public policy that “foster, formulate, perform, and evaluate society’s policies that are in the furtherance of the public good” (Bryce, 2012, p. 10). Therefore, nonprofits as agents of public policy are public interest groups entrusted by those who they represent to carry critical functions that preserve democracy and address the needs of citizens. Although many nonprofits view the term “interest group” negatively, nonprofits as public interest groups play a critical role in a democratic political system by representing constituents, facilitating political participation for vulnerable citizens, educating the public and government representatives about important social and economic issues, shaping local and national political agendas, and monitoring efficiency and effectiveness of government programs (Avner, 2001; Berry, 1977; Berry & Arons, 2003; Bryce, 2012; Janda, Berry, Goldman, & Hula, 2001; Jenkins, 2006; Pekkanen, Smith, & Tsujinaka, 2014; Salamon, 2003). In order to understand how nonprofits as public interest groups participate to influence local, state, and national political and policy agendas, it becomes critical to examine the policy setting agenda process.

John Kingdon’s agenda setting framework occupies a prominent place in the public policy literature and is relevant to the implementation of HIP 2.0 because HIP 2.0 was designed at the state level, approved by CMS as “Section 1115 Demonstration” waiver, and funded by state and ACA dollars. “Section 1115 Demonstration” is a federal waiver process that gives states great flexibility to develop and implement their own policies as pilot programs with the goal of testing new and innovative ideas that could further advance the federal policy (Centers for Medicare and Medicaid Services, 2017).

Indiana's architects of HIP 2.0 designed the policy in a way that complied with the ACA but added additional components that are unique to Indiana. Therefore, I argue that HIP 2.0 policy decisions were made at the state level during the implementation of the ACA in Indiana and that makes Kingdon's framework relevant to HIP 2.0 (Lipsky, 1980).

In his book *Agendas, Alternatives, and Public Policies* Kingdon examines three main questions: how are political and policy agendas are set? How the alternatives for policy choices are specified? And why do these processes work the way they do? To answer these questions, Kingdon considers the pre-decision aspects of the policy process (Xinsheng Liu, 2010) and expands the "garbage can model of organizational choice" (Michael D. Cohen, 1972), which is a theoretical framework that explains policy making as a combination of problematic preferences, unclear technology, and fluid participation. According to Kingdon, political and policy agenda setting is enabled through the interaction of three streams: the problem stream, the political stream, and the policy options stream (Kingdon, 2011).

The problem stream addresses how problems capture the attention of politicians and government officials; the policy stream addresses how policy proposals evolve as a result of proposals and ideas that originate within policy networks such as universities, think tanks, public policy institutes, and private entities; and the political stream focuses on public mood, pressure groups campaigns, election results, partisan or ideological distributions in Congress, and changes of administration (Kingdon, 2011). Nonprofits play a critical role in the pre-decision aspects of the policy process by educating the public and government representatives, mobilizing grassroots resources, engaging in public campaigns, organizing public awareness events, and building coalitions to participate in administrative and legislative lobbying (Hessenius, 2007; Mintrom, 1996; Reid, 2000).

Kingdon argues that policy changes only occur if the three streams converge. Therefore, to influence public policy outcomes, participants in the policy making process, including nonprofit public interest groups, must align their collective efforts to help the three streams converge to create the right conditions that lead to a “policy window of opportunity” (Bryce, 2012; Kingdon, 2011).

Similar to Berry and Kingdon, Di Gioacchino, Ginebri, and Sabani studied how interest groups influence policy outcomes. In their book *The Role of Organized Interest Groups in Policy Making*, Di Gioacchino et al utilized empirical approaches to explain the various types of lobbying activities carried by interest groups to buy access to policy makers, strategically gain and transmit asymmetric information, and influence pre-election politics or electoral competition (Bryce, 2012; Di Gioacchino, Ginebri, & Sabani, 2004; Hassenius, 2007). Their contribution is significant to the overall scholarly understanding of the role and impact of lobbying on policy outcomes; however, the theoretical and empirical frameworks that they used were not tested on nonprofit public interest groups.

Thus, their findings can neither be generalized to an existing theory on nonprofit advocacy nor could they be generalized to advocacy organizations in the nonprofit sector. The lack of focus on nonprofits in the political science field creates a window of opportunity for nonprofit researchers to expand and test existing interest groups theoretical frameworks to the nonprofit sector to understand why nonprofits advocate and who do they represent.

In addition to research work presented above, several researchers attempted in recent years to use different theoretical frameworks to explain nonprofits participation in advocacy. Joanne Sobeck conducted a single case study research to examine healthcare nonprofits participation in the early development phase of a substance abuse policy in a local community context.

Sobeck used the advocacy coalition framework (ACF), bureaucratic politics framework, and institutional analysis and development framework (IADF) to examine group membership and participation (Sobeck, 2003). Sobeck's research results showed that ACF and IADF best explained group membership and participation. The theories presented above are helpful in providing a linear explanation of a complex political and policy process but fail to explain why different types of nonprofits engage in the process and whose interest they advance.

### ***Nonprofits and Public Policy Implementation***

This research examines the role played by Indiana's health and human nonprofits in influencing decisions made by state actors such as the Indiana Family and Social Services Administration (FSSA) during the process of implementing the Healthy Indiana Plan 2.0. FSSA led the efforts to design and implement Indiana's Medicaid expansion program as mandated by the ACA. The ACA provided states with the general policy framework that defined minimum eligibility and benefits coverage requirements and gave states some flexibility to experiment with innovative design and implementation programs to reduce cost of services and improve quality of care. Indiana's human and health nonprofits engaged in the implementation process to influence certain program design and implementation decisions such as eligibility requirements, benefits coverage, and financial reimbursements.

Implementation of public policy is the "carrying out or execution of a program that has been adopted by legislation or by executive or judicial order" and involves three activities: organization, interpretation, and application (Knill & Tosun, 2012; Mazmanian & Sabatier, 1983; Rushefsky, 2008, p. 17).

Organization refers to entities that provide resources, funding, facilities, technology, etc.; interpretation refers to the translation of the law into programs or policies at the local or state level, which tends to be complex; application relates to the implementation of changes to a program or funding as prescribed by legislation. The implementation of public policy is “deliberate, institutionally sanctioned change motivated by a policy or program oriented toward creating public value results on purpose. When successful, policy and program implementation creates public value by enabling collective impact beyond the narrow self-interest of any particular actor or institution” (Gerston, 2010; Sandfort & Moulton, 2014, p. 11).

Implementing new public policies and programs that are large in scope and scale require the support of the public through formal democratic processes such as election referenda, federal rule making, or electing candidates who champion shared values and policy proposals. Therefore, it is critical that the implementation of the policy or the program meet the expectations of the public in order for it to be viewed as effective (Conlan, Posner, & Regan, 2017; Sandfort, 2017). Given that there are multiple invested constituencies in the health care policy field, delivery of services by front line workers and the overall programmatic operations of the system influence the perception of the target population (Benjamin, 2012; Benjamin & Campbell, 2015; Sandfort & Moulton, 2014). If the policy is viewed favorably by the public due to the quality of program delivery, then the target group will be more satisfied and engaged with the new program. Effective policy implementation results in systematic changes at the policy field, organization, and frontline levels and promotes firmer integration between ideas and practices in the delivery system and daily operating procedures (Sandfort & Moulton, 2014).

The quality of services offered and the surrounding environment under a new policy or program influence clients' satisfaction; therefore, the means (policy implementation) and the ends (policy outcomes) are equally important.

While policy fields differ, the implementation of public policy across different fields share common concepts. First, policy and program implementation occurs at different levels within a system. Second, "people in the policy or program area share a common understanding about the task at hand, the relationships they have with each other, and the taken for granted assumptions of that setting;" power structures, and the spoken and unspoken rules (Sandfort & Moulton, 2014, p. 17). Third, informal influences shape action and understanding of what is possible and considered legitimate. Fourth, collective action is required from all levels of the implementation system to ensure effective changes (Sandfort & Moulton, 2014). Entities that aim to influence policy implementation using their expertise and resources are mainly interested in dominating the policy field structure and its processes. Therefore, it is critical to consider the resources and processes that exist within key organizations to understand why and whose interest do they aim to advance.

It is worth noting that there is no reasonable distinction between policy formulation and implementation except at the theoretical or conceptual level (Majone & Wildavsky, 1978; Mazmanian & Sabatier, 1983). On a conceptual level, earlier studies divided policy implementation into stages: policy outputs of implementing agencies, compliance with policy outputs by target groups, actual impacts of policy outputs, perceived impacts of policy outputs, and major revisions in statute (Mazmanian & Sabatier, 1983). These stages are often referred to as the feedback loop (Mazmanian & Sabatier, 1983). With the evolution of policy implementation research and after reviewing more than one hundred studies over three hundred implementation variables, many scholars concluded that policy implementation literature does not need more variables; rather, it needs more structure (Matland, 1995; O'Toole, 1986).



Contemporary policy implementation literature divides policy implementation into two main schools of thought: top-down and bottom-up (Knill & Tosun, 2012; Matland, 1995). Top down theorists consider policy designers as the central actors with the ability to influence the implementation of public policy while bottom up theorists consider target groups and service deliverers as influential actors who shape public policy implementation at the local level (Matland, 1995).

Existing studies identify four policy implementation paradigms that help explain the influence of ambiguity and conflict levels within a policy field on the implementation process: (1) low conflict- low ambiguity (administrative implementation); (2) high conflict – low ambiguity (political implementation); (3) high conflict-high ambiguity (symbolic implementation); and (4) low conflict – high ambiguity (experimental implementation) (Matland, 1995). Policy conflicts during implementation occur as a result of interdependence of actors, an incompatibility of objectives and interests, and perceived zero-sum element to the interactions (Matland, 1995). Policy ambiguity during implementation occurs as a result of ambiguous goals and implementation means (Matland, 1995). Figure 1 below summarizes the four policy implementation paradigms.

Figure 1: Ambiguity-Conflict Matrix: Policy Implementation Process

**Ambiguity-Conflict Matrix: Policy Implementation Processes**

		CONFLICT	
		Low	High
AMBIGUITY	Low	<p><i>Administrative Implementation</i></p> <p>Resources</p> <p>Example: Smallpox eradication</p>	<p><i>Political Implementation</i></p> <p>Power</p> <p>Example: Busing</p>
	High	<p><i>Experimental Implementation</i></p> <p>Contextual Conditions</p> <p>Example: Headstart</p>	<p><i>Symbolic Implementation</i></p> <p>Coalition Strength</p> <p>Example: Community action agencies</p>

Administrative implementation, or low policy ambiguity- low conflict implementation paradigm, provide the pre-requisite for a rational decision-making process by which goals are given and a technology or means for solving the existing problem is known (Matland, 1995). Under this paradigm, outcomes are determined by resources and problems that arise are primarily technical. Actors under the political implementation, or low ambiguity-high conflict implementation paradigm, have clearly defined goals but dissension occurs because the clearly defined goals are incompatible (Matland, 1995). Under this paradigm, implementation outcomes are decided by power and actors or coalition of actors have sufficient power to force their will on other participants or resort to bargaining to reach an agreement (Matland, 1995). To achieve successful implementation, policy designers and state actors must secure the compliance of actors whose resources are vital to policy success to ensure that the process is not thwarted by opponents of the policy.

Many actors have independent bases of power and can refuse to participate without having their missions threatened (Matland, 1995). Under the experimental implementation, or high policy ambiguity and low policy conflict, outcomes will depend on which actors are active and involved and contextual conditions will dominate the process. Finally, under the symbolic implementation, or high policy ambiguity and high policy conflict, the policy aims to confirm new goals, reaffirm a commitment to old goals, or emphasize the importance of certain values and principles (Matland, 1995). The policy course is determined by the coalition of actors at the local level who control available resources.

### ***The Policy Implementation Environment***

Public policy formulation and implementation does not exist in a vacuum (Edwards, 1984; Matland, 1995; Mazmanian & Sabatier, 1983; Nakamura, 1980). Policy implementation can be influenced by actors and arenas, organizational structures and bureaucratic norms, and communication networks and compliance mechanisms (Nakamura, 1980). Actors include nonprofits, public and private interest groups, formal implementers, policy makers, intermediaries, administrative lobbies, powerful individuals, policy recipients or consumers, the mass media, and other interested parties have a critical role to play in shaping policy and influencing the implementation process (Nakamura, 1980). Institutional structures and bureaucratic norms can be explained by one of the following four institutional models: (1) The systems management model, which views implementation as an ordered, goal oriented activity; (2) the bureaucratic process model, which views implementation as a more routine process of continually controlling discretion; (3) the organizational development model, which views the implementation as a participatory process in which implementers shape policies and claim them as their own; and (4) the conflict and bargaining model, which views implementation as a conflict and bargaining process (Nakamura, 1980).

A variety of organizational factors can influence an institution's implementation efforts, including internal procedures, allocation of resources, and psychological motivations and bureaucratic norms (Nakamura, 1980). Finally, given the complexity of the implementation environment and diversity of actors and interests, it is necessary for policy implementers to create linkages with policy makers and evaluators via communication networks and compliance mechanisms for actors to comply (Nakamura, 1980).

Few nonprofit researchers, such as Honeycutt and Strong, examined the impact of the external environment on nonprofits' internal decision making process to engage in advocacy. Honeycutt and Strong used social network analysis to predict early collaboration within health advocacy coalitions (Honeycutt & Strong, 2012); Frumkin and Andre-Clark researched the impact of welfare reform politics on social welfare nonprofits' strategy (Frumkin & Andre-Clark, 2000); Salamon and Twombly researched nonprofits adaptation under social welfare reform legislation (Salamon, 1987; Twombly, 2003); and Schmid et al researched the relationship between political activity and advocacy of health and human health service nonprofits outside of the USA (Schmid, Bar, & Nirel, 2008a).

Nicholson Crotty's research re-affirms that political and policy environments do influence nonprofits' decision to engage in the political and policy process. Her research focused on reproductive health providers to examine the likelihood of these nonprofits advocating to change public policy restricting the delivery of reproductive health services. The author expected an increased likelihood of nonprofits advocacy as the political liberalism of the state increases. The findings reveal that there is a connection or correlation between policy and politics on one hand and the political activity of nonprofit service providers on the other. Nicholson Crotty asserted that nonprofit organizations advocate when the threat from government institutions to their ability to deliver core services is sufficient to justify engaging in political activity and when they perceive the highest probability of success (Nicholson-Crotty, 2007, 2009, 2011).

Finally, the author declared that her research findings indicate that measures of institutionalization and resource dependence prove to be inconsistent predictors of political activity and nonprofits' motive to engage in advocacy (Herrnson, 2000; Nicholson-Crotty, 2007).

### **Advocacy by Health and Human Service Nonprofits**

Health and human service nonprofit organizations occupy a prominent space in the American health and social service sector and play a critical role in representing vulnerable populations (Donaldson, 2007; Grogan & Gusmano, 2007; Metcalfe, 2002; Schmid, Bar, & Nirel, 2008b). In order to preserve their mission, serve their constituents, and improve the environmental conditions for vulnerable citizens, nonprofits engage in different forms of direct and indirect advocacy. Research relevant to nonprofit policy advocacy that has been published over the past two decades covered several areas of advocacy by nonprofit human service organizations. The following sections provide an overview of existing research.

#### ***Definition and Theories of Advocacy***

The term advocacy is used differently in nonprofit studies (Reid, 2000). Several researchers examined the various definitions of advocacy, origins of the term, and its current uses in studies related to nonprofits (Almog-Bar & Schmid, 2014; Berger, 2011; Ezell, 2001; Kimberlin, 2010; Pekkanen et al., 2014; Reid, 2000). Reid defines advocacy as a “wide range of individual and collective expression or action on a cause, idea, or policy” (Reid, 2000, p. 1) to educate the public, shape public opinion, propose policy solutions, mobilize resources, influence political and policy agenda setting, influence design and implementation of a policy, gain access to policy makers, or influence the outcomes of elections. These activities illustrate the critical role nonprofits play in representing their constituents and facilitating citizens' participation in the political process.

Both Reid and Berger distinguish between advocacy as a form of civic engagement, citizens' collective action, social protest, and other forms of advocacy such as professional lobbying, whether administrative, legislative, or judicial. Berger argues that advocacy is one form of civic engagement, which is a broad definition that includes several types of advocacy such as political activity, lobbying, and community organizing (Berger, 2011). Pekkanen et al define advocacy as "the attempt to influence public policy, either directly or indirectly" (Pekkanen et al., 2014). Definitions of advocacy used by Reid, Jenkins, Boris, Andrews and Edwards, Donaldson, Salamon, and Donaldson overlap and complement each other (Kimberlin, 2010).

Nonprofit scholars, political scientists, sociologists, and economists use different theoretical frameworks to explain nonprofit advocacy. During the last two decades, nonprofit scholars expanded their use of theoretical frameworks to examine why nonprofits advocate (Almog-Bar & Schmid, 2014; Clerkin, 2006; Gray, Lowery, & Benz, 2013; Grogan & Gusmano, 2007; Hasenfeld & Garrow, 2012; Jenkins, 2006; Kimberlin, 2010; Nicholson-Crotty, 2007). Jenkins used the following five reasons to explain the formation of nonprofit advocacy organizations: 1) disturbance or strain ideas, 2) resource mobilization, 3) political opportunities, 4) organizational ecology theory, and 5) social constructionist arguments about the framing of collective grievance and organizational repertoires. Jenkins suggested that all these explanations could be considered critical to the formation of new advocacy organizations with one or more of these theories more relevant depending on other factors present (Jenkins, 2006). Schmid and Bar used a framework that combined neo-institutional theory and resource dependence theory to analyze political activities of nonprofits (Schmid et al., 2008b). Clerkin also used neo-institutionalism to test whether the isomorphic pressures of organizational fields inhibits or facilitates an organization's engagement in advocacy (Clerkin, 2006).

Findings by Schmid, Bar, and Clerkin indicate that institutional, organizational, and environmental features have an impact on level of nonprofit advocacy and that more formal organizations with greater number of volunteers are more likely to engage in advocacy. Neo-institutional theory emphasizes the rules and procedures emanating from the institutional environment while resource dependence asserts that organizations often become dependent on their environments for resources that are critical for their survival (Schmid et al., 2008b).

Salamon, Gronberg, and Child used resource mobilization, bureaucratization of nonprofits, and theories of conflict and partnership between nonprofits and the state to examine whether or not government funding affects how nonprofits advocate (Kimberlin, 2010). Research findings by the three scholars indicate that larger, more professionalized, and government funded nonprofits tend to engage in advocacy more frequently and more aggressively than smaller nonprofits (Donaldson, 2007; Kimberlin, 2010). Garrow and Hasenfeld used institutional logic to study the difference between advocacy for social benefits versus advocacy for organizational benefits (Garrow & Hasenfeld, 2014). Their findings indicate that organizations that place the cause of the problem on the individual tend to advocate less than organizations that blame the external environment. Similar to Garrow and Hasenfeld, Gray et al examined advocacy by healthcare interest groups to influence the 2010 healthcare reform proposal in the United States. Gary et al conducted empirical studies and used innovation theory and population ecology theory to answer the above question and they concluded that interest groups in the field of healthcare are multi-level structured interest group systems that innovatively engage effectively on state level to influence the design and implementation of several policy areas (Gray et al., 2013). In her book, Gray focuses on the configuration of interest groups under the healthcare subsector and she pays close attention to advocacy by managed care entities, pharmaceutical drug enterprises, healthcare finance organizations, healthcare advocacy groups, health professional associations, and direct patient care

providers. She also traces legislative and media activities relating to healthcare reform from the early 1980s to 2010 at the state level and concludes that the intensity of these activities and lack of reform initiatives on the national level led states to innovatively design state solutions to address healthcare issues. However, her book does not focus on the role of nonprofits as interest groups in influencing state level policy implementation.

### ***Role, Scope, Types, and Funding of Nonprofit Advocacy***

Advocacy by nonprofits differ from one organization to another depending on the organization's mission, role, scope, and services offered (Andrews & Edwards, 2004; Child, 2007; Donaldson & Shields, 2009; Kimberlin, 2010; Leroux & Goerdel, 2009; Yoshioka, 2012). Yoshioka focused on the representational roles of nonprofits (Yoshioka, 2012); Caira focused on the role of health experts and policy entrepreneurs in advocacy and policy (Caira et al., 2003); Kerlin and Reid focused on the relationship between funding sources of advocacy and ability to influence policy (Kerlin & Reid, 2010); and Andrew and Edwards focused on the growth and characteristics of advocacy organizations along the key dimensions of organizational structures, membership and participation, resources and inter organizational networks.

The research conducted by Andrew and Edwards examined the role and influence of advocacy organizations in politics in five categories of the policy process: 1) agenda setting, 2) access to decision-making arenas, 3) achieving favorable policies, 4) monitoring and shaping implementation and 5) shifting the long term priorities and resources of political institutions. Andrew and Edwards concluded with a recommendation to reorient scholarship towards the interactions between advocacy organizations and political institutions to understand the patterns of influence and answer core questions about democracy and government responsiveness (Andrews & Edwards, 2004).



Balassiano and Chandler examined the emerging development of state associations of nonprofit organizations and a national federation of state associations to determine if these associations increase the role of nonprofits in advocacy and participation in community decision making and to what degree they help the sector exert influence in the public policy arena? Balassiano and Chandler contend that the recent trend to devolve power from the federal government to the state and local levels has resulted in the transfer of a large amount of decision making authority to individual state legislatures. States are contracting out to nonprofits and exerting new authority to define how nonprofits function. A study of the National Council of Nonprofit Associations (NCNA) and seven high performing member state nonprofits indicated that among the proven strategies for organizational survival and sustainability are networking and collaboration for resource mobilization, service delivery and policy advocacy. The NCNA and state associations are helping nonprofits grow, adapt and do the work of impacting public policy (Balassiano & Chandler, 2010)

### ***Strategies, Tactics, and Effectiveness of Nonprofits Advocacy***

Several nonprofit researchers examined the topic of strategies, tactics, and effectiveness of nonprofits policy advocacy over the past three decades (Ezell, 2001; Mosley, 2011; Nicholson-Crotty, 2009; Wallack & Dorfman, 1996). Ezell focused on four broad nonprofit strategies: agency advocacy, legislative advocacy, legal advocacy, and community advocacy. He argued that in order for nonprofits to engage in effective advocacy, nonprofits must use appropriate tactics under each strategy. The following are examples of such tactics under each strategy: (1) Agency advocacy strategy – watch dog tactic: monitoring agency activities, planning and decision making processes, budgets, programs, and outcomes; meeting with agency officials; working with insider advocates; accessing information using administrative procedures such as the Access to Public Records Act; and joining task forces.

(2) legislative advocacy: legislative monitoring, lobbying and testifying, publishing position papers, testifying in committee meetings, alerting constituents and advocates, working with legislative staff, seeking executive veto or signing, and engaging in non-session activities such as organizing networks and coalitions, training advocates, and participating in political campaigns. (3) Legal advocacy: litigation and non-litigation tactics to change court rules, challenge agency rules, and stop detrimental practices. (4) Community advocacy – using media, direct community education. In addition to Ezell, other scholars attempted to develop a framework for measuring the effectiveness of advocacy, especially in the healthcare field (Fagen, Reed, Kaye, & Jack, 2009). However, the majority of nonprofit researchers recognize the challenges associated with measuring the effectiveness of advocacy due to the limitations of current theoretical frameworks that explain nonprofit advocacy (Berry & Arons, 2003; Kimberlin, 2010; Lowi, 1976; Pekkanen et al., 2014; Schmid & Almog-Bar, 2013).

In summary, existing research on health and human service nonprofit organizations did not examine in depth the question of whose interest do nonprofit organizations advance when they attempt to influence the implementation of public policy? To answer this question, an in depth research is needed to understand the role and influence of health and human service nonprofits as interest groups in the implementation of public policy (Almog-Bar & Schmid, 2014; Berry & Arons, 2003; Browne, 1990; Garrow & Hasenfeld, 2014; Gray & Lowery, 1996; Kimberlin, 2010; Nicholson-Crotty, 2011; Schmid & Almog-Bar, 2013). Alford' theory provides a suitable framework to examine the role of Indiana's health and human nonprofits in the implementation of the largest extension of domestic social welfare policy in Indiana since the "War on Poverty." In addition, Alford's theoretical framework of structural interests is capable of modeling: the complexity of relationships between nonprofits as actors within a policy field, the complexity of the policy and political environment, and the competing interests between dominant, challenging, and pressed interests.

## **CHAPTER THREE: METHODS AND RESEARCH DESIGN**

### **Qualitative, Document Analysis, and Visual Trending**

In terms of a theoretical analysis, this study uses Robert Alford's interest group theory to help us understand why and how Indiana's nonprofits engaged in the implementation of the ACA on a statewide level. Due to the complex nature of the public policy process and the ways by which nonprofits engage to influence the implementation of public policy, this study uses three research methods: (1) A qualitative method to extract meaning from nonprofit leaders regarding their organizational interest and ability to influence the implementation of health care policy; (2) Review of state published HIP 2.0 documents; (3) Visual Trend Analysis to validate whether or not patients' interest, measured by level of satisfaction of the quality of services they received, was advanced through the expansion of Medicaid. Indiana's health care advocacy and service providing nonprofit leaders argued that any expansion would improve services to their patients. While an increase in patients' satisfaction rates cannot be fully be attributable to the ACA expansion, the trend analysis is used to validate whether or not Indiana's patients perception confirms the claims made by Indiana's nonprofits health care organizations. To test for a correlation between the ACA expansion and customer satisfaction an advanced statistical analysis is needed, which is outside the scope of this study.

The qualitative analysis aims to explore and uncover how nonprofits prioritize and mitigate competing or contradictory interests between organizations' financial stability and the interest of constituents they serve. For example, the Indiana Hospital Association, which is a nonprofit organization that represents over one hundred and fifty hospitals in Indiana, declares that one of their main policy goals is to increase reimbursement and financial stability for hospitals that they represent (Indiana Hospital Association, 2017).

Other nonprofit organizations such as the United Way of Central Indiana advocate for affordable health care coverage for working families. Therefore, different types of nonprofits may advance different types of interests based on their missions and motives.

Furthermore, the findings from the qualitative analysis will confirm whether or not dominant interest groups truly advance the interest of their constituents and will provide additional insights into how nonprofits mitigate and prioritize competing interests.

In addition to interviewing leaders of nonprofits, an examination of select HIP 2.0 state published documents informed the findings of this study. Three main questions researchers must consider when using a document analysis method: (1) what constitutes a document? (2) What is the context of the document? (3) How does a researcher approach analysis of the document content? Documents should not be treated as stable, static and pre-defined artifacts; rather, they should be considered in terms of fields (involving creators, users and settings), frames (context) and networks of action (Prior, 2011). Documents may be texts, printed and electronic documents, sculptures, paintings, architectural organization of space and different forms of written texts; are “social facts” which are produced, shared and used in socially organized ways (Bowen, 2009); and are produced in a context of socially organized projects that include certain social rules, structures and production interactions that occur between the author “function”, consumers and producers. Authenticity is an issue when the use has significant social or political consequences, as consumers shape the form and content of the document. The strategy for content analysis depends on whether the researcher wishes to move beyond the surface content of the document and more into its functioning, in which case schemes of referencing and social activities offer insights into analysis of document content and function.

Document analysis is a systematic procedure for reviewing or evaluating documents that requires data to be examined and interpreted in order to elicit meaning, gain understanding and develop empirical knowledge. Document analysis is also used as one strategy in triangulation, which combines methodologies in the study of the same phenomenon: drawing on multiple sources of evidence and methods, the researcher seeks convergence and corroboration. Documents serve five specific functions: (1) they provide background and context; (2) prompt additional questions to be asked; (3) are a source of supplementary data; (4) a means of tracking change and development; and (5) a way to verify findings from other data sources (Bowen, 2009).

The document analysis process involved the following steps:

1. Searched for, downloaded, and examined tens of documents from FSSA's HIP 2.0 website to evaluate their relevance to the research project.
2. Conducted additional research to understand the context that the documents were created within, such as the time period, the author, publication site, target audience, political events that occurred during the time of drafting and publishing the documents, etc.
3. Analyzed the documents to construct and interpret meaning and craft answers to the main questions that this project is concerned with.

Literature on document analysis cautions researchers from two types of bias when using documents are: (1) selection bias, which events are covered; and (2) description bias: how, and how well, the events are covered (Bowen, 2009; Earl, Martin, McCarthy, & Soule, 2004; Prior, 2011). Selection bias may be loosely considered a function of how "newsworthy" a given story is, whether "newsworthiness" is considered an event characteristic or a social construct, and is thus context-specific, as well as variable among types of publications (Bowen, 2009; Earl et al., 2004; Prior, 2011).

Similarly, description bias takes into account not only any active framing or representation choices made by the publisher or an author, which may reveal readership preferences as well as editorial preferences; it also includes omission of information. Researchers must assess potential biases, and considering options for reducing their effect on the research such as triangulation by use of multiple resources (including electronic databases), and methodologically sound imputation of missing information. The use of documents should be considered with respect to how well the source fits the research question, and with an understanding of the strengths and limitations of the source.

The third method used is Visual trending analysis, which illustrates the change in patient satisfaction levels for services they received within a local hospital in Medicaid expansion and non-expansion states. The visual trending analysis utilized the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), attached in Appendix E, which is a national standardized survey instrument that is administered by the Centers on Medicare and Medicaid (CMS). CMS is the authorized federal agency that is entrusted with overseeing the design of the collection methodology for measuring patients' perspectives on hospital care.

The HCAHPS survey is administered to a random sample of adult patients across medical conditions between 48 hours and six weeks after discharge; the survey is not restricted to Medicare beneficiaries (The Centers for Medicare & Medicaid Services, 2017). Hospitals may either use an approved survey vendor, or collect their own HCAHPS data (if approved by CMS to do so). HCAHPS can be implemented in four different survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR). Hospitals can use the HCAHPS survey alone, or include additional questions after the core HCAHPS items.

Hospitals must survey patients throughout each month of the year. The survey is available in official English, Spanish, Chinese, Russian and Vietnamese versions. CMS cleans, adjusts and analyzes the data, then publicly reports the results. The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care. The survey also includes four screener questions and seven demographic items, which are used for adjusting the mix of patients across hospitals and for analytical purposes. The survey is 32 questions in length. For purposes of this study, the visual trending analysis relied on data collected for questions 10 and 11 of the survey: questions 10 (H\_HSP\_RATING\_9\_10) and 11 (H\_RECMND\_DY) of the survey (The Centers for Medicare & Medicaid Services, 2017).

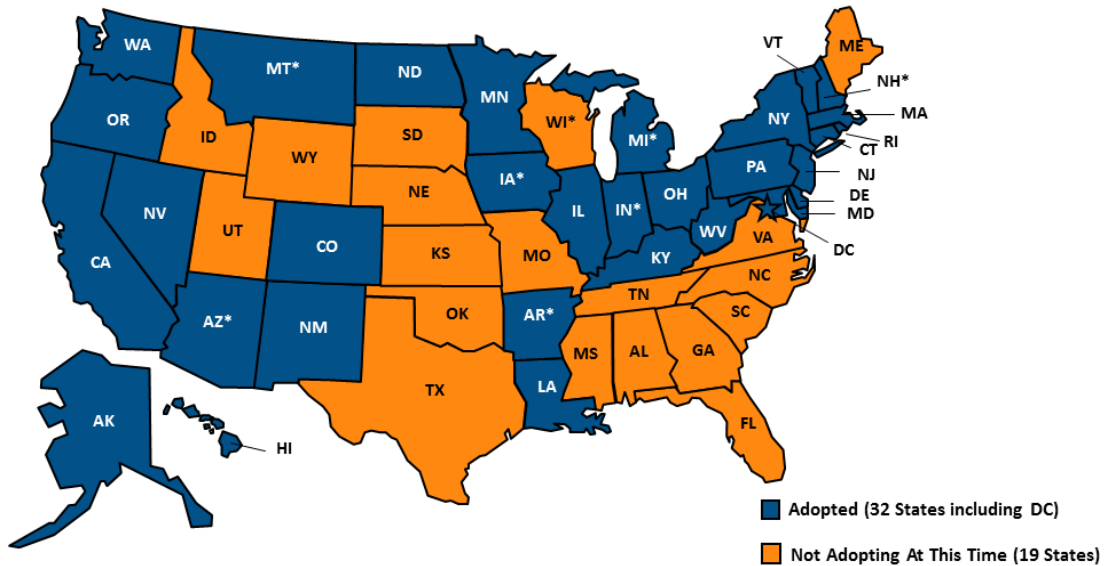
To ensure that HCAHPS scores allow fair and accurate comparisons among hospitals, it is necessary to adjust for factors that are not directly related to hospital performance but which affect how patients answer survey items. CMS and the HCAHPS Project Team (HPT) apply adjustments that are intended to eliminate any advantage or disadvantage attributable to the mode of survey administration or characteristics of patients that are beyond a hospital's control. In addition, the HPT undertakes a series of quality oversight activities, which include site visits of HCAHPS survey vendors to inspect survey administration procedures and trace records, and statistical analyses of submitted data, to assure that the HCAHPS Survey is being administered properly and consistently (The Centers for Medicare & Medicaid Services, 2017).

As shown in Figure 2 below, states that expanded Medicaid by January 1, 2014 were AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MN, NJ, NY, ND, NM, NV, OH, OR, RI, VT, WA, WI, and WV; and states that did not expand Medicaid or expanded later than January 1, 2014 were AK, AL, FL, GA, ID, KS, LA, ME, MI, MS, MO, MT, NE, NC, NH, OK, PA, SC, SD, TN, TX, UT, VA, and WY. The Medicaid expansion became effective in January 2014 for all expansion states except for the following: AK (September 2015), IN (February 2015), LA (July 2016), MI (April 2014), MT (January 2016), NH (August 2014), and PA (January 2015). Since data go through 2015, we identified those states that expanded after January 2014 but before January 2016 as expansion states only in the quarters after the expansion was implemented.



Figure 2: Current Status of State Medicaid Expansion Decisions

### Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. \*AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.  
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016.  
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Coverage under the Medicaid expansion became effective January 1, 2014 in all states that have adopted the Medicaid expansion except for the following: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016).

Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire have approved Section 1115 waivers for the Medicaid expansion. Arizona received CMS approval on September 30, 2016 to transition expansion coverage to 1115 waiver authority; implementation of the waiver provisions related to the expansion population are pending CMS approval of the state's Operational Protocol. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA expansion.

## Research Hypothesis

This research hypothesizes the following:

- 1- Due to the high cost of providing quality health care, there is an inherent conflict between nonprofit financial interest and the interest of their Medicaid patients. Patients desire to receive the highest quality of care at the lowest cost possible while hospitals desire to maximize revenues by providing services at the lowest cost. Therefore, dominant health care organizations prioritize their interest as a top priority and engage in the policy process to protect their interest.
- 2- Challenging and suppressed interest groups engage to protect the interest of the most vulnerable in their communities.
- 3- The more benefits nonprofit health care organizations receive from government, the more these nonprofits will attempt to dominate the policy field.
- 4- Unlike challenging and suppressed interest groups, dominant health care nonprofits tend to be very influential, connected to the political elite, have abundance of resources, and are focused on protecting long term goals. Challenging and suppressed interest groups tend to collaborate with each other to counter public power and private interest via networks of coalitions.

## Sample Group

To comply with the federal requirements, FSSA conducted public hearings prior to the implementation of HIP 2.0 to collect public feedback on the implementation of HIP 2.0. The public hearing events were conducted at the Indiana Government Conference Center and the State House while the public conversations events were sponsored and organized by several health provider organizations across the state. Among those who testified during the public hearing events are the following: Sherri Jawett CEO of Valle Vista Health, a mental health hospital and mental health organization in Greenwood, Indiana; CEO of Wellstone Regional Hospital; Michiana Behavioral Health Center; Ambre Marr, state legislative director for AARP; Rylin Rodgers Family Voices – Indiana; Tanya Shelburne, Vice President at Little Red Door Cancer Agency; Brian Tabor, Indiana Hospital Association – representing 160 hospitals in Indiana; Jocelyn Forehand, CEO of SouthSide OBGYN and legislative liaison for Medical Group Management Association - Indiana Chapter; Bob Holda, citizen (advocating on behalf of the Medicaid-Employed-Disabled population); Michael Schwing – homeless citizen and serves on several committees of the CoC; Mark Monson President of Fairbanks, Alcohol and Drug Treatment Center; Kristen Metzger President of Blue Cross Blue Shield Medicaid Division; Paul Chase, deputy director of policy and administration for Covering Kids and Families Indiana; Jean Scallon CEO of Bloomington Meadows Hospital; Katherine Wentworth – Chief Operating Officer of MDwise; and Rev. Dan Gangler Director of Communications Indiana Conference of the United Other organization Church, 1020 congregations across Indiana. The Public Conversations on the Future of Healthcare in Indiana took place at Saint Joseph Regional Medical Center Education Centers; Indiana University Northwest/IU School of Medicine-Northwest; Southwest Indiana Chamber luncheon; Hendricks Regional Health YMCA; Ivy Tech Community College Northeast; St. Elizabeth Hospital; Memorial Lodge; and Community East Hospital.

## Selection Criteria

Eight nonprofit organizations were selected from the pool of organizations that testified publically during the implementation of HIP 2.0 and engaged with FSSA during the implementation phase. Leaders of eight organizations were interviewed and interview data was analyzed to evaluate the role played by the eight organizations using Alford's framework of dominant, challenging, or repressed interest groups. The following organizations were selected: (1) two health care providers and two trade associations that represents health care institutions in Indiana. Given that health care institutions are major providers of health care services, this group tends to be a dominant group that enjoys large influence over state actors and the health care policy field in Indiana. (2) Two challenging interest organizations such as advocacy nonprofits. These groups tend to challenge the proposed design and implementation of the program to achieve better outcomes for those who they serve. (3) Two repressed interest groups that represent the working class. This group tends to represent the voices of repressed individuals and communities.

Similar to Alford's approach, the selection of nonprofits for this study was based on professional judgement and knowledge of the role of Indiana's nonprofits in the health care policy field and delivery system. More specifically, the selection criteria focused on nonprofits that interact with funding, regulating, and planning agencies.

The empirical materials of this study are derived from only few organizations judged to be key ones in the process of decision making. The angle of vision is thus influenced to some extent by the choice of organizations, since the specific documents available will inevitably represent the interests of the organizations which provide the point of entry or access into the system (Alford, 1975).

It is also critical to note that interviewees from the selected nonprofits were high level executives who had the authority to represent and speak on behalf of their organizations regarding their values and policy positions. Emulating Alford's framing of this issue, this study considered interviewees as social actors within diverse organizational and professional context. Alford's study was "concerned with the ways in which ideologies are constructed to defend structural interests composed of social roles and positions attached to only parts of the individuals" (Alford, 1975, pp. 18-19). For the purposes of this study, and given that all interviewees were senior executives within their organizations, the researcher treated statements made by interviewees as formal representation of their organizational positions.

Following Alford's approach proved useful in shedding light on roles played by the system of different types of nonprofits during the implementation of the ACA in Indiana and whose interest they advance. This study emulates Robert Alford's methodological approach, which was concerned with how a complex system of organizations handles a problem rather than the behavior or history of one organization or analyzing organizational variables such as dependence, resources, strength, or persistence (Alford, 1975).

### **Interview Instrument**

This qualitative research is focused on exploring, describing, and understanding nonprofits that participated in Indiana's Medicaid expansion as public interest groups. Data was collected from interviews with leaders of Indiana based health care nonprofit organizations with primary focus on health care service delivery or health care advocacy using questions in the interview tool in Appendix A to collect data that is relevant to answering the following questions: Do these organizations advocate for their interest or the interest of their patients? Do these nonprofits have similar level of influence on the policy outcome and if not then why?

Do these nonprofits focus on macro policy issues or do they focus on micro level niche areas that are more transactional in nature? How do these nonprofits resolve conflict among themselves and with public power (state) and other private interest? What internal and external organizational factors strengthen an organization's ability to influence outcomes of health care policy in Indiana?

### **Data Analysis Procedures**

Interview data analysis procedures included line by line coding, categorization, conceptualization, and text analysis. The data analysis process involved multiple steps as outlined below:

1. Focused coding of interviews
2. Raised the most important codes to categories.
3. Selected main themes that relate to the main question of this project, and drafted analytical memos.
4. At the end of the research project, all memos were further developed and the findings are included in the next section.

The document analysis process involved the following steps:

1. Searched for, downloaded, and examined over 50 documents from FSSA's HIP 2.0 website to evaluate their relevance to the research project.
2. Conducted additional research to understand the context that the documents were created within, such as the time period, the author, publication site, target audience, political events that occurred during the time of drafting and publishing the documents, etc.

3. Analyzed the documents to construct and interpret meaning and crafted answers to the main questions of this research study.

### **Strategies for Validating Findings**

The strategy to validate findings includes member checks, peer review, providing thick description and evidence, and clarifying the researcher's role and biases. All interviewees were offered to receive a copy of the final transcript to review for accuracy of statements.

### **Anticipated Ethical Issues**

Participants of this study did not belong to any marginalized or vulnerable population and no emotional or physical stress was expected as a result of participating in this study. In addition, I addressed the necessary research concerns about privacy issues relating to protecting the identity of participants and their organizations and protecting data in my approved IRB protocol.

### **Limitations of the Study**

This study has several limitations:

- 1- The study solicited empirical data from executives of Indiana's health and human service nonprofits only. Due to limited time and resources, the study did not solicit empirical data from interviewing patients.
- 2- Over twenty organizations received interview requests but only eight organizations accepted to participate.
- 3- A quantitative study using an advanced statistical design is needed to confirm any correlation between patients' level of satisfaction with services

they received before and after Medicaid expansion. If Medicaid expansion directly correlates to an improved patient satisfaction, then the policy actions of health and human service nonprofits in support expanding Medicaid confirm that nonprofits acted to advance the best interest of their patients.

- 4- Certain findings that were generated from this study cannot be generalized to nonprofits on a national level because Indiana's Medicaid expansion customized certain components of the expansion that are different from traditional Medicaid expansion.
- 5- While statements made by senior executives were treated as formal statements representing their organizational positions on public policy, there is a potential that certain statements were more of a personal opinion rather than formal representation of organizational positions.



## CHAPTER FOUR: DATA ANALYSIS

The interview analysis process led to the discovery of seven main themes that emerged from the categories that evolved out of the initial coding phase and from my Interviews. The main themes that emerged out of my interviews are presented and briefly discussed below.

### Interview Data

#### *Theme 1: Experienced in Politics and Policy*

##### **Question 1: Describe your professional background?**

All interviewees are highly educated nonprofit leaders who hold prominent leadership roles within their organizations. They all have extensive experience in the fields of law, politics, lobbying, and health care policy and administration. Five of the eight interviewees are registered lobbyists.

##### **Participant A**

Participant is highly educated, served in advanced leadership roles, worked for both nonprofits and state government, worked directly with clients (service provision) and indirectly (formulating and implementing new state programs and policies), has a deep level of understanding of the role of public policy, and engaged in educational initiatives.

##### **Participant B**

Participant B decided to join the health care advocacy field after experiencing health care complications within the participant's family.

This participant is highly educated, served in advanced leadership roles, worked primarily for nonprofits and a health care system, worked extensively on policy issues and connecting clients with resources, has a deep level of understanding of the role of public policy, and engaged in educational initiatives on a local and national level.

### **Participant C**

Participant C worked is highly educated, served in advanced leadership roles, worked in state and local politics for over two decades, is a registered lobbyist, mainly focused on policy issues, has a deep understanding of the role of public policy, and engages in formal lobbying and educational initiatives on a local and statewide level.

### **Participant D**

Participant D is highly educated, served in advanced leadership roles, connected with elected officials and state politicians on a personal and professional levels for over four decades, has a deep understanding of the role of public policy, and extensively engaged in educational initiatives on a local, state, and national levels.

### **Participant E**

Participant E is highly educated, served in an advanced role in a local faith-based nonprofit, a registered lobbyist, mainly focused on policy issues, has a deep understanding of the role of public policy, and is engaged in initiatives to educate elected officials and membership organizations.

### **Participant F**

Participant F is highly educated, served in an advanced role in a statewide nonprofit, a registered lobbyist, mainly focused on policy issues, has a deep understanding of the role of public policy, and is engaged in initiatives to educate elected officials and membership organizations.

### **Participant G**

Participant G is highly educated, served in an advanced role in a statewide 501-C-3 nonprofit, a registered lobbyist, worked in politics for over two decades, mainly focused on policy issues, has a deep understanding of the role of public policy, and is engaged in initiatives to lobby elected officials and educate membership organizations.

### **Participant H**

Participant H is highly educated, served in advanced leadership roles, has a deep understanding of the role of public policy, and spent close to two decades in health care administration.

## ***Theme 2: Their Membership, Patients, and the Larger Community***

### **Question 2: Organization's Constituents: Who is your main constituency?**

The primary constituency for four organizations are their board members and CEOs of member organizations [two 501-C-6 Trade Association, the 501-C-3 faith-based organization, and the statewide mutual benefits organization]. By extension, these four organizations view the larger community as their target constituency. The other four organizations view the patient and the larger

community as their primary constituency [two 501-C-3 health care providers and the two 501-C-3 hospital systems].

### **Participant A**

Participant A indicated that the organization's primary constituents are low income, chronically ill patients, with income below 225% of the Federal Poverty Line (FPL). Donors, staff, and volunteers are considered secondary.

### **Participant B**

Participant B indicated that the organization's primary constituents are families who are navigating systems and services while caring for family members with disabilities and complex health care needs. Families that may have connected with the organization in the past tend to become volunteers and donors. Therefore, the organization is led by individuals who are passionately connected to the mission of serving families who care for disabled individuals.

### **Participant C**

Participant C indicated that the organization's primary constituents are state-wide for-profit and nonprofit health systems and their CEOs and board members.

### **Participant D**

Participant D indicated that the organization's primary constituents are patients and their families and the larger community in which the health institution operate within as the secondary constituency.

We have a duty of responsible grace. We have to discharge that duty and the only way to discharge that duty is to hold it at the center of our work, [which is to serve] the patient and their families.

### **Participant E**

Participant E indicated that the organization's primary constituents are board members who represent local houses of worship.

### **Participant F**

Participant F indicated that the organization's primary constituents are member organizations from across the state. These state-wide organizations are comprised of all of their donors, volunteers, and all funded partners, and local community. By extension, Participant F considers communities as the targeted constituency, which is much broader than the board membership.

### **Participant G**

Participant G indicated that the organization's primary constituents are member organizations from across the state. However, Participant G believes that the public benefits greatly from good health policies that are advanced by this organization.

### **Participant H**

Participant H indicated that the organization's primary constituency includes patients, their families and the larger community.

If you look at it truly down to the granular side of it, [our constituents] are those people who are struggling... those who are poor and vulnerable. So when you truly look at the granular nature of it, we are all poor and vulnerable at some point in our lifetime... so for us that's everybody. We look at that and say those are our patients, our consumers, our constituents... Maybe we would say the communities, it so much broader than that [more than patients]. It is the broader community. We believe everybody at some point in their life will have an issue, we want to be able to help them solve it. So when we understand that side of the community, our role [is] to help make communities thrive. [We ask ourselves] how do we improve [the] health status [and] health outcomes in the communities in which we are present, which is every county in the state of Indiana.

### ***Theme 3: Different Levels of Organizational Maturity***

#### **Q3: Organization's Background: Describe the organization's service model, funding, staffing, and relationship with local or state government?**

The two Hospital systems are very unique because they are among the largest employers in the state with tens of thousands of employees statewide, highly structured, operate almost in every county of the state, maintain budgets with billions of dollars, serve millions of people, very well connected to policy makers and the corporate community, engage in direct and indirect lobbying and advocacy activities, highly regulated and operate in a very volatile market place, and very focused on long term strategies and goals. The two trade associations are very different in their size, scope, budgets, and level of influence. The more influential trade association is the one that represents primary and acute health care services. The other trade association represents a stigmatized community that suffered from lack of societal investments for centuries. The mutual benefits association and the faith-based nonprofit share similar characteristics: small budgets, small teams, boards are composed of executives of locally affiliated chapters or branches, self-preservation is important to both organizations given the diversity of their membership, advocacy and policy stances are evaluated based on political calculus, religious values, and internal consensus.

The two health care providers are very committed to their patients, they are focused on their mission, operate with small budgets, employ few staff members, have a very limited influence over policy, they serve a very specific segment of the population, and do not receive state funding.

### **Participant A**

Participant A indicated that the board is composed of diverse group of members who work mainly in the private sector. The organization employs a small team of staff that serves disadvantage, poor, undocumented, and uninsured individuals. The organization operates in a locally limited geographical area and provides limited health care services that are philanthropically funded. The organization does not rely on local or state government funding.

### **Participant B**

Participant B indicated that the board consists mainly of individuals who experienced living with a disabled family member. The organization was founded to focus on policy, advocacy is carried by volunteer parents, operates statewide, employs a small team of staff, serves families with disabled family members, funded by a federal grant and does not rely on state government funding, and provides research and information to families, physicians, teachers, elected officials, and state agencies.

### **Participant C**

Participant C indicated that this trade association is a state-wide organization that represents 179 member organizations (includes for-profit and nonprofit health institutions, behavioral health facilities with inpatient beds and emergency rooms, community mental health centers, free standing psychiatric hospitals). The organization employs 30 staff members, funded by membership dues,

occasionally receives federal grants for statewide health care initiatives, and not affiliated with national organizations but occasionally coordinates fundraising activities with national organizations who share similar missions and goals. The core mission of the organization is to advocate and lobby state and federal entities to enhance reimbursement rates and protect member organizations from disadvantageous regulatory issues.

### **Participant D**

Participant D indicated that the organization is one of the largest health care organizations in the state of Indiana, controlled by members with deep religious values who are commitment to high standards of ethics and are very well connected to policy makers, legal experts, and the corporate community. Few board members are appointed by the church. The board has a formal values committee chaired by an expert on law and ethics and the organization has a values fund and a values officer who reports directly to the CEO and the board. The organization employs over 40,000 individuals, holds billions in fixed assets, and operates state-wide in urban, suburban, and rural areas. The organization receives state and federal funding for participating in state and federal health care programs. The organization requires large budgets to mitigate operational and budgetary risks associated with the complexities of the federal health care system, constant changes in federal and state laws, shifts in populations, and socio-economic swings that resulted in a highly volatile health care market or industry. The organization employs registered lobbyists and also contracts directly with lobbyists.

### **Participant E**

Participant E indicated that the board represents liberal and conservative local houses of worship and organizations that belong to that specific faith. The organization employs a very small team of staff that includes one registered



lobbyist, focused on advocacy and public policy, funded from membership dues, does not contract with any governmental entity, and formulates policy based on religious principles.

### **Participant F**

Participant F indicated that board members are CEOs of statewide affiliates who represent different communities (liberal and conservative; rural, urban, and suburban; affluent and disadvantaged; etc.), the organization employs a small team of advocacy staff with one registered lobbyist, funded from membership dues, does not receive state dollars, focused on multiple policy areas that include health care, and enjoys a decent working relationship with state agencies and elected officials. The organization tends to be politically neutral and does not take formal positions on controversial issues to avoid internal conflicts within the membership.

### **Participant G**

Participant G indicated that the organization is a state-wide trade association, the board consists of CEOs of locally affiliated chapters or institutions, has a very limited budget, employs a small team of staff with one registered lobbyist, does not receive state or federal dollars or participate in government programs, focused on promoting good policies that relate to a specialized area of health care that benefits a specific segment of the population.

### **Participant H**

Participant H indicated that the organization operates statewide in almost every county, is a subsidiary of a national organization with a budget of over \$23 billion dollar dedicated to health ministry, heavily driven by religious values, organization receives federal and state funding, employs professional advocacy

staff, contracts directly with lobbying firms, and formulates policy based on religious principles.

***Theme 4: Different Methods (Formal, Informal, Direct, Indirect)***

**Q4: Organization's Advocacy decision making process, type and purpose: During the implementation of HIP 2.0 in Indiana, what was the decision making process to formulate your organization's policy position?**

The eight organizations fully supported HIP 2.0 because the policy expands coverage to the uninsured population and allows organizations to improve their finances, which in return allows them to serve more people. HIP 2.0 was viewed favorably by most organizations thus minimizing internal conflicts. All organizations have a formal process to finalize policy and advocacy positions, some are more complicated than others. With the exception of the two health care providers, the remaining six organizations engaged in formal and informal lobbying activities. The two Hospital systems were focused on long term strategic goals, business model stability, and securing favorable regulations. The two trade associations have similar process to formulate policy, policy positions represent the best interest of their membership, and by extension they think they benefit the population they serve. The mutual benefits association, the faith-based nonprofit, and the two health care providers formulated advocacy and policy decisions based on political environment, a calculus of cost-benefits to their organizations and constituents, religious values and guiding missions and principles, and aimed to mitigate internal conflicts through consensus building.

**Participant A**

Participant A indicated that organizational conflicts do exist at different levels within the organization: board, volunteers, donors, and clients. When the ACA became law, board members who were mainly Republican business leaders

objected to certain aspects of Medicaid expansion. However, when HIP 2.0 was introduced as the state model for expanding Medicaid, board conflicts were mitigated by the board's commitment to formulate their policy positions based on the organization's mission, values, and commitment to serve their clients. This allowed the board to support HP 2.0 even-though the position contradicted personal or political ideology of certain board members. Among the examples of controversial issues that the board had to decide on are two examples: the smoke ban law and serving undocumented women who needed treatment. The organization did not solicit client input to formulate the organization's policy stance. Clients did not always understand their own interest due to the complexity of HIP 2.0. According to Participant A, the organization did not consult with patients but strongly felt that the organization must represent their interests. Clients were not always engaged in the process except on rare occasions when they were asked to testify.

Most constituents did not engage in the [policy decision making] process. They were not fully educated about the impact of the proposed policy. We felt strongly about being their voice.

### **Participant B**

Participant B indicated that the board makes policy and advocacy decisions based on data, research and best practices. Clients did not always understand the details of the policy and how it may help or hurt their own interest. Therefore, the organization played a role in educating clients about the policy and how it impacts their interest. Given that clients were not always engaged in the process, the organization tried to engage constituents using surveys and social media. During the implementation of HIP 2.0, organizational conflict was minimal given that HIP 2.0 did not directly impact the organization or their population.

## **Participant C**

Participant C indicated that the association's advocacy agenda is formulated based on feedback from districts and executives of member organizations.

Proposals are presented to sub committees called councils.

Council on government relations is the most prominent and plays significant role in developing policy. The Council recommends policies to the board. In the past, the association outsourced all lobbying activities. Most recently, the organization decided to insource, or bring back in house, most of the lobbying activities. The association has full time staff in senior positions dedicated to governmental affairs and legislative relations. The association supported HIP 1.0 and HIP 2.0 for many reasons including: higher reimbursement rates, expanded coverage to help the uninsured, and the ability to influence health outcomes.

## **Participant D**

Participant D indicated that the organization engaged in formal lobbying activities by staff, coordinated external lobbying activities with the trade association, and worked directly with governors and executives of state agencies. Top executives spent a great deal of time educating the public, employees, and peers. The CEO gave over a 1000 speeches in 5 years, engaged with mayors and governors for over 5 decades, had direct access to governors to discuss HIP 1.0 and HIP 2.0., and firmly believed that health care was not just an employee benefit but also the social issue of our time.

We [employ] 40,000 employees, if you add [their] dependents, that [is a] six figure workforce. So a lot of times we were educating ourselves. [We engaged in educational initiatives during] the HIP 1.0 [in collaboration with] Governor Daniels and HIP 2.0 with Governor Pence. [Our educational initiatives focused on motivating] people about [HIP 2.0 especially] in the for-profit world because most of the insurance payers are for-profit.

There was body politics [that my organization] had to deal with. [I worked with] everybody. I would deploy myself on a discrete basis when [there was a need for] direct communication with the head of the FSSA, the head of any state department, the head of OMB, the Governor himself. I think I met with governor Pence onetime alone in his office at my request to make sure that we are all on the same page.

## **Participant E**

Participant E indicated that the board formulates policy based on religious principles. Self-preservation is important to the board given the diversity of the faith-based community that they represent, advocacy and policy stances are evaluated based on political calculus, religious values, and internal consensus.

The fundamental sort of question that we ask ourselves is this a religious issue? And that really determines what our public policy is going to be. The reason that we're involved in public policy is little bit self-serving. Is that our primary mission is to make sure that the religious community is safe and secure and that we have a place where we can live, practice freely, engage freely, communicate freely, and ensure [these freedoms] for [our] community. We also need to have a hand in ensuring [those freedoms] for the entire community. [But I recognize that our positions] are a little bit self-serving.

We have an internal system here, our Board of Directors is made up of representatives from almost all the houses of worship in town... as well as other membership organizations. We have a couple of at-large members that represent [specific communities]. What we say is that we work on a process of consensus. To determine what a policy issue before us, it is a process. My government affairs committee hears the issue, talks about the issue, addresses a policy position and then the board will ultimately decide, but the biggest piece is consensus. We do not act unless there is clear consensus in the community and we do not have a definition of consensus. [Consensus] is somewhat something less than unanimity but more than a simple majority. Kind of you know it when you see it. But if we don't feel like we have the clear consensus of the community we don't act on the issue.

## Participant F

Participant F indicated that advocacy and policy positions are determined through a highly structured process that uses a set of principles that aim to protect the organization's reputation and relationship with communities and donors. The organization avoids taking positions on controversial issues and plays the role of a convener to help opposing parties reach a compromise.

I will start with the broadest level and that is we have a lot of e-mail communications throughout our policy update newsletter, which goes out to about 1500 staff. I also communicate by actually visiting a lot of communities where we hold a lot of community conversations or we have feedback sessions throughout the year. So I'm always collecting information in that way. Our local chapters have their funded partner organizations meeting. I go to those meetings and listen for what are the policies [of interest], what's working, and what's not working. Then at the membership level we have meetings with all of our executives ... this is an executive roundtable that meets four times a year. We [also] have a board of directors that is elected from the membership and they are the ones who decide on the decisions or policy priorities as recommended by the policy committee that meets every month. So we have [many] different ways to listen.

Our policy committee tends to be more politically savvy, so they will weigh the politics, interests of donors, volunteers, nonprofit organizations, the larger community, and [they consider the] diversity of our membership.

[The] board adopted a set of principles, one of the first principles [is] do no harm to any of our members of the movement ... we have principles around advancing the common good, sound policy, and [achieving] long term solutions, not [just] short term gains. [We are] always looking at [developing] long-term relationships.

We have been criticized for being too middle of the road, too milk toast [laughter]. I think we were called that once. But we feel that it is [important to help organizations find] compromise solutions. We help negotiate compromises among the different parties, parties who do not ordinarily talk together.

Well, initially [we were] cautious [to] not lose donors. Over the last 5 to 7 years, in this age of highly partisan political partisanship, [our philosophy has been] more about [being] the big person, [taking] the high road, and [sitting] down across the table from people that we disagree with. Someone has to [illustrate] that compromise [is sometimes necessary and acceptable], and we don't see that happening. So I think it started out as a do no harm principle and now it's more of we need to elevate ourselves for them.

## **Participant G**

Participant G indicated that policy and advocacy decisions and priorities are informed by the association's strategic plan and are made by the association's public policy committee that is appointed by the board chairperson. The CEO of the association develops an initial public policy concept paper and then works with the public policy committee to review concepts for the coming year. A formal vote is taken to approve the policy document, then the paper gets presented to the board of directors for further review and a final vote, then the paper is presented to the entire membership at any of the quarterly membership business meeting.

We supported the Healthy Indiana Plan. Obviously, as with most things, it will never be designed perfectly, but we did remain supportive of the idea of the Healthy Indiana Plan because we knew that our system was now [going to] be prepared to provide services to incredibly important part of our society that historically did not have access to Medicaid, especially people with criminal justice background, people coming out of the criminal justice system. Some people need access to substance abuse treatment. In the old days, prior to HIP 2.0, it was very difficult to be eligible for Medicaid [if you had a mental health issue] or if you had a disability. We could not provide substance abuse treatment under Medicaid unless it was a co-occurring disorder. [HIP] opened the door now for anyone under 138% or below of the federal poverty level who qualifies to receive services to address [mental health issues]. [The implementation of HIP 2.0 came during the] opioid crisis, which is unfortunately [late]. I believe we have [an opioid crisis] because we did not invest [previously] as a society in mental health. So given those factors we were supportive [of HIP 2.0].

## **Participant H**

Participant H indicated that policy and advocacy decisions are made based on data, research by the policy and advocacy staff, organization's strategic priorities, and discussions and final votes on the executive and board level.

One of the main principles in deciding policy is the impact of the policy on the business model and long term stability of the organization. Patient feedback was not formally solicited.

Public Policy, or Health Care policy, is what I believe to be the foundation of what a health care leader [should focus on] as an advocate for their community regardless of their size. I would say that [looking after my community] was a trade instilled in me early not only in the University of Kentucky but early on in my career and it has been a corner stone of every role I've had throughout my career.

Reading it from a Federal aspect of how do we have expansion? What does each of our market position looks like based on what that state is considering doing? How do we support that individual market with resources? [What] other intelligence [do we have]? [What] conversations and connections [we need to pursue] at the Federal level to make sure everyone of our markets has some form of expansion that goes along with getting more people served? [These are the policy questions we must consider].

### ***Theme 5: Different Levels of Influence***

#### **Question 5: Influence over the implementation of the policy process: How did you influence the policy implementation?**

With the exception of the two health care providers, the remaining six organizations engaged in formal and informal lobbying activities. The two Hospital systems were focused on long term strategic goals, business model stability, and securing favorable regulations. The two trade associations have similar process to formulate policies that serve the best interest of their



membership organizations and by extension they believe their policies will benefit the population they serve. The mutual benefits association, the faith-based nonprofit, and the two health care providers formulated advocacy and policy decisions based on the political environment, a calculus of cost-benefits as it relates to their organizations and constituents, religious values and guiding missions and principles, and aimed to mitigate internal conflicts through a consensus building process.

The data illustrates that a complicated web of relationships exists within the nonprofit sector by which leaders of the largest health care organizations serve on boards of other health care nonprofits and help shape their agendas. One health care executive had a direct access to the governor and government staff. Nonprofit leaders and organizations are divided into two camps with differing worldviews. One camp views themselves as humanitarians while the other camp views themselves as pragmatic. Humanitarians tend to criticize dominant groups like hospitals. Leaders of large hospital systems believe that smaller organizations do not fully understand the complexities of running large enterprises.

### **Participant A**

Participant A indicated that the organization did not engage in formal lobbying. Policy and advocacy were not part of the organization's mission until the last few years mainly due to hiring progressive leadership with policy background. The organization engaged in educating the general public, provided testimony on advocacy days, and educated public officials. Communications with state agencies and elected officials were sporadic and infrequent. The organization joined a partner organization groups or a coalition that was focused on health and human services policies and programs. The coalition was loose, not formally registered, consisted of many groups with different focus areas, did not always represent the underserved, and many organizations represented clients with

multiple needs. The coalition was led by leaders of prominent health care organizations. National organizations with local chapters were engaged in the coalition and frequently dictated to the local level certain positions that complicated the work and decision making process at the local level.

A few really active engaged individuals or organizations [led of the coalition]. Individual organizations were always given the opportunity to [either support] or not participate in a call to action...A lot of politics were involved. It was a Medicaid expansion but done in a certain way... [And many] organizations tried to take credit for the [coalition's] work.

## **Participant B**

Participant B indicated that the organization did not engage in formal or direct lobbying. Volunteers who were also parents advocated for their own cause. The organization engaged in educating the general public by disseminating research and fact papers, provided testimony as needed, and educated public officials on issues confronting families with disabled members. The organization communicated very frequent with state agencies, at least daily, on specific health care issues. The organization was viewed as a trusted partner particularly as it relates to maternal and child health in the department of health and FSSA and department of disability services and Medicaid. The organization participate in a coalition that was loose, not formally registered, consisted of many groups with different focus areas, did not always represent the needs of the underserved, and many organizations represented clients with multiple needs. The coalition was led by leaders of prominent health care organizations. The coalition's internal decision making process allowed member organizations to opt-in or opt-out of calls to action, voted on certain issues, or co-signed letters supporting or opposing certain positions. National organizations with local chapters were engaged in the coalition and frequently dictated to the local level certain positions that complicated the work and decision making process at the local level. Many organizations tried to take credit for their work. Private for-profit entities did not

participate in the coalition directly, but many member organizations had that representation on their boards.

We have developed relationships where our volunteer policy voices are seen as key and trusted resources from many members of our congressional delegation. We have some emerging, but not as effective as we would like, relationships with state legislators.

Member organizations provided resources. Few organizations had paid lobbyists or full time lobbyist staff. Organizations came to the table with their resources depending on what the need was (a letter, a lobbying meeting, a newspaper ad, it this a rally, who is going to be the primary host, how are we [going to] collaborate resources and maintain the letter of the law related to advocacy and then also be most effective in messaging.... A lot of politics were involved.

Faith-based nonprofits favored rallies and public demonstrations. Insurance companies and trade associations opted out.

[We] supported HIP 2.0 even though the program does not cover our primary constituency. We felt like we could be the voice for parents who did not have coverage and whose abilities to [give care] was impacted by their lack of access to health care.

### **Participant C**

Participant C indicated that the association engaged in direct negotiations with top state executive, conducted formal lobbying activities, educated the general public, testified on health care related policies, and shared policy proposals with elected officials. The organization communicated very frequently with state agencies and enjoyed a very strong working relationship with elected officials. In addition, the association participated in a coalition with other organizations to advance the goal of expanding coverage through HIP 2.0. The coalition was organic, informal, not registered as a legal entity, and engaged in a constant iterative process of responding to changes in the political environment. The CEO serves on the boards of multiple organizations that were members of the

coalition. The HIP Finance Overview document (see appendix D) clearly states that the state and the trade association engaged in direct negotiations.

[The organization] was pulled into some direct negotiations with the state around funding. Most of that was informal but regular.

## **Participant D**

Participant D indicated that he was very connected to many former governors, elected officials, and policy decision makers. He was personally engaged in direct negotiations with former governors, his organization engaged in formal lobbying activities, and participated with a trade association to represent the interest of all hospitals. The CEO served on critical government commissions that influenced health care policy in Indiana.

We have a large lobbying operations and [a] state-wide footprint. So we were able to communicate as the largest employer in [legislators] local [communities]. I personally spent a lot of time [lobbying and educating] because [rural legislators] got the same number of votes [similar to those] who serve in downtown Indianapolis. In some cases, because of seniority, [rural legislators had a] lot more influence [than urban legislators] especially [when rural legislators] are in the majority, which in Indiana is more likely to be Republican than Democrats [especially over] the last 10-15 years. So I spent a lot of time with [legislators] and deployed my own personal time [to shape] public policy.

In 2009 the Affordable Care Act passed. Governor Pence was [then] the whip in the minority [party of the United States Congress] so he was whipping votes against [the ACA]. [He] personally voted against [the ACA]. [Few years later, he] becomes governor [after Governor] Mitch [Daniels left]. [As a result], we started focusing on Governor Pence. [Governor Pence] is younger than I, I [have] known him his entire professional life pretty well. I knew that he was a reasonable person, but very conservative. [So when he became governor], we had to help him get from [HIP] 1.0 to [HIP] 2.0.

## Participant E

Participant E indicated that the organization did not formally lobby elected officials to expand Medicaid, participated in a broader coalition, and engaged with executives of state agencies under the umbrella of a broader coalition. The board of the organization did not reach consensus regarding whether or not to support Medicaid expansion, so Participant E participated individually through the coalition to express his personal views and beliefs. The relationship between Participant E and the executive of the state agency that was responsible for implementing HIP 2.0 was turbulent for the first six to eight months due to conflicting views on how to expand Medicaid. After it became clear that the political environment in Indiana will not advance a full Medicaid expansion, Participant E worked with the coalition to advance HIP 2.0 as a local model of the ACA expansion.

Going back to that particular meeting with the Medicaid director, definitely it was more adversarial at the beginning... and even though we were not successful in pushing a traditional Medicaid expansion, I think what we did there that was successful was keeping the issue [of Medicaid expansion] at the forefront, and I really feel good about us having a hand in doing that. It could've been easy for Governor Pence particularly with his politics and particularly with future aspirations to just say we're not expanding, no way, no how, and I do not want to talk about it anymore. But by strongly advocating for Medicaid expansion we kept the issue alive and we kept it there so he [Governor Pence] had [to] engage. [He had to either] not expand Medicaid [or] find a different way to do it, and so that was the benefit [of our advocacy].

Later as our position evolved we were able to deliver over 10,000 signatures to the governor's office on Medicaid expansion and we heard directly from the executive of the state agency especially in the last couple of months. [We were aware that] not only did the governor receive some pushback from conservative circles on the HIP 2.0 program, but obviously he's also received a lot of pushback from sort of classically progressive policy think tanks [such as] the Center for Budget and Policy Priorities, Families USA, the Georgetown Center on Families.

[These organizations were] basically saying you can't do this, you can't have copayments, you can't have sliding scales, you can't have lock out periods, and things like that. [Therefore], the way that we have engaged over the last 6-8 months is to strategically push on these issues but be supportive of HIP 2.0 because at that point with politics that was the best thing to do.

## **Participant F**

Participant F indicated that the organization engages in formal lobbying, conducts formal advocacy, and engages with elected officials throughout the year. The organization supported HIP 2.0 but did not aggressively lobby for traditional Medicaid expansion under the ACA to avoid internal conflicts between liberal and conservative donors and communities that the organization serves. Participant F engaged on a personal level in a broader coalition to express her views and carry on the mission of her organization.

I think our role as an organization was not as strong on the legislative side so I would argue that our engagement has been more with state officials because again we didn't initially take a position. So we did not, we were not as engaged in the policy as the implementation side.

When the state filed its application and submitted its proposal for HIP and its proposal to extend HIP 1.0, I wrote all the comments. Very overly lengthy set of comments around our concerns. It was about our support for HIP. So they read the details, and they were very detailed, [explaining] why we supported [HIP]. We [also] conveyed our concerns about [coverage for] pregnant women, how [unbanked] people can make payments, [and suggested allowing HIP 2.0 members to pay their] power account payments online or by mail.

In addition, we had a lengthy list of concerns about the lockout [provision], [the ambiguity of rules regarding] people who are right at [the eligibility level], who go [above the eligibility level], who have changes in income over the course of a year, the concept of personal responsibility, and the cost curve for so many of the uninsured who never have access except to the emergency room.

It will take a lot of education, and [we questioned] what kind of support will FSSA provide? Or what does the faith-based community need to provide to help with the educational piece?

We will sometimes engage in a coalition so that we can be more active than what our membership allows us, so sometimes we hide in a coalition and honestly there are times that we do a lot of that work.

So for example, I write a lot of policy positions for the Indiana Coalition for Human Services that maybe [my] organization cannot take but under the coalition umbrella we can engage and influence [policy].

We knew politically that it would not be accepted by all advocates to say all child care [advocates] needed to focus on [the HIP legislation], or on tax funded childcare [centers]. That's how we negotiated [by allowing different advocates focus on their area of expertise]. Our policy committee tends to be more politically savvy, so they will weigh the politics [while considering] interests of donors, volunteers, nonprofit organizations, the larger community, and also weighing the diversity of our membership. So for example on the immigration issue some of our rural communities did not want us to touch that [issue]. Some of our urban communities felt it is a moral obligation and we have to engage. So [we] wrestled [with] how do you balance the needs of all of your members? [This] is a challenge so we try to craft a middle ground.

## **Participant G**

Participant G is a registered lobbyist. He indicated that the association supported HIP 2.0 because it expanded coverage for uninsured individuals, which was a good public policy that had a positive impact on the general population even-though HIP 2.0 benefits and funding for the segment of the population that was served by Participant G's membership was not increased.

The association engaged in formal lobbying activities while also utilizing a contracted lobbyist to perform additional lobbying services. Participant G informally participated in certain events as part of a larger coalition.

Participant G believes that his organization was isolated throughout the process.

The hospitals contributed financially to fund a portion of HIP 2.0, therefore,

Participant G believes that his association was not influential in impacting the crafting of HIP 2.0 because his membership did not contribute to funding HIP 2.0.

The public good is at the heart of everything that we are trying to do. And at the end of the day, it is the highest level. But in terms of day to day we are not just talking about [the public good] to the public, we are doing it, working in the weeds. [The Health care field] is a very complicated system.

Unfortunately [my] organization is not a major player. Our ability to influence the spectrum is not that great but we [issued] a press release and certainly when [HIP 2.0] was working its way through the legislature we were supportive in areas related to [health care coverage]. But mostly since [HIP 2.0] was done on the administrative level as an amendment to the previous waiver, [the expansion] was mostly administrative in terms of how it unraveled.

## **Participant H**

Participant H indicated that the organization engaged in both formal and informal lobbying. The organization's chief advocacy officer and contracted lobbyists communicated frequently with state legislators, helped build strong relationships between hospital executives in different counties with their state representative or senator, and worked very closely with the trade association to formulate policy positions and lobbying strategies. The organization sees its advocacy efforts as part of the day to day operations through the engagement with patients and communities.

For [my] organization advocacy starts with the relationships we develop with our elected officials and patients and consumers. We look at our elected officials no different than a patient or a consumer in that we want them to understand what the organization is all about and to look to us when they have a question, [they can call us and say] help me understand this, what should this be for a system that covers individuals from pre-natal to end of life? We feel being the advocate for that in several different fields.



For [my] organization, our philosophy [is] not only for the leadership [to promote] but for every associate and medical staff member [to know] how we advocate for public policy. [Public Policy] is a formal and informal process, it is a formal and informal job duty, and it is something that must be done on a continual basis. There are aspects of [policy advocacy] that are [embedded in] how we operate on a daily basis in terms of how we believe health care [services] should be conducted [and] how [service costs] should be reimbursed. There are also the formal pieces of policy advocacy [that are handled by professional staff and formal lobbyists].

### ***Theme 6: Hospitals Were the Most Influential***

**Q6: Impact of influence over Medicaid Expansion in Indiana: Please explain the impact of your efforts to influence the implementation of Medicaid expansion in Indiana?**

The eight organizations fully supported HIP 2.0 because the policy expanded coverage to the uninsured population and allowed organizations to improve their finances, which in return allowed them to serve more people. HIP 2.0 was viewed favorably by most organizations thus minimizing internal conflicts within and between organizations. Hospitals were the most invested stakeholders given the financial commitment they made in financing HIP 2.0, so the state negotiated directly with hospitals because they were the most important stakeholders, they have statewide impact on improving access to health care, and they are the largest employers in many counties of the state. Given the political environment and the general consensus between organizations that implementing HIP 2.0 was better than maintaining the status quo, most organizations supported the policy but focused on the transactional aspect of the implementation.

## **Participant A**

Participant A indicated that the organization advocated for positions that supported the expansion of Medicaid, and ultimately the state implemented HIP 2.0 and expanded coverage. This allowed the organization to get services paid for by Medicaid and re-allocate existing funds to other areas of the organization where they were most needed, such as wrap around services. Clients benefited by getting more coverage and became more educated about the new policy. The organization was very pragmatic about what to advocate for given the political parameters that were set by the state. Success was evident through the reduction of number of screenings that became a covered benefit under HIP 2.0.

[The organization] always [focused on setting] policy that covers as many people as possible. Our focus was [to] make sure we set our policy for the 80% [of the population] that [the policy] works for; the 20% that it does not work for we will figure out [a different solution], but we can't set the policy around the 20%.

Certain organizations like the hospital system had more influence, power, and financial stake than others. Their staff were fulltime and focused on policy.

## **Participant B**

Participant B indicated that the organization advocated for expanded coverage without the cost participation requirement, also known as the Power Accounts. Uninsured families with children or disabled family members benefited by having access to health care coverage. The organization was very pragmatic about what to advocate for given the political parameters that were set by the state. Participant B believed that certain organizations like the hospital system had more influence, power, and financial stake than others. Participant B believed patients were happier with HIP 2.0.

I will give [HIP 2.0] a 7 out of a 10 point scale. I would have preferred that Indiana take straight Medicaid expansion, I think that would be a better policy that would've created less barriers to coverage for the HIP population. It would [have] been a better way to ensure a healthy state but [HIP 2.0] was significantly better than not taking anything. A lot better than nothing.

### **Participant C**

Participant C indicated that initially member organizations had different views about the ACA. However, once it became the law of the land, the focus shifted to implementation. The association advocated for expanded coverage because they believed it was the right policy for Indiana's population and focused on mitigating the risk of financial loss due to cuts in DISH payments, Market Basket, and Medicare reimbursements. Due to the political environment, the organization supported HIP 2.0 without calling it Medicaid expansion.

The association was given direct access to negotiating with the state because of two reasons: (1) viewed as trusted partners and the most important stakeholder in the policy arena since the inception of HIP 1.0. Hospitals were the most impacted by uncompensated care. Market Basket cuts exceeded \$1 billion in 2015, and will exceed \$8 billion by 2020. (2) There was no other mechanism to fund the program without the Hospital Assessment Fee (HAF). So the state had to negotiate directly with hospitals to ensure that the new policy did not negatively impact hospital operations because financial stability) could lead to closure of hospitals or reduced access to health care providers.

In addition, the association participated in a broader coalition. Calls to action within the coalition were driven by representatives of particular disease or syndromes groups or local chapters of a national organization. Some organizations within the coalition were affiliated with national organizations that imposed their national agenda to expand Medicaid on their local affiliates despite the governor's opposition to the ACA and the pragmatic understanding of

Indiana's organizations that HIP 2.0 was a better policy than having no expansion. This dynamic created tension within the coalition.

## **Outcomes**

In terms of outcomes, Participant C indicated that there are 250 thousand individuals that have coverage today that would not have had coverage had his association not been engaged and ultimately worked to find a solution.

Indiana, from the policy side, was one of the most restrictive states in Medicaid eligibility. HIP 1.0 covered individuals who were 23-24% of the Federal Poverty Level for care takers, no coverage, no really program for adults outside of the HIP 1.0, which was limited, I really think [HIP 2.0 is] a huge step forward for us in many respects. So I feel very good about the bi-partisan support [for HIP 2.0]. I think the primary beneficiary are the people that have coverage now that would otherwise would have not if the politics were different.

All of our members would say that coverage is the right way to get people the right care, at the right time, not through the ED, but have coverage through primary care physicians to try [taking] care of chronic conditions before they become worse and much more expensive.

We had the most to lose, so we were the loudest voice ... our members exist in every large community. We encouraged our members to write op-eds, visit with their lawmakers, talk with the administration, talk about coverage on social media, and [we] undertake a lot of activities to push [information] out there. [Our efforts] helped promote the sense that hospitals are behind this policy and [hospitals] want to see it enacted. Hospitals are large employers, almost 200 thousand Hoosiers are employed across the state. In many communities, they are the largest employers in the county if not in the multi-county region.

## Participant D

Participant D indicated that his organization engaged in direct but informal negotiations with the governor and state officials to expand coverage. In addition, he worked closely with the trade association to finalize the details of the program. Participant D leveraged his personal relationship with the governor and other state officials to remind them of the importance of expanding coverage to the uninsured.

We were very successful in dealing with [state officials], very successful, never really had a bad year. The recession was bad but [government] had nothing to do with that, Mr. Market did that.

In 2009 the Affordable Care Act passed. Governor Pence was [then] the whip in the minority [party of the United States Congress] so he was whipping votes against [the ACA]. [He] personally voted against [the ACA]. [Few years later, he] becomes governor [after Governor] Mitch [Daniels left]. [As a result], we started focusing on Governor Pence. [Governor Pence] is younger than I, I [have] known him his entire professional life pretty well. I knew that he was a reasonable person, but very conservative. [So when he became governor], we had to help him get from [HIP] 1.0 to [HIP] 2.0.

I was directly involved in dealing with governmental representatives on the [Hospital Assessment Fee] committee, [which played a critical role] in [designing the financing model for] the implementation of HIP 2.0. We also received DISH payments. As a result of these algorithms [and the complexity of the funding streams], I was very much involved in [these decisions].

I had to remind state staff [working for FSSA and the Governor's Office] why are we doing HIP 2.0? [I explained] that [HIP 2.0] was not a bureaucratic exercise, it was to get people enrolled to fill the hole for folks who otherwise [were] uninsured.

There was body politics [that my organization] had to deal with. [I worked with] everybody. I would deploy myself on a discrete basis when [there was a need for] direct communication with the head of the FSSA, the head of any state department, the head of OMB, the Governor himself. I think I met with governor Pence onetime alone in his office at my request to make sure that we are all on the same page.

The trade association was going back and forth with him on the funding as you can imagine. I [met with the Governor to] reinforce the idea that we did share a common value which is to serve as many people as possible and improve the health of particularly the underserved. His political argument may have been about self-determination and federal budget deficit mandates, but at the end of the day his goal was the same as mine. [The Governor's challenge was] how you translate that into marching orders to other folks? [This is] the art of administration and politics. That was up to him, so I remained focused on [the idea of] expansion.

The profit margin did increase after HIP 2.0 after we started getting paid for our compensated care at Medicare rates for Medicaid expansion.

### **Participant E**

Participant E indicated that he represented the coalition in 2012-2013 and advocated for a traditional Medicaid expansion. In meetings with state officials, the conversations were adversarial at the beginning; however, even though the coalition was not successful in pushing a traditional Medicaid expansion, Participant E indicates that the coalition was successful in keeping the issue at the forefront.

The coalition delivered over 10,000 petitions to the Medicaid Director from supporters of Medicaid expansion. Participant E feels that his personal involvement in the coalition with other organizations and like-minded individuals pushed Medicaid expansion over the finish line.

I really feel good about us having a hand in doing that. It could've been easy for Governor Pence particularly with his politics and particularly with future aspirations to just say we're not expanding, no way, no how, and I do not want to talk about it anymore. But by strongly advocating for Medicaid expansion we kept the issue alive and we kept it there so he [Governor Pence] had [to] engage. [He had to either] not expand Medicaid [or] find a different way to do it, and so that was the benefit [of our advocacy].

Later as our position evolved we were able to deliver over 10,000 signatures to the governor's office on Medicaid expansion and we heard directly from the executive of the state agency especially in the last couple of months. [We were aware that] not only did the governor receive some pushback from conservative circles on the HIP 2.0 program, but obviously he's also received a lot of pushback from sort of classically progressive policy think tanks [such as] the Center for Budget and Policy Priorities, Families USA, the Georgetown Center on Families. [These organizations were] basically saying you can't do this, you can't have copayments, you can't have sliding scales, you can't have lock out periods, and things like that. [Therefore], the way that we have engaged over the last 6-8 months is to strategically push on these issues but be supportive of HIP 2.0 because at that point with politics that was the best thing to do.

## **Participant F**

Participant F indicated that it was a pragmatic decision to support HIP 2.0 instead of a traditional Medicaid expansion under the ACA. Once the state frames the parameters for expanding Medicaid using a locally invented model and not the traditional Medicaid expansion model, Participant F and other members of the coalition focused on improving the design and implementation of certain transactional aspects of the program.

I think I'm satisfied because we did not cross the line with our members. Am I happy with the policy? Probably not. We did not get everything we wanted. I don't think people fully understand the demand or the challenges for low wage workers. We won't be satisfied [until more people understand]. So I'm satisfied that it is what it is given the circumstances but I'm not satisfied with the outcome yet.

I think [the policy discussion with the state] is more of a dialogue and this is where the rubber meets the road in terms of the intervention of politics. [We recognized] that there are certain public positions that the governor advertised in the media. [However] there are certain activities that the managers and staff of FSSA or Medicaid are able to carry out and do good work.

[The administrative level is] where I want to have influence even if the top level [i.e. the governor] was ranting about Obamacare as evil or whatever [he] wanted to say. If the [Medicaid] program can be improved by my friends, the bureaucrats that I love [laughter], state employees, then that's where I want to have the influence. A very specific example, one of the ongoing questions is with an issue of prepayment versus monthly payment. I, as a consumer, can go and get a discount if I prepay my insurance, I get a nice discount. Why won't we allow low-wage workers to prepay when they get their tax refund? It just makes sense, they have the money, they are making a good decision, it is good planning, and that's good responsible activity. So that's a conversation that the Medicaid Director and I had and we have weighed in a public way through the coalition. Why [did we advocate for this change]? [We asked FSSA to consider how would] 80,000 Hoosiers who are still unbanked and do not have a checking account [pay their power account fees]? [We offered a solution to] create a mechanism for the [unbanked] to pay through no additional fee through a partnership with a vendor like a Kroger or CVS or Wal-Mart.

[We raised many questions such as] where can [the unbanked] go and make their safe and secure payment? How do we make sure that that population gets the best service? Because the lockout is scary and even non-payment is scary for someone who has no track record in making monthly payments. And how can we make sure that there is an appeal process and coverage [continues] if an error on the state side [occurs as a result of a losing, not filing, or not processing the right document? How we can make sure that [a] person doesn't get a bill [while they still] have credit. So those are the kinds of [policy implementation] conversations [that we had], [these were] client or consumer focused issues.

The other concern we brought to the Medicaid Director and had conversations about it is the cost of implementation. There is an administrative burden to providers to collect the copayment, the administrative payment, and what we've heard from health physicians is that it is cheaper for them to write it off than try to collect a five dollars co-pay or three dollars. So I don't think there is a fair recognition of how the [power accounts or co-pays] work because healthcare providers are [focused on health care delivery] and [should not] be distracted with a lot of things that may not be recognized. We don't have data to actually evaluate how well [power accounts and co-pays] works and I would love to have more data that shows [how] it works out.



## **Participant G**

Participant G indicated that the organization supported the implementation of HIP 2.0 because it was a good public policy that will reduce the number of uninsured individuals in Indiana. The association supported the policy despite the fact that they felt they were excluded from negotiations about the design and implementation of HIP 2.0, which did not increase reimbursement rates for member organizations of Participant G's association. Participant G thinks his association was able to influence one transactional aspect of HIP 2.0 that impacts the designation of elders who are considered medically frail.

HIP 2.0 has done a lot of amazing things for a lot of people. One of the requirements of HIP 2.0 is also that health centers could use presumptive eligibility determination with respect to Medicaid eligibility. That helped. That really assisted us getting people into care, I will tell you the problem we will have with HIP 2.0 and for the way it was envisioned to the way it was implemented. We simply have not been able to adequately respond to the demand of services because there are so many new people who are eligible and in need of services as we sit in the opioid crises. There are a lot of addiction out there we haven't been able to respond to in a way that provides them with easier access to care and almost exclusively because we do not have enough licensed professional staff to carry the service requirement in order to bill Medicaid or commercial insurance.

Certain standards have to be met [to get reimbursed]. This is very challenging especially in rural areas. Even in urban areas, [it is difficult] to find enough licensed staff to carry on the responsibilities associated with [mental health treatment]. While there was some increase in MRO rates associated with the expansion of the HIP 2.0 program, those rates have not been raised for many years.

## **Participant H**

Participant H indicated that his organization fully supported HIP 2.0 because it expanded coverage for the whole population that was not currently served, which

then would lead them to the right care at the right place at the right time. That's the end goal, to have a healthy community.

Hope, justice, dignity, truth [are values we believe in]. [It is part of our value system to] look at ourselves and say how we practice virtues as servant leaders and extend our mission to everybody?

When you speak with an individual who does not seek health care proactively [you discover that] their biggest barrier [is that they] do not have coverage, [the uninsured would say] I can't afford this. HIP 2.0 immediately [took] down almost every bit of that barrier and then that allowed [the hospital system to develop] a closer connection with an [uninsured] individual to figure out how [the hospital system] can serve [this person]? How [can the hospital system stay in touch with this person]? How [can the hospital system] restore another level of dignity with this person? The Governor used to say HIP 2.0's biggest success is [that the program is] a hand up and not a hand out. Now with the successes of [HIP 2.0] we [thought of] how [can we] utilize [this program] to generate more and more momentum that come with it.

In general our biggest belief is we have to have [a] safety net. We want more coverage for more individuals and those to me are fundamental aspects of how we improve health outcomes.

### ***Theme 7: They Switch Roles Based on the Issue***

#### **Q7: Whose interest does your organization represent: Does your organization represent dominant, challenging, or repressed groups?**

The two 501-C-6 Trade Associations, the 501-C-3 faith-based organization, and the statewide mutual benefits organization represented the interests of their board members and CEOs of member organizations. One of the trade associations represented dominant interest, the other association represented challenging and repressed interest. Both the faith-based nonprofit and the statewide mutual benefits association represented their membership's interest and they valued internal consensus over taking public positions on controversial policies. Therefore, leaders from both organizations engaged under the umbrella

of broader coalitions to challenge certain policies. Thus, they represented challenging interest to improve the transactional aspects of certain policies. The other four organizations viewed the patient and the larger community as their primary constituency [two 501-C-3 health care providers and the two 501-C-3 hospital systems]. Large health care providers were very dominant and influential over health care policy in Indiana. However, participants from these organizations firmly believed that they use their dominance to represent challenging and repressed interest. They did not see a contradiction between their business model and values to serve the repressed. They disagreed with those who criticized their business model by explaining the connection between profits and an improved health care delivery system to the repressed population and the larger community. Participants representing advocacy groups believed in representing the interests of the repressed and voiceless. They viewed their roles as humanitarians and they criticized dominant trade associations, large health systems, and other health care providers for being profit driven. However, under HIP 2.0, they decided to support the policy because it was a win-win-win for the state, the health care industry, and the larger population.

### **Participant A**

Participant A indicated that her organization advances the interest of the repressed.

We advance the interest of the underserved, the uninsured, and the low income chronic disease population... We represent the repressed. We engage in challenging certain aspects of the policy, but we mainly represent the repressed.

We were pushing for healthcare or Medicaid expansion because that was to us what was on the table that was right for our clients. As that evolved and became HIP 2.0, we didn't dig in our heels and say no we just want Medicaid expansion. We really looked at [HIP 2.0] and said okay this has a better chance. [HIP 2.0] got the political will and it's really good for our clients so we became very supportive of the program.

## **Participant B**

Participant B indicated that they represent the repressed. She views herself as a humanitarian who represents the voices of an underserved population. Her organization is willing to lose funding if funding will limit their ability to remain a voice for the voiceless.

We try to stay in our lane so we focus on policy where we have expertise and connection to our mission and vision. So HIP 2.0 is a policy that touches the lives of families who are raising disabled family members with complex health care needs...we really try to make sure the things we focus on connect with our mission and vision.

We are always interested in grants and support from our state partners and our federal partners and are aware that public positions that are against an administration can make that challenging. So we try to be mindful of that and have a clear conversation with the board around the pros and cons and are able to move forward. A recent example, the last legislative session we were asked to give comments on a bill around abortion based on prenatal diagnosis and so there was a board discussion whether this is an issue we should give a comment on and we declined to give comment on it as it did not really fit within our vision and mission.

We always start with our vision and mission and we always start with the needs of our children and families in Indiana who have a lived experience of medical complexity and disability and if that means we will miss a funding opportunity or other things then that is what it means.

I think the people involved were savvy enough to understand the competing priorities and that for some people in the room this was about reimbursement and profit margins and for other people in the room this was about a more humanitarian mission and the impact on end users. The fact that people understood that allowed it not to be a significant issue. Generally the humanitarians among us which I probably would put myself into that category were not opposed to the hospital system making more money because more people have insurance.

## Participant C

Participant C indicated that his organization represents dominant interest but does not see a contradiction between their business model that serves the membership and the advancing the interests of population they serve. Participant C thinks they are mutually inclusive.

Ideally what I would like to say, the political answer I would give you, I have to acknowledge [that we are] a dominant interest, but I think there are elements of the others. I will give you two answers, which is very political. I would say dominant because if I have to pick one that would make sense because I think that is what we are, we are the trade association and that's how we are identified.

[It is worth noting that] even within our for-profit systems we have physicians [who took an oath] with their leadership positions to [serve their patients and be] passionate about things like infant mortality.

[Our organization could also be viewed as representing challenging and repressed interest]. Some of our faith-based religious affiliated institutions were founded by the mission taking care of the poor and I think our members do live up to those commitments today [especially] when you look at their hospitals they still continue to operate in our state [and advocate to enroll] individuals in those programs and directly help them.

Back to the dominant interest [question]. Yes, the fact that we were able to reduce the uncompensated care helps [hospitals] run their business and their operations and continue [their] missions. Otherwise they would wither. It is mostly dominant but with input from the others.

## Participant D

Participant D views his organization as a representative of dominant interest but does not see a contradiction between the business model and serving their patients and communities. Participant D also believes that conflict of interest may appear in all sectors and fields including the public sector or government. The perception that hospitals are profit-driven is misleading because it implicitly

suggests that hospitals with fixed assets that are worth billions of dollars and employs tens of thousands of employees should not care about profits. He argues that hospitals that lose profits tend to close and subsequently stop serving the needs of the most vulnerable in our society. Most hospitals tend to run a distribution of profits model by which hospitals in suburban areas subsidize losses of hospitals in urban areas where they serve the most vulnerable in our society.

I view my role as continuity to the original purposes of the organization, and the only reason I mention that this informs our position on Medicaid expansion. I view it as a values based decision and not an economic decision or a political decision. My true north so to speak was the values proposition that our purpose was to provide health care and innovation to everybody [and] not a [specific] segment.

You can make both arguments, it is easier to argue [nonprofits advocated] for their own interest. Our customer is the patient. The patient, not Anthem, not the State of Indiana, it's the patient. So my job as a CEO is [to serve] all the patients. Your job as a practitioner is [to serve individual patients]. The two of those coming together means I look like I am arguing for more money, and [others] look like [they were] arguing for more money for [their] area. So if you are a policy maker, it is essentially hard to disagree with [groups such as the] neurosurgeons [who argued that if] you give me [these resources], we will do that.

[Policymakers had to think about] where can I do the most good that I can? I think most of [nonprofits] would come off as if we were arguing for ourselves, and I believe in most cases [that was true]. Confirmation bias convinces us that we are arguing on behalf of the greater good but in fact we are arguing on behalf of ourselves. So you [have to] do a gut check and I cannot say with any reasonable assurance that what I was doing and what I actually did was the same thing. It could be what I thought was doing and what I was actually doing was more than just accidentally benefiting my organization. So I'd admit to a conflict of interest, but I also say that [government] as the policy maker is to figure that out.

The core function of hospital systems is acute care. The organization is one of three acute cases in the State of Indiana, so we would be the dominant by far on the core business.

And [as for] repressed [interest], [this relates] to the values. [Ethical dilemmas at the hospital system] would include end of life decisions. I must tell you that if I agonized over anything, and the chairman of my organization's values committee knows this, I agonized over [what we were doing with acute care]. We were so focused on acute care [and] providing unnecessary care to 96 years old with dementia patients who are voiceless, or the pregnant mom how comes in labor and never brings the baby back for a well-baby visit and we know where she lives. In fact, we got the data from the state board of health that tells the infant mortality rate is high [in Indiana].

You can ration care in a number of ways. One [example] is in the form of access. [The organization could choose to] close the clinic at 4 o'clock. Anthem used to shut down their customer service line in the afternoon, so that's an access issue. [If] you do not build a clinic on a bus line what do you think is [going to] happen? [What happens if you're not open on Saturdays or weekends? So you can do it that way [by shrinking service hours or limiting service locations], or you can say we can't afford to do it [unless we] charge this co-pay. So there would be well intentions, sometimes high minded sometimes not so high minded, debates at the governance levels between what you and I call the finance people and the values people and then the patients' folks group.

## **Participant E**

Participant E indicated that they represent the voices of their own membership. Even though this organization is driven by religious values, they place a higher value on internal harmony within their membership over taking public positions on controversial policies. This approach positions them to challenge certain policies indirectly without sacrificing their self-interest.

I think if you asked a number of us individually we would say that we are still more supportive of a traditional expansion but if this is the program that's going to allow those individuals get covered we can support it...

[We had] a lot of discussions about whether the HIP program had the ability to take on these new clients? Should it be the vehicle? Could we be supportive of this knowing that there were some real deficiencies within the program that we thought would make it difficult to expand into that much larger population? Are we hurting the possibility of traditional expansion if we too quickly support a HIP model? So there was a lot of disagreement over time and there was a period of over multiple months that eventually the position evolved.

The fundamental sort of question that we ask ourselves is this a religious issue? And that really determines what our public policy is going to be. The reason that we're involved in public policy is little bit self-serving. Is that our primary mission is to make sure that the religious community is safe and secure and that we have a place where we can live, practice freely, engage freely, communicate freely, and ensure [these freedoms] for [our] community. We also need to have a hand in ensuring [those freedoms] for the entire community. [But I recognize that our positions] are a little bit self-serving.

We have an internal system here, our Board of Directors is made up of representatives from almost all the houses of worship in town... as well as other membership organizations. We have a couple of at-large members that represent [specific communities]. What we say is that we work on a process of consensus. To determine what a policy issue before us, it is a process. My government affairs committee hears the issue, talks about the issue, addresses a policy position and then the board will ultimately decide, but the biggest piece is consensus.

We do not act unless there is clear consensus in the community and we do not have a definition of consensus. [Consensus] is somewhat something less than unanimity but more than a simple majority. Kind of you know it when you see it. But if we don't feel like we have the clear consensus of the community we don't act on the issue.

Yeah, I think that the term interest group has been hijacked a little bit, it's viewed negatively now. Just like I don't call myself a lobbyist because the term has been hijacked a little. But we are an interest group and our interest is our community. Just from a very basic definitions perspective we are an interest group.



## Participant F

Participant F indicated that her organization primarily advocates for the repressed. However, when it comes to controversial policy issues, individuals tend to engage under the umbrella of other coalitions to challenge certain aspects of the policy. Organizational self-preservation and protecting the cohesiveness of the membership is a top priority for the organization; therefore, the organization makes decisions based on consensus, compromises, and long term strategic goals. Under such circumstances, the organization represents challenging interests.

We tend to focus on four primary areas: education, income [or] financial stability [to] help people become financially stable, health, and strong communities, which we define as having a thriving charitable sector.

We took no position on the Affordable Care Act after it passed and it was a law. We were hopeful [that Indiana will] implement the law and educate communities about the ACA and [its] impact on communities, clients, nonprofit organizations, business partners, faith partners, and then how to implement it.

We try to position ourselves as the trusted research, not the hair on fire kind of advocate... We try to present ourselves as the trusted resource where we will do the research, will document it, and [maintain] a very good relationship around the state.

Our primary first constituency are our members ... comprised of all of their donors, all of their volunteers, and all of their funded partners, plus all of their community because they have a mission to make their community better.

We have been criticized for being too middle of the road, too milk toast [laughter]. I think we were called that once. But we feel that it is [important to help organizations find] compromise solutions. We help negotiate compromises among the different parties, parties who do not ordinarily talk together.

Well, initially [we were] cautious [to] not lose donors. Over the last 5 to 7 years, in this age of highly partisan political partisanship, [our philosophy has been] more about [being] the big person, [taking] the high road, and [sitting] down across the table from people that we disagree with. Someone has to [illustrate] that compromise [is sometimes necessary and acceptable], and we don't see that happening. So I think it started out as a do no harm principle and now it's more of we need to elevate ourselves for them.

Yes, absolutely. We are members of a number of coalitions....We will sometimes engage in a coalition so that we can be more active than what our membership allows us, so sometimes we hide in a coalition and honestly there are times that we do a lot of that work. So for example, I write a lot of policy positions for a coalition that maybe my organization cannot take but under the coalition umbrella we can engage and influence [policy].

I don't get any financial benefits by advocating for health insurance, for low income people. There is nothing that we do other than the goodwill and accomplishing our mission.

In a very crass way, we do not have or can spend the money that they have. Our currency is our information and our relationships. So we do not have as big of a voice as the Hospital Association or the name of any of the big healthcare organizations. But I feel we are often a trusted resource because we don't have that kind of leg in the game.

I think in a room full of nonprofits advocates all of us [I would] separate the big players because they are different. There are times where we have a meeting and we won't invite the big players because we know that they have lots of money, partisan activity, and political activities. They have things that none of the rest of the nonprofits in the room have.

## **Participant G**

Participant G indicated that his organization represents the interests of the membership, and the membership represents the interests of the repressed. Therefore, the organization represents either challenging or repressed depending on the issue. The organization represents challenging interest when opposing

policies that may harm the public and represents repressed interest when promoting policies to expand access to health care services.

[We represent] challenging [interest]. We did have some discussion about the medically frail designation the feds had just amended the definitions for medically frail under the HIP 2.0 program, or the HIP state plan. There is a distinction here, was afforded the opportunity for additional treatment services and so the way it was crafted they did engage us in conversations to talk about how we can ensure a seamless designation process so that the people can get access to treatment quickly [based on a] national model. In fact, the team and I did a national webinar on this process [and] it was so well received.

[We also represent the] repressed. [Those are the] voices who did not have access to health care services, we indirectly [became] their voice. I stay up at night and I think about how the Association serves these repressed voices and their interest in a complicated way, it's not [a simple] one size fits all scenario. [We have to make the challenging business model work...

I think we are doing some pretty cool stuff. In fact I was pretty instrumental in working on getting the language changed around [providing health care services] for folks coming out of the criminal justice [system] from both the DOC and the County jails and into treatment. By that standard alone I think we've really done a good job getting people better access to care. Again, the presumptive eligibility [provision] made a big difference.

## **Participant H**

Participant H indicated that his organization switches roles in representing challenging and repressed interest. Even though some may view the organization as dominant, Participant H indicated that they will use their dominance as a large employer to serve the needs of the repressed. In addition, Participant H does not see a contradiction between his organization's values and business model. He indicated that profits are necessary for business continuity to serve more communities and patients. A reduction in uncompensated care and

an increase in profit margins allows the organization to increase their missionary work and investment in communities that they serve.

I would say we are challenging and repressed for those who are voiceless, and it is a combination of the two because as large as we are we have the ability to influence [policy]. We should always be looking out for those who are on the margins and take care of them the way that Jesus found those who were naked and clothed them, found those who were hungry and gave them food. We should find those who are struggling and help them. But that does not mean we can't be dominant in how we do it because our mission is always grounded in serving those who are struggling.

It is disappointing [that other nonprofits criticize us] because [they] have the traditional [view] of [how] a nonprofit [should operate] that I do not believe in. I believe that we should be great at what we do and do more with the fruits of our labor. So with it how do we show that [we do more with the fruits of our labor]?

It is not something that we have to prove but if we are caring for one poor and vulnerable individual and now we have the ability to care for two, [then] by God we are [going to] go out and find that second one and when we are done with that we are [going to] evolve and find a way to care for three because we can show that evolution over time. [This approach will improve] health outcomes.

## **Visual Trend Analysis**

Indiana's nonprofit leaders argued that they supported HIP 2.0 expansion under the ACA because the program benefited the most vulnerable in our society by expanding coverage to the uninsured, increasing access to care, and improving services offered to patients. Indiana's nonprofit health care leaders claimed that customers are more satisfied with services offered under HIP 2.0. To validate the accuracy of their arguments, this study examined the HCAHPS data on a national level before and after the implementation of the ACA to verify whether or not customer satisfaction increased. The HCAHPS survey measures patient's satisfaction with services they received at hospitals. While we cannot fully attribute any increase in customer's satisfaction rates to the ACA, the results of the trend analysis will confirm whether or not services at hospitals improved

during the expansion period. To test for a correlation between the ACA expansion and customer satisfaction or any other variables, an advanced statistical analysis is needed, which is outside the scope of this study. If rates of customer satisfaction in Indiana and nationwide increased, then the findings only validate statements made by nonprofit health care leaders and should not be viewed as conclusive evidence.

The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care. The survey also includes four screener questions and seven demographic items, which are used for adjusting the mix of patients across hospitals and for analytical purposes. The survey is 32 questions in length. For purposes of this study, the visual trending analysis relied on data collected for questions 10 and 11 of the survey: questions 10 (H\_HSP\_RATING\_9\_10) and 11 (H\_RECMND\_DY) of the survey (The Centers for Medicare & Medicaid Services, 2017).

The visual trend analysis clearly illustrates that in Indiana and on a national level the ACA expansion did improve patient satisfaction measured by patients' perception of the quality of care they received. The following trend line charts illustrate that both Medicaid expansion and non-expansion states experienced an increase in patient satisfaction after the implementation of the ACA. In response to the question "How do you rate this hospital?" respondents from expansion and non-expansion states rated their hospitals as either a 9 or 10 on a scale of 0 to 10. The two charts below clearly show that in 2015, a year after the expansion of Medicaid under the ACA, patients were more satisfied with services they received at hospitals after the implementation of the ACA. Even though Indiana expanded Medicaid via HIP 2.0, which was approved as a waiver program under

the ACA, the state is included on the non-expansion chart because Indiana's expansion occurred in February of 2015.

Figure 3: Chart 1A compares patient responses to the question "How do you rate this hospital?" for patients residing in Medicaid expansion states before and after the expansion of Medicaid. Figure 4: Chart 1B represents patient responses to the question "How do you rate this hospital?" for patients residing in non-expansion states before and after the ACA took effect on January 2014. The results in Figure 3: Chart 1A clearly illustrate that hospitals in twenty two out of the twenty five expansion states reported an increase in patient satisfaction when comparing 2013 to 2015.

Figure 3: Chart 1A- Comparison of Hospital Ratings in Medicaid Expansion States before and After the Implementation of the ACA.

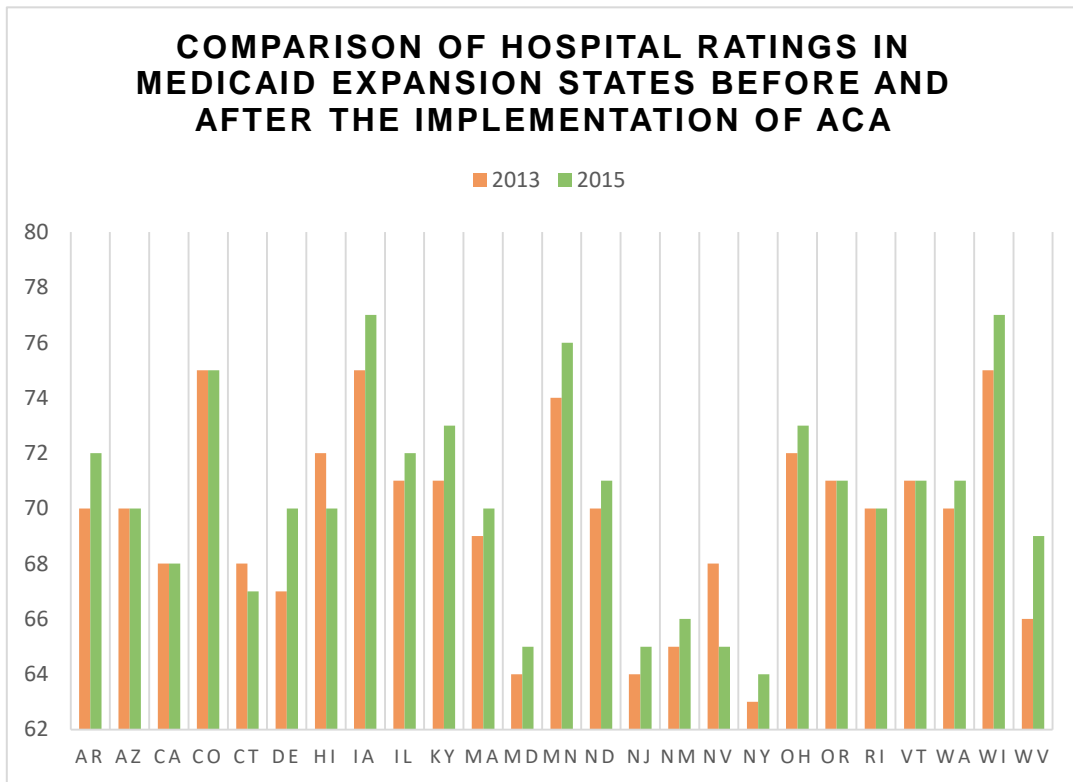


Figure 4: Chart 1B compares responses for patients residing in non-Medicaid expansion states before and after the expansion of Medicaid or when the ACA took effect on January 2014. The results in Figure 4: Chart 1B clearly illustrate that hospitals in twenty four out of all twenty five non-expansion states reported an increase in patient satisfaction when comparing 2013 to 2015. Indiana's customer satisfaction rates increased by 1 percentage point.

Figure 4: Chart 1B-: Comparison of Hospital Ratings in Non-Medicaid Expansion States before and After the Implementation of the ACA

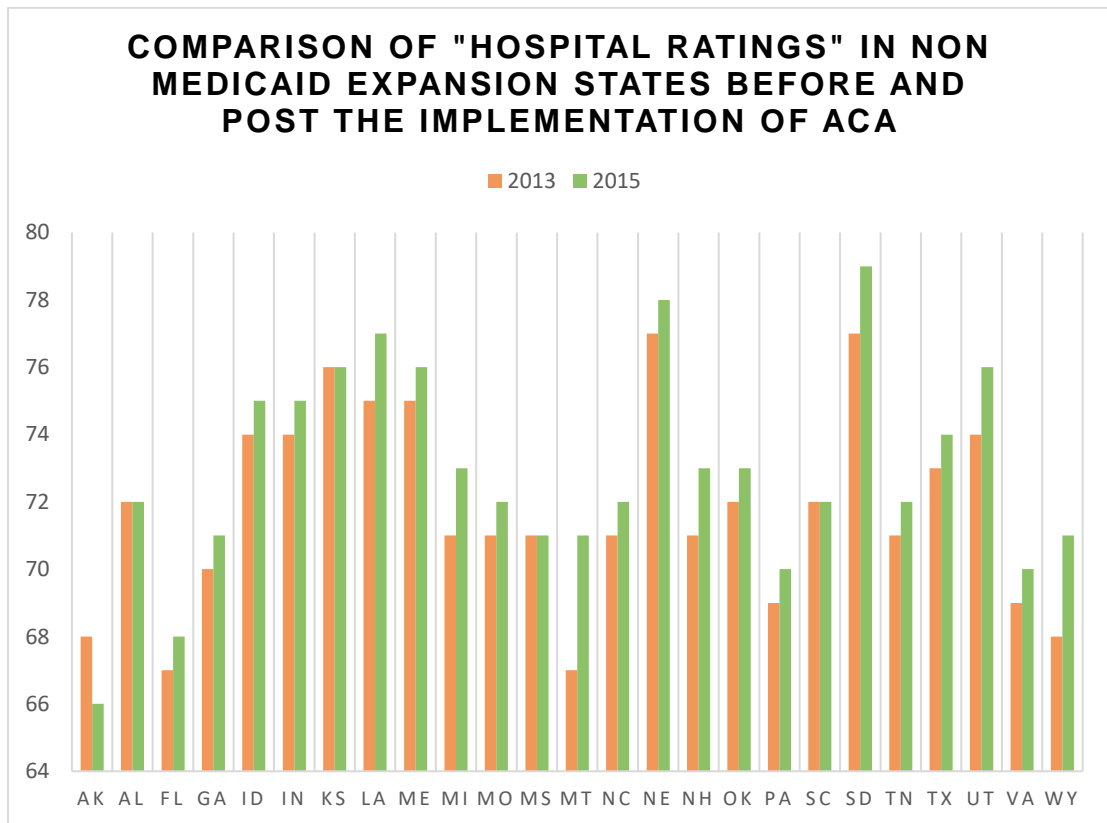


Figure 5: Chart 1C compares patients' responses to the question "How do you rate this hospital?" over a period of nine years between Medicaid expansion and non-expansion states. On an aggregate level, all states reported a rising trend over the period of 9 years. It is worth noting two findings: (1) the trend has been rising since before the implementation of the ACA; and (2) Patients in non-expansion states tend to have a better rating of their hospital experience compared to patients living in expansion states (a difference of approximately 2

percentage points). Both findings confirm that the visual trend on its own is not enough to validate arguments made by hospital leaders in Indiana claiming that HIP 2.0 made patients more satisfied. In addition, the results confirm the need for an advanced statistical analysis to test the correlation between a set of different variables and customer satisfaction before attributing the improved rates to the implementation of HIP 2.0.

Figure 5: Chart 1C -Comparison of Averages of “Rate of Hospital” between Expansion and Non Expansion States between 2007 and 2015

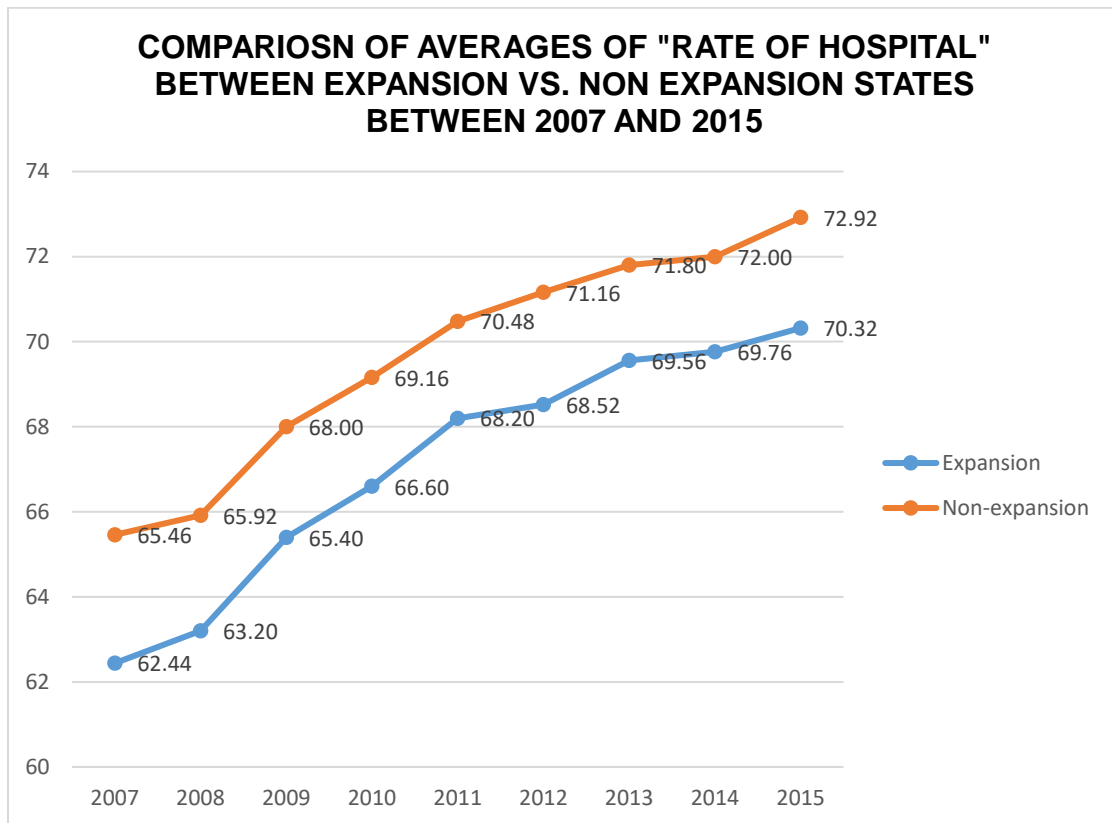


Figure 6: Chart 1D compares patient responses to the question “Do you recommend this hospital to others” for patients residing in Medicaid expansion states before and after the expansion of Medicaid. Figure 7: Chart 1E represents patient responses to the question “Do you recommend this hospital to others” for patients residing in non-expansion states before and after the ACA took effect on January 2014. Figure 8: Chart 1F compares the averages for responses to the question “Do you recommend this hospital to others” over a period of nine years (2007-2015) between Medicaid expansion and non-expansion states.



It is worth noting the following findings: (1) the trend has been rising (between 2007 and 2015) since before the implementation of the ACA; (2) Patients in non-expansion states tend to recommend their hospital to others more than patients living in expansion states but the margin of difference is very minimal; (3) On an aggregate level, there is an anomaly in reporting in the year 2009.

The significant drop in 2009 is attributed to non-reporting, or reporting 0, for a couple of states due to changes in reporting guidelines at the state level. These findings confirm that the visual trend on its own is not enough to validate arguments made by hospital leaders in Indiana claiming that HIP 2.0 made patients more satisfied. In addition, the results confirm the need for an advanced statistical analysis to test the correlation between a set of different variables and customer satisfaction before attributing the improved rates to the implementation of HIP 2.0.

Figure 6: Chart 1D - Comparison of "Recommend Hospital to Others" in non-Medicaid expansion states before and after the expansion of the ACA

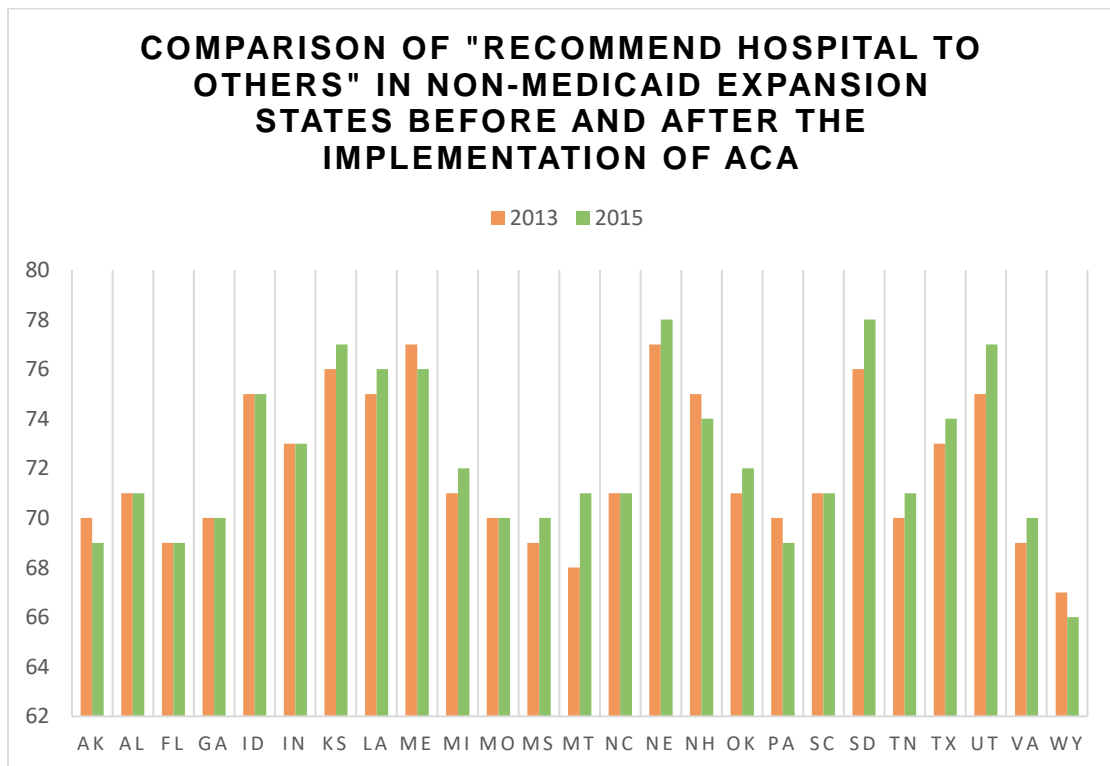


Figure 7: Chart 1E - Comparison of "Recommend Hospital to Others" in Medicaid expansion states before and after the expansion of the ACA.

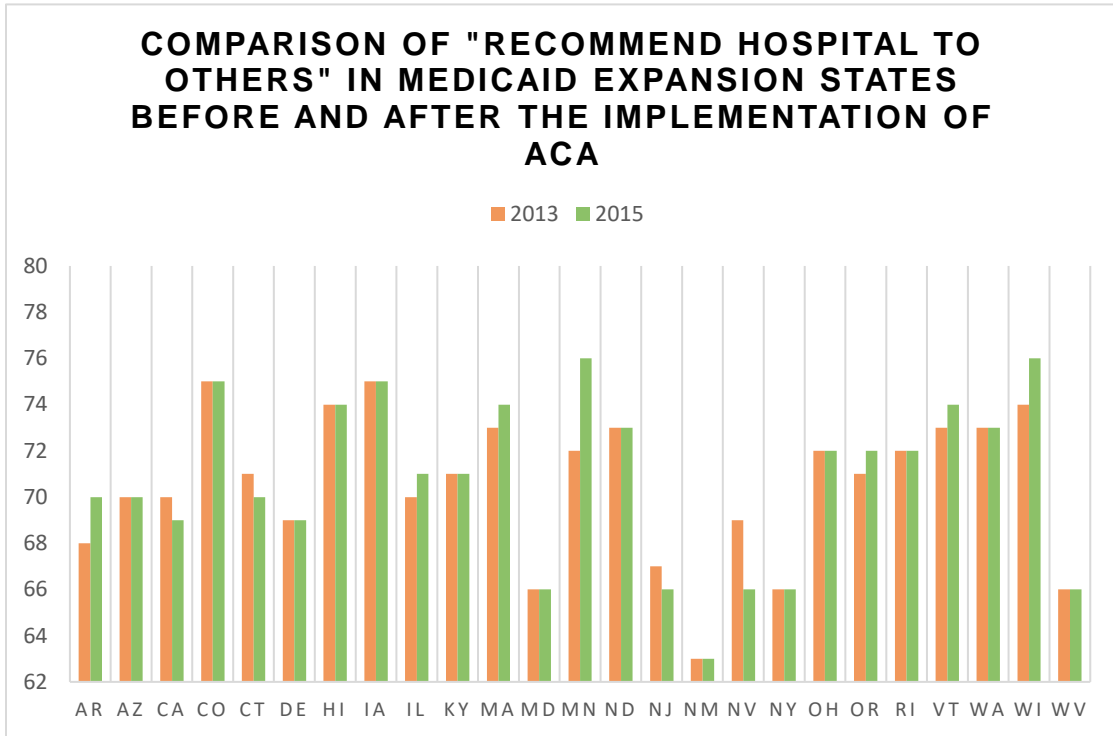
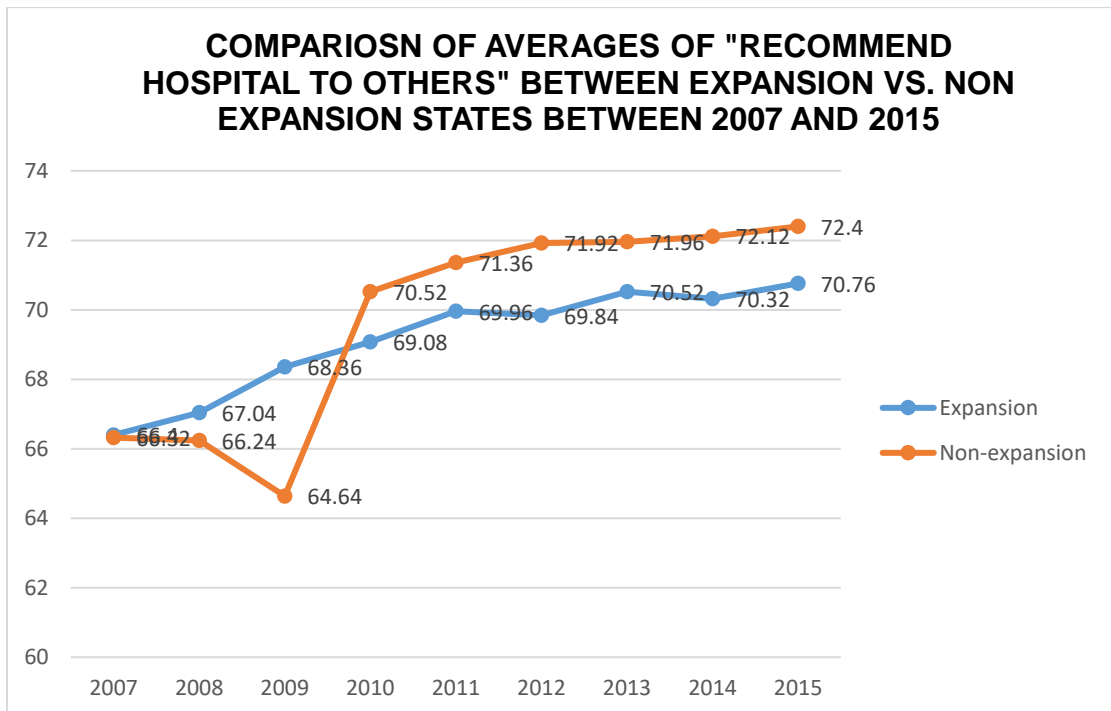


Figure 8: Chart 1F - Comparison of Averages of "Recommend Hospital to Others" between Expansion and Non Expansion States between 2007 and 2015



## CHAPTER FIVE: FINDINGS, DISCUSSION, AND THEORITICAL APPLICATION

### Summary of Findings

The main research question of this study is whose interest do nonprofit organizations advance when they attempt to influence the implementation of public policy? To answer this question, it is critical to understand why nonprofits engage in the public policy process (motivation and values), the policy actions that nonprofits make during the implementation of the policy (how?), and the method by which nonprofits address or mitigate conflicts and contradictions between organizational interest and constituents' interest (whose interest do they advance?). Analysis of interview data produced consistent themes that were further analyzed to answer the above questions. The results of the analysis can be summarized in six major findings that inform the hypotheses of this study: (1) a complex web of relationships exist among nonprofits and with elected officials and state executives resulting in different levels of influence; (2) nonprofit's pursuit of private and public interest can be explained and justified; (3) the political environment impacts the implementation of public policy and there is a political cost that nonprofits consider when participating in the public policy implementation; (4) for some organizations, conflict between values and the business model can be explained and justified; (5) nonprofit leaders are pragmatic and know when to compromise; (6) nonprofits are divided into two camps that view each other differently: humanitarians vs. a profit driven. Below is an expanded explanation of each of these findings by participant. This section concludes with a summary of findings and explains the outcomes of applying Robert Alford's theory to those findings to verify whether or not public interest theory helps us explain Indiana's nonprofits political behavior during the implementation of HIP 2.0.

### ***Why they advocate?***

- 1- Indiana's nonprofit health care advocacy and health provider groups advocate to achieve their missions and values, driven by the commitment to the public good, represent different interests and constituencies, act with self interest in mind, are pragmatic and willing to compromise if the proposed policy benefits the most vulnerable in our society, and they believe that advancing their self- interest benefits the populations they serve.
- 2- Hospitals advocated because they had the highest financial risk, they serve millions of people, employ hundreds of thousands of employees, operate in almost every county of the state, and are considered the most critical stakeholders with the capability to operationalize HIP 2.0.
- 3- The health care industry is one of the most regulated industries. The legal and financial complexities of operating large hospital systems require hospital leaders and trade associations to protect the business model of these institutions.
- 4- For-profit hospitals who contributed towards the HAF did not benefit from HIP 2.0 as much as nonprofit hospitals because uncompensated care at for-profit hospitals is insignificant. As a result, nonprofit hospitals engaged to protect their financial interest.

### ***How they advocate?***

- 5- Internal and external competing interests, the impact of the political and policy environment, and funding implications are factors that nonprofits consider when making advocacy decisions.

- 6- Organizational variables such as structure, membership diversity, funding sources, and community interests and demographics could either restrain or empower the advocacy of health care nonprofits.
- 7- Larger organizations tend to engage in formal lobbying, direct advocacy, and direct negotiations with elected officials and state agencies. Mutual benefit associations, faith-based advocacy groups, and smaller advocacy organizations tend to informally advocate through 501-C-4 or non-registered coalitions.
- 8- Not all 501-C-6s have the same level of influence. Mental health and addiction nonprofits do not have the same level of influence as primary health care providers and institutions.
- 9- Nonprofit leaders with experience in policy and advocacy tend to give a higher priority to advocacy than leaders with little or no advocacy experience. Not all health care leaders who were interviewed had a background in health care policy. They were hired for different reasons given their expertise in law, public policy, and health care administration.

***Whose interest do they advance?***

- 10- They advance the interests of their constituents, whether they are patients or member organizations.
- 11- Nonprofits advocate because of their missions and values, driven by the commitment to the public good, represent different interests and constituencies, act with self interest in mind, pragmatic and willing to compromise if the proposed policy benefits the larger population.

- 12- Nonprofits believe that advancing their self- interest results in benefits to the populations they serve.
- 13- Smaller advocacy nonprofits acknowledge that there is an internal tension between nonprofits and believe that the health care nonprofits are divided into two camps or types of nonprofits: a camp that considers themselves as humanitarians who advance the interests of the repressed, and a camp that is driven by profits. Almost all participants confirmed that this worldview does exist; however, dominant organizations argued that they are not different from smaller organizations in terms of securing funds to serve their mission.

***What level of influence do they have?***

- 14- A complicated web of political, social, and professional relationships exist within the nonprofit health care sector.
- 15- Leaders of dominant organizations serve on boards of other 501-C-3 advocacy nonprofits, which allows them to influence advocacy methods and policy positions of other nonprofits. This seems to be a revolving door for few professionals to influence the direction of multiple organizations at the same time.
- 16- Dominant interest groups are well connected to policy makers, powerful and elite leaders in the community, and have more resources to influence the implementation of public policy. However, the analysis revealed more details about the connection between dominance and serving the most vulnerable in our society. In the case of HIP 2.0, dominant interest groups supported HIP 2.0 because it was the right policy for Indiana's uninsured population. Hospitals and other health care providers assert that an improved financial position as a result in increase of state reimbursements

will allow their organizations to provide more services to a segment of the population that was historically uninsured.

17-There is a political cost to advocating for certain policy positions that could impact future funding for certain organizations.

18-Internal political dynamics within health care coalitions allowed powerful organizations to not participate in certain calls to action. Faith-based nonprofits preferred rallies or public demonstrations as methods to express their views. Dominant organizations engaged in direct negotiations with the state and conducted formal lobbying activities. Dominant organizations benefited from actions performed by other organizations and leveraged their outcomes during negotiations with state officials.

19- Challenging and repressed interest groups tend to support positions that are promoted by dominant interest groups if the policy benefits the public.

***Is there a conflict between values and organizational interest?***

20- Ethical dilemmas exist in every sector and every organization including government. Example: allocating resources based on values. Participants argued that every organization, including governmental organizations, are confronted with ethical dilemmas around allocating resources based on values on policy priorities.

21- Even though one of the 501-C-6's advocacy focused on achieving better reimbursement rates, they did not see a contradiction between their mission and values on one hand and an improved finances on the other. To serve the repressed or the uninsured, health care providers argue that they need financial resources to cover the cost of services offered. They

argue that protecting the financial model for large health institutions protects access to health care services and coverage for the uninsured. Therefore, their dominance may appear as driven by profits; however, dominant groups think they use their dominance to fulfill their mission to serve the most vulnerable in our society.

22- Even though uncompensated charity care declined as a result of HIP 2.0, hospitals dedicated a portion of their HAF to fund HIP 2.0. The financial impact of HIP was a net positive for large health institutions. Hospital systems believe that this positive outcome allows them to serve more uninsured clients by enrolling them into HIP 2.0 and by reaching more communities through their missionary and community based charitable initiatives.

23- Leaders of hospital systems and their trade associations view an enhanced financial position as a benefit to the communities and patients being served by these institutions.

### ***Are these organizations profit-driven?***

24- Small advocacy nonprofits acknowledge that there is an internal tension between nonprofits and believe that health care nonprofits are divided into two camps or types of nonprofits: a camp that considers themselves as humanitarians who advance the interests of the repressed, and a camp that is driven by profits who advance the institutions private interest. Almost all participants confirmed that this worldview does exist; however, dominant organizations argued that they are not different from smaller organizations in terms of securing funds to serve their mission.



### ***Does the political environment have an impact?***

- 25- Healthcare Nonprofits have different levels of understanding of the impact of the political environment in shaping the implementation of public policy. However, most organizations exercise a pragmatic decision making process and utilize political cost-benefit analysis to evaluate short term versus long term benefits.
- 26- Nonprofit leaders maintain professional networks composed of like-minded individuals who are focused on health care policy. These networks get activated as needed especially during the time of policy changes. These networks allow individual leaders to express their views especially when their individual organizations avoid taking public stances on policy proposals.
- 27- Each organization has a political capital and they pragmatically decide how to leverage their political capital.
- 28- Some organizations waited, hesitated, and did not engage in the policy implementation discussions. They remained idle waiting to react to the final outcome of the policy implementation due to the politically charged environment as it related to the ACA.
- 29- The state participated in few meetings with the coalition, called upon organizations to testify and engage in the process. In a way, the state sought the engagement of nonprofits to legitimize its policies.
- 30- The state strategically chooses who to communicate with and when to participate in and engage with certain coalitions or organizations to advance the state's interests.

Table 1- Summary of Key Responses Based on Nonprofit Type

	501-C-6	501-C-3 Hospitals	501-C-3 Health Care Providers & Advocacy groups	501-C-3 Faith- Based
<b>Who do they advocate for?</b>	Membership organizations	The institution. Focused on the business model.	The client or the patient	Their own Community
<b>How do they advocate?</b>	Formal lobbying, direct negotiations	Formal lobbying, through trade associations	Via coalitions and through mobilizing the public	Via coalitions and through mobilizing the public.
<b>What role do they play?</b>	Advocates and representatives of the industry	Advocates and representative of the institution that serves communities and patients	Advocates for patients or clients	Represent the voices of their board
<b>Policy decision making process?</b>	Formal, structured, driven by policy data, skilled professionals, and the board.	Formal, structured, both direct and indirect, works through the trade association.	Formal, driven by the board. Focused on long term goals	Formal, driven by the board
<b>Whose interest do they advance?</b>	Dominant only if representing primary health care providers.	Mainly Dominant, but plays a challenging role on certain issues	Challenging and repressed	Challenging and repressed

## Discussion

### ***First: Driven by their mission and values***

*Why do they advocate? They are driven by their missions and values. They do not see a conflict between values and their business model.*

**Summary:** All participants indicated that they were motivated by their missions and values. They do not see a conflict between their organizational values and their policy positions even at times when they advocate for better reimbursement rates. They argue that HIP 2.0 was a good policy that expanded coverage, which is aligned with their organizational missions and values. They argue that expanding coverage required a sound business model to fund providers and the cost of additional services provided. Therefore, some organizations were more engaged than others because they contributed funds towards the program, they increased their risk by serving more patients, and they were the largest stakeholders in the state of Indiana.

### **Participant D**

Participant D indicated that his organizations decision to expand coverage was based on values and the mission of the organization and not driven by economics.

I view my role as continuity to the original purposes of the organization, and the only reason I mention that this informs our position on Medicaid expansion. I view it as a values based decision and not an economic decision or a political decision. My true north so to speak was the values proposition that our purpose was to provide health care and innovation to everybody [and] not a [specific] segment.

You can ration care in a number of ways. One [example] is in the form of access. [The organization could choose to] close the clinic at 4 o'clock. Anthem used to shut down their customer service line in the afternoon, so that's an access issue. [If] you do not build a clinic on a bus line what do you think is [going to] happen? [What happens if you're not open on Saturdays or weekends? So you can do it that way [by shrinking service hours or limiting service locations], or you can say we can't afford to do it [unless we] charge this co-pay. So there would be well intentions, sometimes high minded sometimes not so high minded, debates at the governance levels between what you and I call the finance people and the values people and then the patients' folks group.

You can make both arguments, it is easier to argue [nonprofits advocated] for their own interest. Our customer is the patient. The patient, not Anthem, not the State of Indiana, it's the patient. So my job as a CEO is [to serve] all the patients. Your job as a practitioner is [to serve individual patients]. The two of those coming together means I look like I am arguing for more money, and [others] look like [they were] arguing for more money for [their] area. So if you are a policy maker, it is essentially hard to disagree with [groups such as the] neurosurgeons [who argued that if] you give me [these resources], we will do that. [Policymakers had to think about] where can I do the most good that I can? I think most of [nonprofits] would come off as if we were arguing for ourselves, and I believe in most cases [that was true]. Confirmation bias convinces us that we are arguing on behalf of the greater good but in fact we are arguing on behalf of ourselves. So you [have to] do a gut check and I cannot say with any reasonable assurance that what I was doing and what I actually did was the same thing. It could be what I thought was doing and what I was actually doing was more than just accidentally benefiting my organization. So I'd admit to a conflict of interest, but I also say that [government] as the policy maker is to figure that out.

We have a duty of responsible grace. We have to discharge that duty and the only way to discharge that duty is to hold it at the center of our work, [which is to serve] the patient and their families and try to throttle back the inclination to treat the bond market as if it is the customer, which is very easy to do. They give me a bond rating report as a CEO, so during the recession we were downgraded. I think it wasn't too bad but we got upgraded couple of times since then. So the new questions is the new tax bill, who deserves the tax exemption. Center Township has 44% of tax exempt properties, one of the hospital systems has many toilets to flush. Other business and homeowners are paying for that. So have we earned the exemption?

The law says we earn it through charity care, but there all of these counter measures for charity care, so is there a public good that is charity? So should the law said have you improved the health of the community you serve? And how would you know? So it's like value based purchasing. If the health of Center Township became less obese, less diabetic, less drug abuse, should we have paid more for having done that? What would the incentive be? That's the [question for] policy makers. I always argues strongly give us the incentive that actually makes the population healthier.

I saw some of the 501-c-3s that would measure the success of their mission by how much money they made, and that was true for the majority of them including county hospitals. So how sincere does my organization looks because we were the biggest and profitable as we argued to expand coverage? It's a hard a sell! So it was very difficult for me to call somebody out and say [you're not sincere about serving patients]. So yes, there was tension because most of the folks were focused, as they always are, on the money. And because the values connection here, and I am 100% sure that our major partners would totally disagree with what I am about to say, they say their values are the same. I do not measure values by television ads, and by check registers. The check register would disclose your true values pretty fast. At the end of the day they were arguing for no margin no missions, give us more money! My view is that the county boundaries were drawn between 1816 and 1832 and they have very little relevance to the portability to disease and sickness and so forth. Just look at the drug crises now, it's the same sort of thing, that's my view.

The profit margin did increase after HIP 2.0 after we started getting paid for our compensated care at Medicare rates for Medicaid expansion.

## **Participant G**

[I do not see a conflict of interest between the business model and our values]. [It is not a conflict of values. It is a core. Our ability to ensure that the system functions, we know what the business model is. It comes down to the business model. And at the end of the day it is not necessarily about protecting the entities themselves, it is about creating a business model that functions and carry out the functions of the delivery of health so that the public then benefits from the service.

## **Participant B**

We always start with our vision and mission and we always start with the needs of our children and families in Indiana who have a lived experience of medical complexity and disability and if that means we will miss a funding opportunity or other things then that is what it means.

## **Participant C**

There are certainly reimbursement battles that ensue whether you're religious affiliated or nonprofit or private nonprofit or for-profit. You have to engage [in the policy process]. It is a competitive environment because of the nature of [business]. [Consumers have options such as] the private insurance market, the role that choice plays, and the ever increasing consumer driven economy where people seek care.

Profit generating functions within the hospital systems subsidize other areas of the system were losses occur. For example: building new hospitals in Hamilton counties could subsidize services offered in the inner city.

When you look at the number of rural hospitals that are a part of their system some of them would have gone out of business. One hospital filed for bankruptcy [but a larger organization took over and the] hospital became part of their system so they were able to sustain their business model and [preserve] the jobs in the community that were associated with the hospital. [Keeping the hospital open and preserving jobs in the community] were part of the [parent hospital's] broader mission. I do not think that this is part of their profitable venture. Building a facility in an area where population growth is going to continue allows the system to be healthy enough in this competitive free market environment to be able to sustain those other initiatives.

## **Participant H**

Did not see a conflict of values as it relates to HIP 2.0. Outside of HIP 2.0, abortion and birth control continue to be ethical dilemmas for this organization.

The other aspect to it is we use our medical missions at home when we go out to a neighborhood that is disadvantaged. In every aspect of it we provide soup to nuts health care services for them. Part of this is our rural and urban access to healthcare workers that were able to use [HIP 2.0] and [ask members of the community] do you have coverage? HIP 2.0 was a phenomenal [program to expand coverage]. So we look at those coverage vehicles as helping us go find individuals [who need] coverage. Everyone we serve with coverage allows us to go out and find more that do not have [coverage] and offer them coverage.

### ***Second: A Complex Web of Relations and Advocacy Methods***

*How do they advocate? Using a complex web of relationships and formal and informal methods to influence policy implementation at different leadership levels.*

**Summary:** Leaders of dominant organizations are well connected with smaller health care advocacy groups, they serve on their boards, and influence their decision making process. Leaders of small 501-C-3 organizations tend to join coalitions to advocate for certain policy positions, especially when those policy positions are controversial and not publically endorsed by their boards. Dominant organizations deploy formal and informal methods to influence public policy positions of elected officials and state agencies.

### **Participant F**

This 501-C-3 organization participates in a coalition to carry on policy positions that their organization cannot publically support for political and financial considerations. Through her service on multiple coalitions, Participant F built an extensive network with other nonprofit leaders who coordinate policy and lobbying activities to influence health care policy implementation.

We will sometimes engage in a coalition so that we can be more active than what our membership allows us, so sometimes we hide in a coalition and honestly there are times that we do a lot of that work. So for example, I write a lot of policy positions for the Indiana Coalition for Human Services that maybe [my] organization cannot take but under the coalition umbrella we can engage and influence [policy]. I wrote the comments around the Healthy Indiana Plan, around ACA, around funding for Medicaid, and those might have not been filed with my organization but they were filed under the coalition for human services.

### **Participant E**

Similar to Participant F, Participant E's 501-C-3 organization participates in coalition to carry on policy positions that their organization cannot publically support for political and financial considerations.

There are few [coalitions] that maintain themselves from year to year that we are actively involved in. Probably the biggest is the Indiana Coalition for Human Services. This [coalition is composed of] about 25 or 30 nonprofits [who are] both direct providers and advocacy organizations like us. [These organizations] come together around issues affecting low-income Hoosiers and work pretty heavily on [state] appropriations and funding [for] various agencies and programs. We [are] also interested in education and access [to quality education] and even immigration.

Over the years we have been involved in a number of sort of ad-hoc coalitions [that revolve] around specific issues. The role of my organization is just to be an active member in this coalition. The purpose of these coalitions is to come together, to band together, and to raise our voice as member organizations. [Many smaller nonprofits are] fairly small, have limited constituency, and a limited voice. [Therefore] coming together raises the collective voice of small organizations. [Most member organizations] within the coalition are sort of volunteer-based, it's up to individual member organizations [to decide their level of engagement].



We [created] the Indiana Coalition for Health Services, [which] is a 501(c)-4. [The coalition] has a Board of Directors [who are] volunteers from the member agencies. [The coalition] has a [decision making] process and a public policy committee [that decides] our public policy priorities. Sometimes we speak on behalf of the coalition. If there is an instance where the coalition needs to testify on a particular [legislation] that is not [a priority for] my organization I can still testify and say I'm here representing my organization but today I'm speaking on behalf of the coalition. One of the other coalitions actually employs a lobbyist. [If the lobbyist is] not available then [a volunteer member of the coalition] will say hey this is who I am but today I'm speaking on behalf of the coalition.

## **Participant H**

Participant H indicated that she serves on the boards of several health care nonprofit advocacy organizations. When engaging in public policy, she tends to promote the policies of her employer, which is a large health care provider in the state of Indiana. This arrangement complicates the decision making process for smaller nonprofits due to the influence of board members who are employed by large dominant health care systems. In other words, health care systems can influence the decisions of local nonprofits at the board level. Participant H does not participate in loose coalition to advocate because they have more effective means to influence policy through lobbying, direct negotiations, and through influencing the policy positions of other nonprofits.

We are all very connected with these organizations so I am on the board of many organizations. We [learn about other organizations' policy priorities by serving] as board members [of other organizations].

I do not remember being part of a broader coalition, but certainly you had organizations that were representing the positions of the hospitals.

We do things at various different levels by doing it formally and informally, [and through] educating and participating in groups [such as] the Chamber, the United Way, Covering Kids and Families, and Gleaners. We [serve] on the boards of those [organizations]. So we participate in a variety of different [ways].

### **Participant C**

Participant C works for a large trade association. Similar to Participant H, he serves on the board of other health care advocacy nonprofits and uses formal and informal methods to influence nonprofits, coalitions, and state officials.

We collaborate [with other organizations] a lot. For example, on HIP 2.0 we collaborated with the Primary Health Care Association, Mental Health America, and Covering Kids and Families of Indiana, State Medical Association, and AARP. I serve on the boards of many of these nonprofits. [We decide how to collaborate] depending on the issue. We do work with other trade associations.

[We informally participate] in loose coalitions. I don't know that we ever created a formal coalition. We certainly talked about it whether or not we need to do that but we had regular discussions through the various trade associations and with others who shared a similar interest in seeing Indiana expand Medicaid eligibility to include a program like HIP 2.0. To expand Medicaid through a waiver we met regularly, we had calls, and [participated] with other groups who have a public policy aspect to their operation. So we participated in these [activities] and [served with] the provider policy committee that I used to chair at the time. That was in some ways a formal aspect of coordination advocacy. [We were] one of the stakeholders and [we were] pulled into some direct negotiations with the state around funding; [however], most of our work was informal but regular.

### ***Third: Private and Public Interests Converge***

*Whose interest do they advance? They advance their own institutional interest to serve their constituents.*

**Summary:** All participants justified their policy positions by connecting their private interest to the public's interest. They do not see a contradiction between their values and policy positions. Influential health care organizations argue that they are not unique in that sense, all nonprofits advocate for their private interest to advance the public good.

#### **Participant C**

Participant C leads a trade association that represents both for-profit and nonprofit health care institutions. From Participant C's point of view, member institutions are perceived by other nonprofits as if they advocate for their private interest and disregard the public interest; however, Participant C firmly believes that both for-profit and nonprofit institutions share the common mission of improving health outcomes for the populations they serve. Keeping patients well and healthy is in the best financial interest of the hospital system, it lowers costs of services that are subsidized in the long term. If institutions do not protect their business model, which largely revolves around reimbursements, then they risk reducing services or closing facilities. Subsequently, this will lead to limited access to care. Therefore, the institutions private interest is directly connected to the public's interest.

[There is] no difference between policy agendas of for-profit and non-profit hospitals. Everyone supported expanded coverage while also mitigating financial cuts in Medicare payments and Market Basket. The financial impact of the policy was similar on both types of hospitals.

There are several for-profit hospitals that are safety net hospitals for the underserved and qualify for DISH payments.

The financial impact on rural and smaller for-profit hospitals could be significant. If they close, then access and coverage is reduced.

The main difference could be seen in the level of reinvesting back in the community. For example: expanded focus on population health.

Whether you are a for-profit or nonprofit, you must have a margin of profit to be able to operate, that's why reimbursement is a priority for both.

For-profit and non-profit hospitals share the same compassion to provide safe care for patients. In addition, keeping patients well and healthy is in the best financial interest of the hospital system, it lowers costs of services that are subsidized in the long term.

I can't get into the minds of all the leaders to speculate [whether they were] focused on a cost benefit analysis associated with the Medicare cuts, reimbursement, and expanding coverage to stabilize the impact [of federal funding cuts]. Maybe organizationally or institutionally, but a lot of that sort of strategy happens beyond what I can see at the association. I work more with the individual CEOs.

## **Participant B**

Participant B believes that private and public interest tend to mix at the board level. For-profit entities influence policy by participating on boards of key health care organizations and through formal lobbying. For-profits tend to not participate in coalition based advocacy, but many member organizations had representation on boards of nonprofits. On the nonprofit side, Participant B's organization engaged in educating clients about the impact of the policy on their clients' interest and relied on data to make decisions. Clients did not always understand their interest. Tensions between local affiliates of national organizations and Indiana based nonprofits were evident. The source of tension revolved around maximizing the public's interest based on the policy positions of Indiana's nonprofits.

A lot of politics were involved [in the implementation of HIP 2.0]. Organizations tried to take credit for the [coalitions] work. National organizations with local chapters were engaged in the coalition. Faith-based nonprofits favored rallies and public demonstrations. Insurance companies and the IHA opted out.

The coalition's internal decision making process allowed member organizations to opt-in or opt-out of calls to action, voted on certain issues, or co-signed letters supporting or opposing certain positions.

The [political] environment in Indiana has made significant commitment to being business friendly and we have large corporate voices that represent both the insurance industry and the pharmaceutical industry. And organizations who have advocated around treatment may leverage legislative bills or any efforts of policy to frame it around those interests and this may be different than what evidence based or best practice would say about the most cost effective or appropriate treatment.

We represented the repressed. We engage in challenging certain aspects of the policy, but we mainly represent the repressed.

## **Participant F**

Participant F's organization places a higher value on internal harmony within the membership, donors, volunteers and communities over taking a stance on controversial policy positions to protect the organization's long term goals. Participant F justifies this by asserting that internal harmony within the membership and protecting long terms goals aims to serve the public and advance the public good. Therefore, the organization's private interest is directly linked to the public interest. In a way, this is not different from the justification provided by large health care institutions.

Our policy committee tends to be more politically savvy, so they will weigh the politics [while considering] interests of donors, volunteers, nonprofit organizations, the larger community, and also weighing the diversity of our membership. So for example on the immigration issue some of our rural communities did not want us to touch that [issue].

Some of our urban communities felt it is a moral obligation and we have to engage. So [we] wrestled [with] how do you balance the needs of all of your members? [This] is a challenge so we try to craft a middle ground.

## **Participant D**

Participant D makes similar arguments as Participants C and F asserting that on a surface level the political posturing of influential health care organizations creates the perception that they only care about advancing their own private interest. However, a deeper analysis shows that there is a link between an organization's private interest and the public's interest.

I think most of [nonprofits] would come off as if we were arguing for ourselves, and I believe in most cases [that was true]. Confirmation bias convinces us that we are arguing on behalf of the greater good but in fact we are arguing on behalf of ourselves. So you [have to] do a gut check and I cannot say with any reasonable assurance that what I was doing and what I actually did was the same thing. It could be what I thought was doing and what I was actually doing was more than just accidentally benefiting my organization. So I'd admit to a conflict of interest, but I also say that [government] as the policy maker is to figure that out.

### ***Fourth: A Strategic and Pragmatic Decision Making Process***

*Whose interest do they advance? They balance short term versus long term goals and interests. This results in a pragmatic decision making process and leads to short term compromises to achieve long term goals.*

**Summary:** Everyone agreed to the policy because it expanded coverage to over 300 thousand people in Indiana, which was better than maintaining the status quo. Most organizations understood that a gradual change is better than no change. The political environment and political costs associated with opposing certain policies could hurt the long term goals of some organizations who deeply care about their clients and patients. Therefore, these organizations

compromised by accepting and endorsing HIP 2.0 despite the fact that a traditional expansion would have been a better solution for Indiana.

## **Participant B**

I think the people involved were savvy enough to understand the competing priorities and that for some people in the room this was about reimbursement and profit margins and for other people in the room this was about a more humanitarian mission and the impact on end users.

The fact that people understood that allowed it not to be a significant issue. Generally the humanitarians among us which I probably would put myself into that category were not opposed to the hospital system making more money because more people have insurance.

I just think it is part of the pragmatic reality and it is critical when thinking about healthcare in America to find ways to partner effectively.

Right, exactly. I mean this is Indiana and we have a Republican governor and super majorities in both houses, if you are going to have Medicaid expansion here, you had to work with everybody.

In terms of the traditional idea of a Republican versus a Democratic model of social services there is a difference and so you have to understand the climate that you are in and look for avenues and levers to move things forward that would meet the needs. It's often surprising to families the role that politics play and what resources are available because in general you have not considered it until it is something you need. The rhetoric around values is different than the ways that political parties have supported systems and services.

I think that this particular issue [HIP 2.0], the overall winner is the State of Indiana and that's the individuals who received coverage, that's employers who's workforce is healthier, that's our kids and families, that's the providers who have increased reimbursements, we all won.

Supported HIP 2.0 even though the program does not cover our primary constituency. We felt like we could be the voice for parents who did not have coverage and whose abilities to care for their children was impacted by their lack of access to health care.

## Participant F

Our policy committee tends to be more politically savvy, so they will weigh the politics [while considering] interests of donors, volunteers, nonprofit organizations, the larger community, and also weighing the diversity of our membership. So for example on the immigration issue some of our rural communities did not want us to touch that [issue]. Some of our urban communities felt it is a moral obligation and we have to engage. So [we] wrestled [with] how do you balance the needs of all of your members? [This] is a challenge so we try to craft a middle ground.

[The] board adopted a set of principles, one of the first principles [is] do no harm to any of our members of the movement ... we have principles around advancing the common good, sound policy, and [achieving] long term solutions, not [just] short term gains. [We are] always looking at [developing] long-term relationships. We have been criticized for being too middle of the road, too milk toast [laughter]. I think we were called that once. But we feel that it is [important to help organizations find] compromise solutions. We help negotiate compromises among the different parties, parties who do not ordinarily talk together.

Well, initially [we were] cautious [to] not lose donors. Over the last 5 to 7 years, in this age of highly partisan political partisanship, [our philosophy has been] more about [being] the big person, [taking] the high road, and [sitting] down across the table from people that we disagree with. Someone has to [illustrate] that compromise [is sometimes necessary and acceptable], and we don't see that happening. So I think it started out as a do no harm principle and now it's more of we need to elevate ourselves for them.



### ***Fifth: Two Camps: Humanitarians vs. Profit Driven***

*Whose interest do they advance? Nonprofit professionals see each other differently: humanitarians vs profit driven.*

**Summary:** Despite the fact that HIP 2.0 was a good policy, there is a deeply held view by smaller nonprofits that large health care institutions and their trade association are dominant, very influential, and motivated by profits.

Contrary to that view, leaders of large health care institutions and their trade association provided logical arguments about the financial complexities associated with operating a multi-billion dollar industry that employs hundreds of thousands of employees, and serves millions of people in Indiana. Driven by values, hospital leaders and their association argued that it is their legal and fiduciary duty to protect the financial stability of their institutions to ensure business continuity to serve every citizen in the state of Indiana.

#### **Participant D**

[Driving] down the cost demand side to improve the health of the constituency you serve is not a conflict. For examples, [schools have to pay] to clean facilities, [provide] safe bus routes so that kids who go to school through these hot spots with highest crime rate [can make it safely], [feed] hungry kids, etc. [Shouldn't we consider a] pantry in the building that sells food that makes [children] fat [due to] high calorie foods [a conflict of values]? Off course not. It's the same sort of thing how you triage it. [Another example], I made more than one millions dollars a year, [and many people including my kids] would say you ought to do it for free. I never did that. So I can't elevate myself among my peer group. I am 100% sure that some of my peers who view me with disdain because [my organization was] very successful in dealing with [state officials]. We never really had a bad year. The recession was bad but [government] had nothing to do with that, Mr. Market did that. In addition, we have to fund depreciation, most nonprofits do not have to fund depreciation. So we [must] have money in the bank. This is nothing different than a university.

Folks look at my organization or [other hospitals in the state or the country] and [question why] we got \$4 billion in cash investments. [They ask] will you need more money? A 4.57% return [on investment is not enough to offset] a negative margin in downtown [hospitals], that's why we built suburban hospitals [to offset losses] from the downtown [hospital]. We were running a re-distribution system within the organization and that was intentional. One hospital [earned] double digit [profit] margin but the downtown hospital [earned] a single digit margin and sometimes a no digit margin.

The for-profit hospitals had a very low comparative charity care. So they took a very aggressive position in the subsequent [legislative] sessions at the General Assembly on the nonprofit tax status. They thought that was unfair... the psych hospitals, some of these pure for-profit nursing homes they were [making profits] by [billing] days [of service]. They had a patient for 100 days [of rehab]! ... Their business model is [billing for] days [of service]. Our business model is [achieving] health outcomes, so that's the value based [difference between for-profit and nonprofit]. [In the past], I played a big role as I could with Office of the National Coordinator that was writing the policies for value based purchasing, disease state, obesity, etc.

Other hospitals moved out of the inner cities. [Many] feared that the academic side of the downtown medicine wouldn't be able to meet its goals because it did not have enough patients to provide teaching opportunities. The community health provision side was also a concern because patients were getting poorer, payer-mix was getting more and more [dependent on] Medicare and Medicaid.

## **Participant B**

The [political] environment in Indiana has made significant commitment to being business friendly and we have large corporate voices that represent both the insurance industry and the pharmaceutical industry. And organizations who have advocated around treatment may leverage legislative bills or any efforts of policy to frame it around those interests and this may be different than what evidence based or best practice would say about the most cost effective or appropriate treatment.

If Eli Lilly has X psychotropic drug and people work hard to get Medicaid to pay for that even though another company could provide a cheaper drug or a backed cognitive behavior therapy would be a more effective treatment.

This reality exists in navigating our current healthcare system in Indiana and if anything it has been ratcheted up by the number of voices in Indiana who are now part of the administration guiding our healthcare system in America.

### ***Sixth: The Calculus of Politics***

*Policy actions are impacted by the political environment and are assessed based on a political cost-benefit analysis.*

#### **Participant G**

Participant G leads a trade association that represents member organizations that serve a stigmatized population.

I think we have a good relationship [with state legislators] and it was not always the case. What I've seen through the years is that it is a sign of leadership at the state level if leadership at the state level is open to meeting with [advocates], coming up with innovative ideas, getting input, receiving input, then those things are really powerful and helpful in terms of crafting policy. But if the ivory tower wants to operate in a vacuum and does not want to receive input from all parties, [then this is not helpful]. [State legislators] need public input, need input from the providers who are providing the services, need to understand who [needs] help, and who's hurt by public policy. It is a balance.

I mean I do not like the world politics. Politics should not enter the decision making when it comes to health care policy. That does not mean that politicians who are elected shouldn't [engage in politics]. They need to invest themselves in health care policy, they often do not have detailed knowledge on these matters because these matters are so complex. I get upset when politics get involved in health care decision making.

#### **Participant C**

Each organization has a political capital... There was a fear that Governor Pence's Administration was just pulling a political stunt and not serious about [Medicaid] expansion.

## Participant H

I think good policy is bi-partisan. In fact I think good policy has zero partisan favor, belief, and face to it.

[We invest in developing relationships with] City Council, County Commissioners, state senators, and representatives. Every year, sometime between January and February or March, we have a session downtown where we have a lunch with all of the elected officials and those who are on the health committees of the state legislature. We [educate legislators] about the organization. I couldn't tell you who is a Republican and who is a Democrat. [I recognize] couple [of legislators] because they are known, [for example] Brian Bosma. But the vast majority, if not almost all of them, I couldn't tell you what their affiliation is and I'd say it makes a better policy for us and for our connections with them. [We educate them about our] positions.

## Theoretical Application of Alford's Public Interest Theory

### ***Hypothesis #1: Financial Interest vs Patients' Interest***

*Due to the high cost of providing quality health care, there is an inherent conflict between financial interest of health care nonprofits and the interest of their Medicaid patients. Patients desire to receive the highest quality of care at the lowest cost possible while hospitals desire to maximize revenues by providing services at the lowest cost. Therefore, dominant health care organizations prioritize their interest as a top priority and engage in the policy process to protect their interest.*

**Finding:** This hypothesis specifically applies to hospital systems. According to the participants who were interviewed, this hypothesis is partially true. Based on the data analysis, hospital leaders asserted that their financial interest is critical to their values and mission to serve the most vulnerable in our society. Therefore, they see their financial interest and dominance as a requirement to protect their patients and communities that they serve in. In addition, they assert

that hospitals must protect their business model to mitigate risks associated with constant changes in federal and state regulations, a volatile health care market, the responsibility to maintain billions of dollars in fixed assets, and the moral commitment to hundreds of thousands of employees and their families.

### **Participant A**

This organization prioritized their clients need first. Their policy positions supported expanded coverage because it meant more services to a larger group of clients. The organization did not financially benefit from the expansion.

### **Participant B**

This organization prioritized their clients need first. Their policy positions supported expanded coverage because it meant coverage to parents with children. The organization did not financially benefit from the expansion.

### **Participant C**

[There were] places where you have people coming to the emergency room with no coverage [but] now [these institutions] have the opportunity to sign these people up [for HIP 2.0] and get reimbursed for some of those services. But in another areas it is more about the entire health system, [which] is now pushing people towards population health [and] taking care of people so they do not end up in the emergency room.

I think what our [physicians] hear about [are success] stories of someone who was able to get something taken care of before they come to the hospital [because they now have coverage]. [Our physicians] do not think oh shoot that would have been [an] expensive transplant, they do not think that way. They think that's what we are supposed to be doing, [which is] keeping people well so that they don't end up costing the entire system more. [Currently the] health care system is all about treating people who are sick or injured.

A lot of work is being done now on how you completely flip the reimbursement model so that everyone is incentivized to keep people well outside of the hospital.

### **Participant D**

I was directly involved in dealing with governmental representatives on the [Hospital Assessment Fee] committee, [which played a critical role] in [designing the financing model for] the implementation of HIP 2.0. We also received DISH payments. As a result of these algorithms [and the complexity of the funding streams], I was very much involved in [these decisions].

How can the relationship be equal enough that you can have a judgment about what you're receiving, whether you need to receive it or not, so that's what the argument is about. In American healthcare, 80% of those prescribed drugs in the world are prescribed here so how can that be? Do we just simply provide too much and it's too expensive?

Around here we have [an] ethics committees. So any patient, any provider, or any employee can ask for an ethics consultation and actually talk a problem through. Those usually include end of life [decisions], sometimes they involve kids in the NQU but mainly end of life. But talk about waste, and I can't tell you how many times in my years as a CEO I was dragged into those unwillingly because I am not part of the protocol but I knew the people.

### **Participant E**

Organization does not provide health care services.

### **Participant F**

Organization does not provide health care services.

## **Participant G**

The business model should not be viewed as a conflict between patients and providers. The business model has to function for the centers to afford providing services.

## **Participant H**

[The argument about whether or not a conflict exists between our values and business model is] an interesting one, it's going to be an argument that will never be resolved. My belief, is that the consumer in general has one shade of this, but really this goes back to their belief of what a nonprofit organization is. The historical or the traditional aspect of nonprofits, regardless of whatever it is, [believes that nonprofits] are not supposed to make money, they are supposed to squeak by, they are supposed to have raiser thin margins if they have one at all, they are supposed to solicit. And where I disagree with that is my status of whether I pay property taxes or I am tax exempt should not flow into how it is we operate as an organization because our belief is if today we are covering five individuals, hypothetically, who are poor struggling and vulnerable, and we have the ability to evolve what we are doing today to cover six, then we should be doing that. So from our leadership perspective even though we have a tax exempt status, that does not give us a free pass for being able to go and find more [patients to serve]. Our charity care continues to rise every year because you still have people that are struggling and until no one is struggling we have a mission to serve. It just so happens that we are very efficient and effective at [achieving our goals].

### ***Hypothesis #2: Challenging and Suppressed Interest***

*Challenging and suppressed interest groups engage to protect the interest of the most vulnerable in their communities.*

**Finding:** This hypothesis holds true for the most part as confirmed by the responses of participants and the data analysis. However, the faith-based nonprofit and the mutual benefit association placed a higher value on internal

harmony within their membership, engaged in consensus building, and focused on long term goals. They continued to advance the goals of repressed through different advocacy vehicles outside of their formal roles with their organizations.

### **Participant A**

We advance the interest of the underserved, the uninsured, and the low income chronic disease population... We represent the repressed. We engage in challenging certain aspects of the policy, but we mainly represent the repressed.

We were pushing for healthcare or Medicaid expansion because that was to us what was on the table that was right for our clients. As that evolved and became HIP 2.0, we didn't dig in our heels and say no we just want Medicaid expansion. We really looked at [HIP 2.0] and said okay this has a better chance. [HIP 2.0] got the political will and it's really good for our clients so we became very supportive of the program.

### **Participant B**

We advance the interest of children with disabilities and health care challenges.

We represent the repressed. We engage in challenging certain aspects of the policy, but we mainly represent the repressed.

### **Participant C**

Not applicable.

### **Participant D and Participant H**

Not applicable

### **Participant E**

The fundamental sort of question that we ask ourselves is this a religious issue? And that really determines what our public policy is going to be.



The reason that we're involved in public policy is little bit self-serving. Is that our primary mission is to make sure that the religious community is safe and secure and that we have a place where we can live, practice freely, engage freely, communicate freely, and ensure [these freedoms] for [our] community. We also need to have a hand in ensuring [those freedoms] for the entire community. [But I recognize that our positions] are a little bit self-serving.

### **Participant F**

From a public policy, that's a very interesting question because we have struggled with that. Our primary first constituency are our 61 members throughout the state comprised of all of their donors, all of their volunteers, and all of their funded partners, plus all of their community because they have a mission to make their community better. By extension, our constituency, we see much broader than our 61 members.

### **Participant G**

I think it gets back to influence. Let's be honest, hospitals are major employers in local communities, I think they are 20% of the GDP total, and we are a tiny sliver of the 20%, but it's very important part of our economics. Our society valued health care services in a way that has driven up health care cost for specific services over and above those that were not deemed to be reimbursable at the same level or at least on par with certain treatment aspects.

But do not get me wrong other aspects of primary health care have been underfunded too [such as] pediatrics, primary family care practice, all of those things. But that does impact the influence an organization has because again there is a huge economic driver here to the system. It is just the reality of how we valued health care here in the United States and I think it has been a poor public policy decision on our part to go down that path.

We should've been invested in health all along avoiding this drive up of costs. Doctors [are serving] elderly people [and] advancing treatments that they do not need. It's not good for the health care system at all.

### ***Hypothesis #3: Governmental funding is critical***

*The more benefits nonprofit health care organizations receive from government, the more these nonprofits will attempt to dominate the policy field.*

**Finding:** Based on the data analysis of key responses from participants, this hypothesis holds true.

#### **Participant A**

This organization does not receive funding from government and they did not aim to dominate the health care field.

#### **Participant B**

This organization does not receive funding from government and they did not aim to dominate the health care field.

#### **Participant C**

The organization was given direct access to negotiating with the state because of two reasons: (1) viewed as trusted partners and the most important stakeholder in the policy arena since the inception of HIP 1.0. Hospitals were the most impacted by uncompensated care. Market Basket cuts exceeded \$1 billion in 2015, and will exceed \$8 billion by 2020. (2) There was no other mechanism to fund the program without the HAF. So the state had to negotiate directly with hospitals and ensure that the new policy would not lead to a shock to the hospital system (financial instability) that may lead to closure of hospitals or shrinking of coverage.

We had the means to create a fiscal solution to the issue. We had the most to lose, so we were the loudest voice ... our members exist in every large community.

We encouraged our members to write op-eds, visit with their law makers, talk with the administration, talk about coverage on social media, undertake a lot of activities to push that out there, so that also helped promote the sense that hospitals are behind this policy and want to see it enacted. Hospitals are large employers with almost 200 thousand Hoosiers in total employment across the state. In many communities, they are the largest employers in the county if not in the multi-county region.

### **Participant D**

Well, clearly [HIP 2.0 provided] money to hospitals based on a public policy, but the devil was in the details of the calculation. Here's a fact. I never had a direct conversation with Governor Daniels or Governor Pence about the actual calculation, never. I never went above a staff member's head to their boss about an arithmetic calculation. I did encourage both Governor Daniels and Governor Pence that I thought that they needed to refresh the staff's memory to why we were doing these sort of things. Like why are we doing HIP 2.0? So it's not a bureaucratic exercise, it is to get people enrolled. [Why did we implement] HIP 1.0? To fill the hole for folks who otherwise uninsured.

### **Participant E**

Does not receive government funding – does not aim to be dominant

### **Participant F**

Does not receive state or local funding.

Yes, we are currently a CMS navigator grantee through the organization. It was a multi-state grant application. We were the Indiana grantee and ironically only Indiana was funded out of all of the states that applied through the multistate application. We have applied for other grants on behalf of our members or on behalf of Indiana 211 partnership but we were not successful.

The organization does not [receive state funding] directly. We do have a contract with the state to manage the state employee combined campaign.

I feel like we are a trusted resource because we are not political. We do not operate in a political capacity like other organizations. We do not engage in anything partisan. So if we are viewed as a resource [then this is] a success. My board view it [a success] when we are recognized [in the media] and they often see that as are we quoted in an article? Do they see changes happening at the local level? That's how they view success.

But I feel we are often a trusted resource because we don't have that kind of leg in the game. I don't get any financial benefits by advocating for health insurance, for low income people, there is nothing that we do other than the goodwill and accomplishing our mission. The Hospital Association sees very clearly that when there is a Medicare rate versus a Medicaid rate pay loss they have a clear bottom line reason and one could argue that philanthropy is better, is improved, when businesses do better so let's support businesses; but that's not our motivation and that's not part of our thinking.

### **Participant G**

Of course we can't be dominate because we do not have the influence to be dominant, so I would say a balance between the three.

So I want to be dominant but again I do not want to be dominant at the cost of my ability to be transactional or my ability to represent the repressed.

### **Participant H**

This organization is dominant; however, they view their dominance as an instrument to protect the most vulnerable. Therefore, the Participant thinks that the organization may switch roles between challenging and dominant dependent on the issue.

I would not say repressed, we are either a challenging or a dominant depending on what the issue is...Dominant to serve the repressed.

I would say we are challenging and repressed for those who are voiceless, and it is a combination of the two because as large as we are we have the ability to influence [policy]. We should always be looking out for those who are on the margins and take care of them the way that Jesus found those who were naked and clothed them, found those who were hungry and gave them food. We should find those who are struggling and help them. But that does not mean we can't be dominant in how we do it because our mission is always grounded in serving those who are struggling.

It is disappointing [that other nonprofits criticize us] because [they] have the traditional [view] of [how] a nonprofit [should operate] that I do not believe in. I believe that we should be great at what we do and do more with the fruits of our labor. So with it how do we show that [we do more with the fruits of our labor]? it is not something that we have to prove but if we are caring for one poor and vulnerable individual and now we have the ability to care for two, [then] by God we are [going to] go out and find that second one and when we are done with that we are [going to] evolve and find a way to care for three because we can show that evolution over time. [This approach will improve] health outcomes.

***Hypothesis #4: Dominant interest organizations are influential***

*Unlike challenging and suppressed interest groups, dominant health care nonprofits tend to be very influential, connected to the political elite, have abundance of resources, and are focused on protecting long term goals. Challenging and suppressed interest groups tend to collaborate with each other to counter public power and private interest via networks of coalitions.*

**Finding:** Based on the data analysis of key responses from participants, this hypothesis holds true.

### **Participant A**

This organization represented the repressed. They are not very influential, not connected to the political elite, have limited resources. Their focus is to advance the interest of their clients. Advocacy is mainly conducted via joining coalitions.

### **Participant B**

This organization represented the repressed. They are not very influential, not connected to the political elite, have limited resources. Their focus is to advance the interest of their clients. Advocacy is mainly conducted via joining coalitions.

### **Participant C**

This organization represented dominant interest. They are very influential, connected to the political elite, have abundant resources. Their focus is to advance the interest of the hospitals in Indiana. Advocacy is the core function of the organization and conducted formally via lobbying, direct communication with the state, and through coalitions with other nonprofits.

[Our organization could also be viewed as representing challenging and repressed interest]. Some of our faith-based religious affiliated institutions were founded by the mission taking care of the poor and I think our members do live up to those commitments today [especially] when you look at their hospitals they still continue to operate in our state [and advocate to enroll] individuals in those programs and directly help them. Back to the dominant interest [question]. Yes, the fact that we were able to reduce the uncompensated care helps [hospitals] run their business and their operations and continue [their] missions. Otherwise they would wither. It is mostly dominant but with input from the others.

## Participant D

It does not matter if you work for a nonprofit or a for-profit [hospital]. If the policy maker that you're lobbying, for a lack of better word, is someone you know, you are not going to exaggerate [the importance of your policy proposal], it's not going to happen. And you are not going to ask them to do something that's unreasonable or selfish, it's just not going to happen. Others [they] will say this is not true. Most of our competition would say that I had undue influence, [but] it never happened. I just did not talk to them, so you slice this spectrum of influence and [discover that different hospitals] are going to be with more or less influence but the reasons for that may not be obvious.

You may or may not know, you may think it is the size of the check [donated to political campaigns], but I do not think so. At least in my case, I personally wrote big checks to both Mitch and Mike. Mitch is a really good friend of mine and it had nothing to do with that. Mike called me and asked me for a 5 figure gift if I could afford it, I would do it, and did do it, and contributed to his PAC which gave to them. But the truth is I was working with him and contributing to him. Governor O'Bannon was a family friend. Governor Kernan appointed me, a Republican to the state economic development commission, IEDC when it was first formed.

So I talked to a lot to governors about this issue. In fact recently the issue of what data you look at, what data do you actually trust, and what change or outcome do you want to see, so that's the public policy question. If the goal was to expand payment for the underserved, then what would that do? Would that improve the health of the underserved and drive down the demand side?

My operating theory was that the only way you can deal with [cost and quality of health care services] is if you treat this issue as a population health matter and convince policy makers that emergency departments were being abused because they were being used for primary care visits, which was really a big leap for what people thought of the medical model for the emergency departments.

Connecting public policy need with governmental action I thought was within my wheel house, part of that was because I worked for big law firms.

The trade association was going back and forth with him on the funding as you can imagine. I [met with the Governor to] reinforce the idea that we did share a common value which is to serve as many people as possible and improve the health of particularly the underserved. His political argument may have been about self-determination and federal budget deficit mandates, but at the end of the day his goal was the same as mine. [The Governor's challenge was] how you translate that into marching orders to other folks? [This is] the art of administration and politics. That was up to him, so I remained focused on [the idea of] expansion.

The core function of hospital systems is acute care. The organization is one of three acute cases in the state of Indiana, so we would be the dominant by far on the core business.

And [as for] repressed [interest], [this relates] to the values. [Ethical dilemmas at the hospital system] would include end of life decisions. I must tell you that if I agonized over anything, and the chairman of my organization's values committee knows this, I agonized over [what we were doing with acute care]. We were so focused on acute care [and] providing unnecessary care to 96 years old with dementia patients who are voiceless, or the pregnant mom how comes in labor and never brings the baby back for a well-baby visit and we know where she lives. In fact, we got the data from the state board of health that tells the infant mortality rate is high [in Indiana]. I was among those personally who lobbied Governor Pence to make this the number one priority of the State Department of Health. It seems they did a good job on [the issue of infant mortality] and I think this is a work in progress. You got to have forcing functions, and around here the forcing function is the values committee. I think everybody talks the talk [but must advocate for policy changes] to walk the talk. So what would be the forcing function? That's the leadership question. So Congress would say the law.

Measuring community benefit [is critical] and we got to do a community benefit report [to report our progress]. The [current] community benefit reports are not aligned. For example, [as it relates to the] drug epidemic, I suggested that all 120-130 hospitals in the state that own 40% of physician [networks] in the state, which produce two thirds of the state's business, to have a common prescription guidelines for opioid and other pain killers. What a great idea? But that was trying to move an industry on a common problem that does not pay anybody money at the end of the day.



## **Participant E**

I think we have very positive relationships with just about everybody. One thing that we really pride ourselves on at the organization is maintaining good relationships with [state legislators] and on both sides of the aisle. We may as a community [agree to disagree with] a legislator or an elected officials on a policy, but at the end of the day that legislator or elected official knows that the organization will [engage in a] civil and fact-based discussion about that particular issue.

## **Participant F**

Because we tend to do the middle of the road compromise, I think every communication has strengthened our relationship [with state legislators] because even if we agree to disagree about a policy we are still providing good data and not beating them over the head to do something. Though one area that I think we are hampered because we hold the navigator grant, which is a federal grant and some of our sub grantees are also Indiana navigators, we have gone by two sets of rules related to that. So we are extra cautious. For example, because of the navigator grant, we were restricted in how much we could do with the health plans. So sometimes the rules get in the way of wearing multiple hats.

## **Participant G**

This 501-C-6 trade association represented challenging and repressed interest.

We did have some discussion about the medically frail designation the feds had just amended the definitions for medically frail under the HIP 2.0 program, or the HIP state plan. There is a distinction here, was afforded the opportunity for additional treatment services and so the way it was crafted they did engage us in conversations to talk about how we can ensure a seamless designation process so that the people can get access to treatment quickly [based on a] national model. In fact, the team and I did a national webinar on this process [and] it was so well received.

I think we are doing some pretty cool stuff. In fact I was pretty instrumental in working on getting the language changed around [providing health care services] for folks coming out of the criminal justice [system] from both the DOC and the County jails and into treatment. By that standard alone I think we've really done a good job getting people better access to care. Again, the presumptive eligibility [provision] made a big difference.

[We also represent the] repressed. [Those are the] voices who did not have access to health care services, we indirectly [became] their voice. I stay up at night and I think about how the Association serves these repressed voices and their interest in a complicated way, it's not [a simple] one size fits all scenario. [We have to make the challenging business model work.

### **Participant H**

Policy is the only way strategy to me can be successful. If you do not have sound policy that can be evolved, massaged, and changed over time you can never have a grounded success and evolution with a strong health care policy. The Chief Advocacy Officer have shown the board how this works. If we do not have a strong voice in what policy is, [then] we can never advance ourselves to find those who are struggling.

## CONCLUSION

### Summary

This study examined the question of whose interest do nonprofit organizations advance when they attempt to influence the implementation of public policy. To answer this question, a qualitative methods approach was used to analyze why nonprofits engage in the public policy process (motivation and values), the policy actions that nonprofits make during the implementation of the policy (how?), and the method by which nonprofits address or mitigate conflicts and contradictions between organizational interest and constituents' interest (whose interest do they advance?).

The coding of interview data uncovered seven initial themes:

(1) Leaders of Indiana's health and human service nonprofits are experienced in the fields of politics and public policy. All interviewees are highly educated nonprofit leaders who hold prominent leadership roles within their organizations. They all have extensive experience in the fields of law, politics, lobbying, and health care policy and administration. Five of the eight interviewees are registered lobbyists.

(2) Indiana's health and human service nonprofits advocate to advance the interests of their member organizations, patients, and communities that they serve.

(3) Indiana's health and human service nonprofits have different levels of organizational maturity. Hospital systems are among the largest employers in the state with tens of thousands of employees statewide, highly structured, operate almost in every county of the state, maintain budgets with billions of dollars, serve millions of people, very well connected to policy makers and the corporate

community, engage in direct and indirect lobbying and advocacy activities, highly regulated and operate in a very volatile market place, and very focused on long term strategies and goals. Smaller trade associations, mutual benefits organizations, health care advocacy groups, and faith-based nonprofits share similar characteristics: they operate with small budgets, small teams, boards are composed of executives of locally affiliated chapters or branches, self-preservation is important given the diversity of their membership, and advocacy and policy stances are evaluated based on political calculus, religious values, and internal consensus.

(4) Indiana's health and human service nonprofits utilize direct, indirect, formal and informal methods to influence policy. The eight organizations fully supported HIP 2.0 because the policy expands coverage to the uninsured population and allows organizations to improve their finances, which in return allows them to serve more people. HIP 2.0 was viewed favorably by most organizations thus minimizing internal conflicts. All organizations have a formal process to finalize policy and advocacy positions, some are more complicated than others. With the exception of the two health care advocacy groups, the remaining six organizations engaged in formal and informal lobbying activities. The two Hospital systems were focused on long term strategic goals, business model stability, and securing favorable regulations.

(5) Indiana's health and human service nonprofits have different levels of influence. Data illustrates that a complicated web of relationships exists within the nonprofit sector by which leaders of the largest health care organizations serve on boards of other health care advocacy groups and help shape their agendas. One health care executive had a direct access to the governor and government staff.

(6) Indiana's hospitals were the most influential in influencing the implementation of HIP 2.0. Hospitals were the most invested stakeholders given the financial

commitment they made in financing HIP 2.0, so the state negotiated directly with hospitals because they were the most important stakeholders, they have statewide impact on improving access to health care, and they are the largest employers in many counties of the state. Given the political environment and the general consensus between organizations that implementing HIP 2.0 was better than maintaining the status quo, most organizations supported the policy but focused on the transactional aspect of the implementation.

(7) Indiana's health and human service nonprofits switch roles in representing different types of interest depending on the policy issue. The two 501-C-6 Trade Associations, the 501-C-3 faith-based organization, and the statewide mutual benefits organization represented the interests of their board members and CEOs of member organizations. One of the trade associations represented dominant interest, the other association represented challenging and repressed interest. Both the faith-based nonprofit and the state-wide mutual benefits association represented their membership's interest and they valued internal consensus over taking public positions on controversial policies. Therefore, leaders from both organizations engaged under the umbrella of broader coalitions to challenge certain policies. Thus, they represented challenging interest to improve the transactional aspects of certain policies. The other four organizations viewed the patient and the larger community as their primary.

Further analysis of the categories and concepts that emerged from the coding phase confirmed that nonprofits advocate to achieve their missions and values, are driven by the commitment to the public good, represent different interests and constituencies, act with self interest in mind, are pragmatic and willing to compromise if the proposed policy benefits the larger population, and they believe that advancing their organizational self-interest benefits the populations they serve. It is also worth noting that small advocacy nonprofits acknowledge that there is an internal tension between nonprofits and believe that the health care nonprofits are divided into two camps or types of nonprofits: a camp that

considers themselves as humanitarians who advance the interests of the repressed, and a camp that is driven by profits. Almost all participants confirmed that this worldview does exist; however, dominant organizations argued that they are not different from smaller organizations in terms of securing funds to serve their missions.

The micro-level analysis of internal decision making processes within a given organization and the meso-level analysis of the relationship between interest, power, and health care policy confirmed that hospitals tend to dominate Indiana's health care policy field and influence decisions made by other actors to impact policy outcomes.

The application of Robert R. Alford's theory of structural interests to the implementation of HIP 2.0 and findings from the qualitative analysis produced a more comprehensive understanding of Indiana's health care policy field, organizational actors, organizational conflicts based on values and interests, and the distribution of power between nonprofit interest groups. Indiana's dominant institutions were the most powerful, connected and influential; challenging interest groups participated in the implementation process and advocated for certain transactional changes; and repressed interest groups were not as influential as the other groups.

Internal and external competing interests, the impact of the political and policy environment, and funding implications are factors that nonprofits consider when making policy decisions. It is very clear from the interviews that organizational variables such as structure, membership diversity, funding sources, and community interests could either restrain or empower the advocacy efforts of nonprofits that operate either as advocates or as service providers.

The findings clearly illustrate that dominant interest groups have more power, influence, connections to the powerful elite, and have more resources to influence the implementation of public policy. However, the analysis revealed

more details about the connection between the idea of dominance and serving the most vulnerable in our society. In the case of HIP 2.0, dominant interest groups supported HIP 2.0 because it was the right policy for Indiana's uninsured population. Hospitals and other health care providers argued that an improved financial position as a result of an increase in state reimbursements allowed their organizations to provide more services to a segment of the population that was historically uninsured.

The visual trend analysis clearly illustrates that on a national level the ACA expansion did improve patient satisfaction measured by patients' perception of the quality of care they received. The trend line illustrates that both Medicaid expansion and non-expansion states experienced an increase in patient satisfaction after the implementation of the ACA. The results also show that hospitals in twenty two out of the twenty five expansion states reported an increase in patient satisfaction when comparing 2013 to 2015. It is worth noting two findings: (1) the trend has been rising since before the implementation of the ACA; and (2) Patients in non-expansion states tend to have a better rating of their hospital experience compared to patients living in expansion states (a difference of approximately 2 percentage points).

As it relates to hypotheses that were tested, the following conclusions were reached based on the data analysis:

### **Financial Interest vs Patients' Interest**

**Hypothesis #1:** *Due to the high cost of providing quality health care, there is an inherent conflict between financial interest of health care nonprofits and the interest of their Medicaid patients. Patients desire to receive the highest quality of care at the lowest cost possible while hospitals desire to maximize revenues by providing services at the lowest cost. Therefore, dominant health care*

*organizations prioritize their interest as a top priority and engage in the policy process to protect their interest.*

**Finding:** This hypothesis specifically applies to hospital systems. According to the participants who were interviewed, this hypothesis is partially true. Based on the data analysis, hospital leaders asserted that their financial interest is critical to their values and mission to serve the most vulnerable in our society. Therefore, they see their financial interest and dominance as a requirement to protect their patients and communities that they serve in. In addition, they assert that hospitals must protect their business model to mitigate risks associated with constant changes in federal and state regulations, a volatile health care market, the responsibility to maintain billions of dollars in fixed assets, and the moral commitment to hundreds of thousands of employees and their families.

### **Challenging and Suppressed Interest**

**Hypothesis #2:** *Challenging and suppressed interest groups engage to protect the interest of the most vulnerable in their communities.*

**Finding:** This hypothesis holds true for the most part as confirmed by the responses of participants and the data analysis. However, the faith-based nonprofit and the mutual benefit association placed a higher value on internal harmony within their membership, engaged in consensus building, and focused on long term goals. They continued to advance the goals of repressed through different advocacy vehicles outside of their formal roles with their organizations.



### **Governmental funding is critical**

**Hypothesis #3:** *The more benefits nonprofit health care organizations receive from government, the more these nonprofits will attempt to dominate the policy field.*

**Finding:** Based on the data analysis of key responses from participants, this hypothesis holds true.

### **Dominant interest organizations are influential**

**Hypothesis #4:** *Unlike challenging and suppressed interest groups, dominant health care nonprofits tend to be very influential, connected to the political elite, have abundance of resources, and are focused on protecting long term goals. Challenging and suppressed interest groups tend to collaborate with each other to counter public power and private interest via networks of coalitions.*

**Finding:** Based on the data analysis of key responses from participants, this hypothesis holds true.

The convergence of all findings from this research study support assertions made by existing research that found measures of institutionalization and resource dependence to be inconsistent predictors of political activity and nonprofits' motive to engage in advocacy (Herrnson, 2000; Nicholson-Crotty, 2007).

### **Implications to Future Research**

As in the case of every research project, all research is never perfect and assertions made by any researcher are always subject to further investigation, examination, and critique. The findings from this study raise additional questions

to be explored in the future, such as: did large health care institutions increase their charitable investments in communities as a result of the reduction in uncompensated care? Is there a correlation between improved financial reimbursement rates and customer satisfaction? Would findings be different had I interviewed patients rather than executives of health and human service nonprofits? Would a difference-in-difference statistical analysis confirm that the ACA or the implementation of HIP 2.0 had a direct impact on the improvement of customers' perception of services they received at their local hospital? Under which conditions and circumstances do organizations switch roles between representing dominant, challenging, and repressed interest? These are important questions that are worth pursuing in future research studies.

On the theoretical side, Alford's framework assumes that there is an inherent conflict between the three different types of public interests for two main reasons: (1) organizations represent different constituents with different interests, and (2) dominant interest groups desire to maintain the status quo to maximize their benefits. In the case of Indiana's implementation of HIP 2.0, leaders representing the three different interest categories set aside their differences and agreed to collaborate in supporting the implementation of HIP 2.0 because HIP 2.0 was a policy that advanced the public good. In light of this finding, it is important that additional research be conducted to examine under which conditions do repressed and challenging public interest groups support policies that benefit a dominant group? In Indiana, the three types of public interest groups supported the implementation of HIP 2.0 because they collectively believed that the policy to expand coverage benefited the most vulnerable despite the fact the hospitals also benefited financially from the reduction in their uncompensated care.

Finally, this research could be expanded and extended to other policy areas for practitioners in different policy fields either in Indiana or on a national level. The policy process is very complicated due to the engagement of many actors, interest groups, the impact of the political environment, abundance or lack of

organizational resources, and many other factors. Philanthropists and nonprofit leaders must be equipped with the knowledge about power structures in a given policy field to be able to influence the outcomes of public policy.

## APPENDIX A – Qualitative Interview Guide Template

### Qualitative Interview Guide Template

Philanthropy, Policy, and Politics: Power and Influence of Health Care Nonprofit Interest Groups on the Implementation of Health Care Policy (IRB Study # 1411878474)

**Introduction:** Thank you for taking the time to talk to me today. I really appreciate your willingness to help me out with this interview. Have you ever been interviewed before? Well, the main reason why I would like to interview you is to learn about your experiences with advocacy in healthcare.

Findings from this study will add value to existing academic scholarly research on the impact of hospital advocacy on social welfare policies.

**Interviewee Role:** I want you to feel that this is *your* interview. I am here to listen to what you have to say. I am very interested in your experiences, so please feel free to share anything that comes to mind. My job is to listen to you so that I can better understand these experiences.

**Explain Audio Recording Procedures:** As I explained when we talked [on the phone], I will record our conversation so that I do not have to take notes and so I can get your complete answer. This also helps me guarantee that my report will accurately reflect your experiences. After the interview, I will listen to the recording and type up the interview. I will not include any information that identifies you. When I have finished my project, the recorded copy of the interview will be erased. Is this okay with you?

**Assure Interviewee of Confidentiality:** Please feel free to speak openly with me. Maintaining your privacy is the most important thing to me and anything you say during this interview will be kept private and confidential. I will not include your name or any other unique information that could identify you in my report. Also, if I ask you any questions that you do not want to answer, you can just say, “pass” and we will skip those questions.

**Time Frame of Interview:** The interview will last about 1-2 hours. If you need a break at any time, just let me know.

**Obtain Informed Consent:** Before we begin the interview, I would like to go over the study’s information sheet, which describes the nature of the study, your role in the study, the steps taken to maintain your confidentiality, and the voluntary nature of the study. You can take this form with you (Wait for the participant to read the information). Do you have any questions about the study or the information you read? If not, do you give your permission to participate in the study by being interviewed? (If the participant agrees, then start the interview).

Ok thank you for your help with the study. Do you have any more questions before we start?

Gain Verbal Consent and Start Interview: Ok, then I will begin recording the interview now.

## APPENDIX B – Interview Questionnaire

Topic Domain	Main Question	Sample Follow up – Probes
<b>Personal Background</b>	Please describe your background (professional experience, areas of policy interest, etc.).	<ol style="list-style-type: none"> <li>1. How long have you been with this nonprofit?</li> <li>2. What roles did you occupy?</li> <li>3. Please tell me about your experiences in the field of healthcare?</li> <li>4. In your previous/current role, did/do you engage in educating the public or government staff/representatives on issues that your organizations cares about?</li> </ol>
<b>Organization’s Constituents</b>	Who is your main constituency?	<ol style="list-style-type: none"> <li>1. Who do you serve (clients/demographics)? I.e., who are the primary constituents of your organization?</li> <li>2. Does your organization have other important constituents whose needs/interests you must consider?</li> <li>3. Are there conflicts among the needs/interests of your constituents?</li> <li>4. What role do your constituents play in your organizational decision making?</li> <li>5. What role did your constituents play in your work around ACA?</li> </ol>
<b>Organization’s Background</b>	Can you tell me how your organization works with government?	<ol style="list-style-type: none"> <li>1. What government programs does your organization participate in?</li> <li>2. Does your organization engage in educational initiatives that target the public? Government staff &amp; representatives?</li> </ol>

		<ol style="list-style-type: none"> <li>3. Does your organization perform any lobbying activities?</li> <li>4. Does your organization receive any government funding? If so, for what programs?</li> <li>5. Does your organization meet with elected representatives or government staff/managers? If so, who participates from your organization and how often?</li> <li>6. Does your organization engage in educating the public about issues related to your mission? If so, what are these issues (can you give me examples from the last year or two)?</li> <li>7. Can you describe your organization's current relationship with government agencies/staff/representatives?</li> </ol>
<p><b>Organization's Advocacy decision making process, type and purpose</b></p>	<p>During ACA expansion in Indiana, what was the decision making process to formulate a policy position?</p>	<ol style="list-style-type: none"> <li>1. What was the motivation for the meeting?</li> <li>2. What were the goals that your organization wanted to achieve? Who participated? Describe the meeting.</li> <li>3. What was the outcome?</li> <li>4. Who participated in making decisions regarding how to engage, educate, or work with government officials?</li> <li>5. In that instance, did your clients/constituents participate in the decision making process? If so, how?</li> <li>6. Do you remember any instances during this process where your clients and the organization had different ideas of how to educate and</li> </ol>

		<p>engage government staff or representatives? How did you deal with this situation?</p> <p>7. Does your organization coordinate and plan with other nonprofits to educate or engage government programs or policies?</p> <p>8. Which organizations and what was the purpose?</p> <p>9. If so, can you walk me through the process of how these efforts are coordinated (who participated, how did you prepare for the meeting, what were the goals of the meeting, etc.)?</p> <p>10. What was the program or policy area you were trying to influence? And Why?</p>
<p><b>Influence over the implementation of the policy process</b></p>	<p>Did you influence the policy implementation?</p>	<p>1. Did you participate in any events or meetings with government staff/representatives to discuss Indiana's Medicaid expansion?</p> <p>2. If so, who did you meet with?</p> <p>3. What was the purpose?</p> <p>4. Was the process easy /difficult?</p> <p>5. Did your organization have an official stance on Medicaid expansion in Indiana? If so, what was it?</p> <p>6. Can you describe to me the type of educational efforts your organization engaged in to educate the public or government staff/representatives regarding Medicaid expansion in Indiana? Can you explain the process?</p>



		<ol style="list-style-type: none"> <li>7. Why did you choose this method/type of engagement/education?</li> <li>8. What was the purpose you were trying to achieve?</li> <li>9. Who will benefit from your efforts?</li> <li>10. What does your organization like about Medicaid expansion and why?</li> <li>11. What do you dislike about Medicaid expansion and why?</li> </ol>
<p><b>Outcomes/Impact of influence over Medicaid Expansion in Indiana</b></p>	<p>Explain the impact of your efforts to influence the implementation of Medicaid expansion in Indiana?</p>	<ol style="list-style-type: none"> <li>1. Were you able to influence the public or government staff/representatives regarding the design or implementation of Indiana’s Medicaid expansion?</li> <li>2. If so, who did you influence and how?</li> <li>3. What was the outcome of your efforts?</li> <li>4. Where you pleased with the outcomes? Please explain?</li> <li>5. How did the implementation of Medicaid expansion impact your organization? (ex: services)</li> <li>6. How did the Medicaid expansion impact those who you serve?</li> <li>7. Did the implementation of Medicaid expansion impact your organization’s relationship with other nonprofits that you work with? If so, can you share a few examples?</li> <li>8. How do you measure the success of your efforts in regards to Medicaid expansion?</li> </ol>

		<p>9. Did your relationship with those who you tried to influence (public, clients, governor, legislature, state agency executives) change as a result of your engagement to influence Medicaid expansion? If so, how?</p> <p>10. Was your organizational budget affected as a result of your engagement with government representatives/staff or Medicaid expansion?</p> <p>11. Do you coordinate with other nonprofit healthcare organizations to influence health care policy in Indiana? If so, who and why?</p> <p>12. If appropriate, do you think your patients/clients are more satisfied today as a result of Medicaid expansion?</p>
<p><b>Whose interest does your organization represent?</b></p>	<p>Does your organization represent dominant, challenging, or repressed groups?</p>	<p>1. If you are to use one of these labels, which one best represents your organization?</p> <p>2. Why?</p> <p>3. If more than one label applies, then please explain?</p> <p>4. Any final thoughts?</p>

## **APPENDIX C – Study Information Sheet**

### **INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR**

Philanthropy, Policy, and Politics: Power and Influence of Health Care Nonprofit Interest Groups on the Implementation of Health Care Policy (IRB Study # 1411878474)

You are invited to participate in a research study that examines the role of nonprofit health human service nonprofits as interest groups on the implementation of public policy/healthcare policy. You were selected as a possible subject because of your familiarity with nonprofit healthcare advocacy. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Fady Qaddoura in the Indian University Lilly School of Philanthropy at Indiana University - Indianapolis. Dr. Lehn Benjamin, a faculty member in the Lilly School of Philanthropy, is supervising the project. This project is not funded.

#### **STUDY PURPOSE**

The purpose of this study is to examine the role of nonprofit health human service nonprofits on the implementation of public policy/healthcare policy.

#### **PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things: Participate in an interview designed to last no more than two hours. The interview will be recorded on a digital recorder and then transcribed. The interviews will occur at a location of your choice or in a private room at your organization's location.

#### **RISKS OF TAKING PART IN THE STUDY:**

This study involves no risk. However, if you feel discomfort in discussing confidential or personal experiences that may have been difficult then please know that you can stop the interview at any time and we can skip any questions.

#### **BENEFITS OF TAKING PART IN THE STUDY:**

There is no direct benefit to the subject.

#### **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published. Fady Qaddoura and Dr. Lehn Benjamin will have access to the audio recordings of the interview, and they will be deleted at the end of this research project.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP).

### **PAYMENT**

There are no payments for participation.

### **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study or a research-related injury, contact the researcher Fady Qaddoura by e-mail at [fqaddour@iupui.edu](mailto:fqaddour@iupui.edu).

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or for Indianapolis or (812) 856-4242 for Bloomington or (800) 696-2949 or by e-mail at [irb@iu.edu](mailto:irb@iu.edu).

### **VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with IUPUI

## APPENDIX D – Recruitment Email

Dear \_\_\_\_\_

My name is Fady Qaddoura, I'm a PhD candidate at the IU School of Philanthropy - Indianapolis. I have an IRB approval (1411878474) to conduct a research project to fulfill my PhD dissertation requirements under the supervision of Dr. Dwight Burlingame (dburling@iupui.edu office phone: 317-278-8926). My study aims to examine how nonprofits influence the implementation of new health care policies in Indiana using the implementation of the Healthy Indiana Plan 2.0 as a case study. HIP 2.0 is Indiana's Medicaid expansion program under the Affordable Care Act.

I'm interested in interviewing you because you/your organization/or an association or coalition that represents your organization either:

- (1) Participated in the HIP 2.0 public comment hearings back in 2015 or
- (2) Participated (directly or indirectly) with government officials from the Indiana Family and Social Services Administration or other state agencies to influence the implementation of HIP 2.0 in Indiana during the implementation phase (2015).

Your participation would involve meeting with me for a one-on-one private interview designed to last one to two hours. I will ask you questions about your organization, constituency, public policy positions, and advocacy activities. Everything you share with me will be kept very strictly private and confidential. Your identity and your organization's identity will be protected and will not be included in the final publication. The outcome of this research will be used for my dissertation only. If you are interested in participating and your organization is a registered nonprofit then please reply to this email with your formal acceptance to participate in the interview. I can meet with you either at your office/organization or at IUPUI/School of Philanthropy (University Hall, Suite 3000 - 301 University Boulevard - Indianapolis, IN 46202), whichever is more convenient for you. Please feel free to contact me by email at ([fgaddour@iupui.edu](mailto:fgaddour@iupui.edu)).

I appreciate your consideration of my request.

Sincerely,

Fady Qaddoura

## APPENDIX E – Document Summary

I reviewed the public hearing documents on “Medicaid Expansion in the State of Indiana” and “Public Conversations on the Future of Healthcare in Indiana” events, or what is known as expanding the “Healthy Indiana Plan 2.0 (HIP 2.0).” Governor Mike Pence, Secretary of the Family and Social Services Administration, and the Indiana Medicaid director led a series of public events and conversation forums to educate the public about the state’s plans to expand healthcare options to the uninsured and the underinsured Hoosier population. The videos of the public hearing events are posted on the state of Indiana’s website. The pdf documents explaining the history of the program, the proposed new program, public comments by nonprofits, for-profits, and citizens’ groups were also posted to the website. Documents I reviewed could be found on this website <http://www.in.gov/fssa/hip/2442.htm>

The list of documents I reviewed are listed below:

- [Press release](#)
- [Governor Pence HIP 2.0 Rollout recording \(5.15.14\)](#)
- [HIP 2.0 waiver application](#)
- [HIP 2.0 letters of endorsement](#)
- [HIP 2.0: Myths vs. Facts](#)
- [Frequently asked questions](#)
- [HIP 2.0 plans at a glance](#)
- [Infographic: The history of consumer-driven health care in Indiana](#)
- [Public comment period information](#)
- [HIP 2.0 public presentation](#)
- [Presentation to State Budget Committee \(6/20/14\)](#)
- [About the waiver process](#)

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## **CURRICULUM VITAE**

### **Fady A. Qaddoura**

I am an educator, researcher, public servant, and a systems thinker who operates strategically and innovatively to transform individuals, enterprises, and communities. I invest in developing mission-driven compassionate leaders who can mobilize the masses and inspire others to reach their highest potential. I firmly believe in public service, accountability, transparency, excellence, and commitment to the wellbeing of our fellow citizens and our country. My educational and professional backgrounds are multi-disciplinary and span several fields including Philanthropy, Public Administration, Public Policy, Technology, Finance, Health Care, and Higher Education.

### **Education**

Ph.D., Indiana University (2018)  
IU Lilly Family School of Philanthropy  
Major: Philanthropic Studies  
Minor: Nonprofit Management

- Research Focus: Philanthropy, Public Policy, Public Administration, Nonprofit Management
- Dissertation: Philanthropy, Policy, and Politics: Power And Influence Of Health Care Nonprofit Interest Groups On The Implementation Of Health Care Policy
- Chair: Dr. Dwight Burlingame

MPA, Indiana University-Purdue University Indianapolis (2011)  
School of Public and Environmental Affairs  
Major: Nonprofit Management

- Thesis: Assessing the Centers for Working Families Model/Approach

MS, University of New Orleans, LA (2007)  
Major: Computer Science  
Department of Math and Computer Science

- Thesis: Bi-Directional Information Exchange with Computing Handheld Devices

BS, University of New Orleans, LA (2004)  
Department of Math and Computer Science  
Major: Computer Science



## **Certificates**

Mediation in Public Policy Dispute Resolution (2009)  
School of Public and Environmental Affairs - Indiana University (IUPUI)

Certificate: Professional Fund Development and Fundraising (2009)  
School of Public and Environmental Affairs - Indiana University (IUPUI)

Certificate with Distinction: Leadership Institute for Nonprofit Executives (2008)  
Rice University

Certificate: CEO Orientation – Class of 2009  
United Way of Houston, TX

## **Professional Experience**

Controller & Chief Financial Officer: Mayoral Appointee (2016 – Present)  
Director of the Office of Finance and Management  
Consolidated City of Indianapolis and Marion County

- As the Controller and Chief Financial Officer for the 15th largest City in the United States, I am directly responsible for all financial and management aspects of the city and county, which include creating and overseeing an annual budget of approximately \$1.2 billion. My office is responsible for enterprise-wide financial management and reporting, human resources, enterprise management and administration, contracts, fixed assets, real estate, revenue recovery, ordinance violation bureau, grants, risk management, and purchasing/procurement functions of the City of Indianapolis and Marion County.

Senior Project Manager: Data Analytics and Strategies (2013 -2016)  
Division of Health Care Strategies and Technology/Family & Social Services Administration

- Supported the development of FSSA's strategic plans, budgets, policies, and helped inform executive management's decisions using business intelligence and data analytics.
- Directed the operations of vendor contracts in supporting mission critical systems in excess of 1 billion dollars.
- Supervised the operations of functional units that are responsible for FSSA's data analytics and business intelligence. The team was composed of team of 60+ staff (managers, supervisors, contractors, and employees).

- Integrated and aligned critical data sharing strategies, managed agency wide state and federal reporting functions within FSSA and with other state government agencies, Governor's Office, and the Indiana General Assembly.
- Strategized data aggregation, visualization, analysis, and reporting to achieve effectiveness and efficiency and serve FSSA's strategic goals.
- Developed analytics framework that integrated people, technology, and business processes.

#### Program Director – Quality Strategist (2012 – 2013)

##### Office of Medicaid Planning and Policy/Family Social Services Administration

- Coordinated project management activities for the implementation of the Program of All-Inclusive Care for the Elderly (PACE)
- Oversaw the Pay-for-Outcomes (P4P) program (over \$20 Million incentive fund)
- Applied for, received, and administered a \$2 Million federal grant.
- Conducted policy and legal research relative to program design and policy formulation; and performed quantitative analysis and trending of HEDIS, P4P, and Medicaid enrollment
- Analyzed legislative proposals and provided recommendations to agency leaders.
- Led OMPP's Annual Quality Strategic Planning and the process to update the Managed Care Entities Reporting Manual; managed the Annual External Quality Review Process; and monitored compliance and evaluation process of MCEs Quality Management and Improvement Program (QMIP)
- Contracted with state-wide vendors to implement healthcare quality improvement projects. Vendors included behavioral health centers, hospitals, research institutions, and local community organizations
- Designed processes, dashboards, and visual aids to manage workflows and enhance coordination among CareProgram units.

#### Public Policy Intermittent (2011)

##### Indiana Department of Workforce Development Indianapolis, IN

- Conducted research to inform the design of prisoners re-entry program to reduce recidivism
- Conducted benefit cost analysis for incentive programs to retain highly skilled workforce in Indiana
- Conducted legislative and policy research to identify legal barriers for rehabilitating and upgrading workforce skills and qualifications to meet Indiana economic needs.
- Coordinated tasks to develop the Workforce Investment Act Annual report.

Legal and Public Policy Intern (2010-2011)  
Indiana General Assembly (State House and Senate)

- Conducted policy and legislative research
- Monitored and managed bills advancement through both chambers

Volunteer Chief Executive Officer (2007 – 2009)  
Social Services Nonprofit – Houston, TX

- Founded the organization and led its growth
- Managed the organization's budget of \$5 Million
- Managed a total of 11 staff members

Director of Healthcare Research and Information Systems (2005 – 2007)  
University of Texas Medical School: Health Science Center

- Managed six research and information technology staff members.
- Designed and managed 4 national clinical trials with a budget of \$12 Million.
- Oversaw development and implementation of cutting edge Quantitative Magnetic Resonance Imaging software
- Led all data analytics and reporting functions of the neurology department

Regional Director of Business Development (2003 -2005)  
Discount Zone Management - New Orleans, LA

- Led the business development function in a regional district with over 25 stores.
- Contracted with large scale corporations to deploy business and IT solutions
- Managed seven technology staff, including three data analysts and two data warehouse managers.

Programmer - Math and Computer Science Department (2000 -2003)  
University of New Orleans

- Developed desktop and mobile software applications with Bluetooth secure data transfers using .Net
- Developed Java applications for various departmental grants
- Developed networks security applications for the forensics department
- Designed, implemented, and managed Oracle databases
- Designed and developed reports using SQL
- Managed Unix and Windows database servers

## **Scholarships and Awards**

Dwight Burlingame Fellowship (2017-2018)  
IU Lilly Family School of Philanthropy - Indiana University

Eli Lilly PhD Tuition Scholarship (2013-2018)  
IU Lilly Family School of Philanthropy - Indiana University

Philip J Rutledge Commitment to Education in the Spirit of Social Change Award (2011)  
School of Public and Environmental Affairs - IUPUI

Carl and Lisa Schodel Scholarship (2011)  
School of Public and Environmental Affairs - IUPUI

Rick Gudal Memorial Scholarship (2010)  
Indiana General Assembly

Leadership Institute for Nonprofit Executives Scholarship (2009)  
Rice University

Math and Computer Science Scholarship (2002- 2004)  
Department of Computer Science - University of New Orleans

## **Publications**

Health Care as a Social Good – Book Review (2015)  
Nonprofit and Voluntary Sector Quarterly – Sage Publications

Bi-Directional Information Exchange with Handheld Devices (2007)  
Master's Thesis – University of New Orleans

## **Conference Presentations**

Strategic Philanthropy: From Charity to Reform and Social Justice (2014)  
Global Donors Forum – Celebrating Philanthropy in Emerging Economies  
Washington, D.C.

The United Fund of Greater Indianapolis: A Historical Analysis of the Impact of Social Welfare Policy on Mass Philanthropy in Central Indiana during the Great Society Programs between 1965 and 1975 (2016)  
Hoosier Philanthropy Conference: Understanding the Past, Planning the Future

## **Teaching Experience**

P 105- History of Giving and Volunteering in America  
IU Lilly Family School of Philanthropy - Indiana University (IUPUI)

Financial Management for Nonprofit and Public Organizations  
School of Public and Environmental Affairs - Executive Leadership Courses

## **Membership**

Consolidated City of Indianapolis & Marion County – Mayoral Appointee

- Real Estate and Space Allocation Committee – Chair
- Marion County Criminal Justice Planning Council – Board Member
- Financial Investments Board – Board Member
- Information Technology Board – Board Member
- Indy Promise Taskforce – Mayoral Appointee
- City Market - Board Member
- Early Intervention and Prevention Council (EIPC) - Board Member

City of Indianapolis Economic Development Team - Member

Metropolitan Development Commission – Chief Financial Officer

Marion County Audit Committee – Ex-Officio Member