



Health Resources in Action

Advancing Public Health and Medical Research

Health Resources in Action (HRiA) is a national non-profit public health and medical research organization, located in Boston, whose mission is to help people live healthier lives and build healthy communities through policy, research, prevention and health promotion.



UNIVERSAL HEALTH INSURANCE ACCESS EFFORTS IN MA:

Comprehensive Report of Qualitative Findings

December 20, 2013

PREPARED FOR: The Centers for Disease Control and Prevention
through the Office of Health System Collaboration within the Office of
the Associate Director for Policy

ON BEHALF OF: The National Network of Public Health Institutes

Produced by:

Health Resources in Action
95 Berkeley Street
Boston, MA 02116
www.hria.org

Contact:

Brittany Chen, MPH
Senior Program Manager
bchen@hria.org
617-279-2240 ext. 324

Team:

Brittany Chen, MPH
Shin-Yi Lao, RN, BSN
Yoojin Lee, MPP
Laurie Stillman, MM
Toni Weintraub, MD, MPH



Acknowledgements

Special thanks to our expert reviewers:

FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION:

Dr. Frederic Shaw
Jon Altizer

FROM THE NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES:

Sarah Gillen

FROM NORTHEASTERN UNIVERSITY'S INSTITUTE ON URBAN HEALTH RESEARCH AND PRACTICE:

John Auerbach
Kristin Golden
Atsushi Matsumoto

Funding for this qualitative findings report has been provided by the National Network of Public Health Institutes (NNPHI) through a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC - 5U38HM000520-05). NNPHI and Health Resources in Action have collaborated with CDC's Office of the Associate Director for Policy on this project. The views and opinions of these authors are not necessarily those of CDC or the U.S. Department of Health and Human Services (HHS).



Table of Contents

I. EXECUTIVE SUMMARY	i	Local public health departments	22
II. INTRODUCTION	1	Impact of Chapter 58 on the role, function, and funding of local health departments	22
III. QUALITATIVE RESEARCH APPROACH	3	Chapter 58 in Boston: Advocacy and unanticipated effects	24
Key informant interviews	3	Chapter 58 in Worcester: Shifting priorities and finding the identity of local public health	25
Limitations	3	Impact on MA's safety net	26
IV. CONTEXT OF HEALTH CARE REFORM IN MA	5	Overview	26
Massachusetts's unique context	5	Impact upon state-funded public health direct service programs	27
Political environment	5	Impact on community health centers	28
Prior and subsequent reforms	5	Impact on safety net hospitals	30
The Massachusetts public health enterprise	8	Clinical and public health services: Assessing access, outcomes, and overall health impact	31
Massachusetts's safety net	8	Overview	31
V. FINDINGS FROM STAKEHOLDER INTERVIEWS	10	General impact on clinical services	31
The development of Chapter 58: Reflections on the role of public health	10	Long-term effects on health outcomes	31
Overview	10	Access to health care	32
Public health involvement in shaping Chapter 58	10	An in-depth look: Community health workers	35
Public health provisions in Chapter 58	11	Immunization program	38
Public health involvement in Chapter 58's implementation	13	Cancer screening	40
Opportunities and challenges for public health in the national health care reform environment	14	Infectious diseases	40
Impact on the state public health system's structure	19	Family planning	43
Overview	19	Chronic disease management	44
Opportunities	19	Data collection: Future opportunities	44
Unanticipated challenge: The economy	20	Continued roles for public health	47
		Improving community health	47

VI. SUMMARY OF QUALITATIVE FINDINGS AND ASSOCIATED RECOMMENDATIONS	49	VIII. REFERENCES	58
The role of public health in health care reform	49	Appendix A: Executive Summary of <i>Universal Health Insurance Access Efforts in MA: A Literature Review</i>	60
Findings	49	Appendix B: Key Informant Interview Guide	62
Recommendations	50	Appendix C: Key Informants Interviewed	65
Local health departments	50		
Findings	50		
Recommendations	51		
Safety net	51		
Findings	51		
Recommendations	52		
Clinical and public health outcomes	52		
Findings	52		
Recommendations	53		
VII. CONCLUSIONS: LESSONS LEARNED FOR THE NATION	54		
Shifting roles for public health agencies: Emerging and expanding opportunities	54		
Engaging in the process to design and implement health care reform: Getting a seat at the table	54		
Coordinating the public health message and developing the power to be effective	54		
Convening and maintaining multi-sector coalitions: Public health as the chief health strategist	55		
Empowering consumers through outreach, education, and navigation	55		
Providing education and training for clinicians	55		
Proactively preventing workforce shortages and delays in care	56		
Coordinating data collection, monitoring, and evaluation is key	56		
Contextualizing reform through a population health lens	56		
Prevention and Wellness Trust Fund	57		
Looking forward	57		

I. Executive Summary

The federal Patient Protection and Affordable Care Act (ACA), passed in 2010, was largely modeled after the Massachusetts (MA) 2006 health care reform effort entitled *An Act Providing Access to Affordable, Quality, Accountable Health Care* (Chapter 58).¹⁻⁶ With the strong parallels between the ACA and MA's health care reform efforts, the lessons learned from MA's experience are valuable in informing the ongoing implementation of the ACA and its potential impact on the public health enterprise throughout the United States.

A review of the existing body of peer-reviewed and grey literature was conducted to understand the impact of MA's health care reform efforts on public health practice and population health outcomes. In addition to describing what is known about the impact of Chapter 58 and listing lessons learned from the MA experience, the review, entitled *Universal Health Insurance Access Efforts in MA: A Literature Review*, also identifies gaps in the existing literature.

Key informant interviews were conducted to address these gaps and to gain insight into the process and impacts of the implementation of Chapter 58. This report presents the qualitative findings from those interviews and associated recommendations for public health across the nation in the following subject areas:

- The role of public health in health care reform;
- The impact of Chapter 58 on the state public health system's structure and functions;
- The impact of Chapter 58 on the role, function, and funding of local health departments;
- The impact of Chapter 58 on Massachusetts's safety net; and
- The impact of Chapter 58 on clinical and public health services and outcomes.

Massachusetts's experience with Chapter 58 is unique in many important ways due to the structure of MA's public health system, MA's history of health care reform efforts, MA's political environment, and the focus of Chapter 58 on health insurance coverage and access. Although these factors are important to consider when generalizing the findings of this report, the following lessons are useful for other states to inform the implementation of health care reform and increase the likelihood of successfully expanding access to health care and improving individual and community health:

- The role of public health is changing;
- Public health must engage as a full partner in the health care reform conversation;
- Public health needs to develop a coordinated message and increase political power;
- Public health can be the "chief health strategist" in communities and play a role in convening and maintaining multi-sector coalitions;



- Public health can empower consumers through outreach, education, and navigation;
- Public health can provide education and training for clinicians in caring for patients from vulnerable populations and treating diseases that impact population health;
- It is important to proactively prevent workforce shortages and delays in care;
- It is important to coordinate data collection, monitoring, and evaluation;
- Attention to population and community health should be integral to health care reform efforts; and
- Allocating an ample and protected budget for prevention and health promotion efforts is an important vehicle for addressing population and community health issues.



II. Introduction

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, there is much speculation about how national health care reform efforts may impact public health and its organization, delivery, and outcomes at the state and local levels.

The ACA was largely modeled after the Massachusetts (MA) 2006 landmark health care reform effort, entitled *An Act Providing Access to Affordable, Quality, Accountable Health Care*, otherwise referred to as Chapter 58 of the Acts of 2006.¹⁻⁶ With the strong parallels between MA and the nation's health care reform initiatives, the lessons learned from Massachusetts can inform the ongoing implementation of the ACA and its potential impact on the public health enterprise throughout the nation.

In May 2013, the Centers for Disease Control and Prevention (CDC) commissioned the National Network of Public Health Institutes (NNPHI) to develop a case study of Chapter 58, which transformed the state's health insurance landscape, expanded public programs, and impacted the public's health through a variety of other provisions. Health Resources in Action (HRiA), a Massachusetts-based public health institute, was contracted to execute this case study.

The impact of MA's Chapter 58 has been researched in two phases and presented in two separate background reports. In the first phase, a comprehensive literature review was conducted that compiled findings from the peer-reviewed and grey literature to understand its impact upon public health practice and population health outcomes. Specifically, the review describes what is

known about the impact of Chapter 58 on health insurance coverage, access to care, chronic disease management, infectious diseases, utilization of health care services, screening and preventive care, smoking cessation, safety net provider utilization, the role of safety net providers in enrollment, safety net finances, and public health programs. Refer to Appendix A for an Executive Summary of the report, entitled *Universal Health Insurance Access Efforts in MA: A Literature Review*.

Gaps in knowledge and data that were identified through the literature review process include the impact of Chapter 58 on:

- Public health programs and functions;
- Local health departments;
- Structure and funding of the safety net post-Chapter 58;
- Provider supply and demand;
- The delivery of specialized clinical services for conditions with population health significance;
- Health outcomes; and,
- Health care quality.



The second phase of background research was comprised of qualitative interviews with key informants and explored these gaps to the extent possible. This report, entitled *Universal Health Insurance Access Efforts in MA: Comprehensive Report of Qualitative Findings*, presents the qualitative findings and synthesizes lessons learned from this second phase. In some places within this report, highlights from the literature review are integrated with the qualitative findings in order to provide context for the new data. Where possible, these findings are extrapolated to the national scale to help other states and localities anticipate the potential impact of the ACA in their own context.

The final product, a case study entitled *Universal Health Insurance Access Efforts in Massachusetts: Lessons Learned for Public Health Systems*, is a synthesis of both the literature review and this qualitative findings report.



III. Qualitative research approach

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted to address the gaps identified in the literature review and to gain qualitative first-hand insight into the process and impacts of the implementation of Chapter 58. Key informants were strategically targeted based upon the areas identified as requiring more information. Interviews targeted high-level state and local leaders in the following areas: state legislators and policy executives; state and local public health department leaders; epidemiologists; safety net providers; health insurance payers; and statewide professional societies and advocacy groups. HRiA, in collaboration with former MA Commissioner of Public Health John Auerbach, prepared a list of key informants that was expanded and vetted in consultation with NNPHI and CDC project managers. Additional stakeholders were added based on recommendations of state and national experts interviewed.

Informants were contacted by email and/or phone to invite their participation and schedule interviews. HRiA's research team created an interview guide and designed semi-structured interview questions for stakeholders. Interview domains included pre-implementation planning and preparation for Chapter 58; the role of public health professionals in the implementation of Chapter 58; the effect of Chapter 58 on the structure and function of state and local health departments, programs, and services; the impact on safety net services; unanticipated consequences of the law; budget and economic impact; health outcomes; responses to challenges; data collection efforts and data availability; and lessons learned and advice to other states. The key informant interview guide is provided in Appendix B.

Interviews were conducted in person and by telephone. Questions were sent to informants electronically in advance of interviews, upon request. A total of 27 interviews were conducted with 29 individuals. A list of the stakeholders interviewed appears in Appendix C.

Interviewers reviewed procedures and interim findings on an ongoing basis to maintain consistency. When permitted, interviews were audio recorded and transcribed and lasted an average of 45 minutes. Transcripts were coded using NVivo 10 to identify and quantify recurring themes that emerged from the interviews.

The analysis process included the following steps:

- 1) Emerging themes were extracted and reviewed by the interview team for internal consistency;
- 2) Responses were compiled; and
- 3) Findings were synthesized and analyzed qualitatively. Emergent themes are summarized in the Findings section of this report.

LIMITATIONS

It is important to note the limitations of this research. While efforts were made to identify and reach as many relevant stakeholders as possible, not every targeted stakeholder could be interviewed due to time, resource constraints, and/or availability. Due to the parameters of this study, stakeholders were asked to focus strictly on Chapter 58 in their comments.



However, because many of them were involved in subsequent health care reform efforts in MA, interviewees often struggled to limit their comments solely to their observations of Chapter 58, as they experienced the four phases of MA health care reform legislation (Chapters 58, 305, 288, and 224, described below) in their totality. In addition, many mentioned that it is difficult to tease out the impact of Chapter 58, as implementation coincided with the economic recession and was followed by subsequent health care reform legislation. Finally, while MA's health care reform law passed in 2006, it should be noted that, for many health indicators and other impacts, the full impact of reform efforts will take years to manifest. Therefore, rather than referring to existing evidence, stakeholders often spoke more to their subjective impressions of the preliminary and anticipated impacts of Chapter 58. Unless permission was granted, interviewees' opinions are reported anonymously.



IV. Context of health care reform in MA

The following section provides highlights from the literature review describing Massachusetts's unique context and public health enterprise. For further detail on these topics as well as a comparison between Chapter 58 and the Affordable Care Act (ACA), see *Universal Health Insurance Access Efforts in MA: A Literature Review*.

MASSACHUSETTS'S UNIQUE CONTEXT

The experience of Chapter 58's passage and implementation is unique in several important ways. This context should be taken into consideration when considering how Massachusetts's lessons can be applied to the rest of the country.

Political environment

Massachusetts's political environment was favorable for expanding coverage.^{5,6} Chapter 58 received bipartisan support and continues to receive sustained support from stakeholder groups and the public overall.

Prior and subsequent reforms

Chapter 58's passage was the culmination of numerous reforms that occurred over two decades; these reforms had already strengthened MA's safety net structure, introduced insurance market reforms, and expanded health insurance access. Thus, prior to the passage of Chapter 58, Massachusetts already had a lower uninsured rate compared to the United States as a whole, at 6.4% versus 15.8% in 2006, respectively.^{7,8}

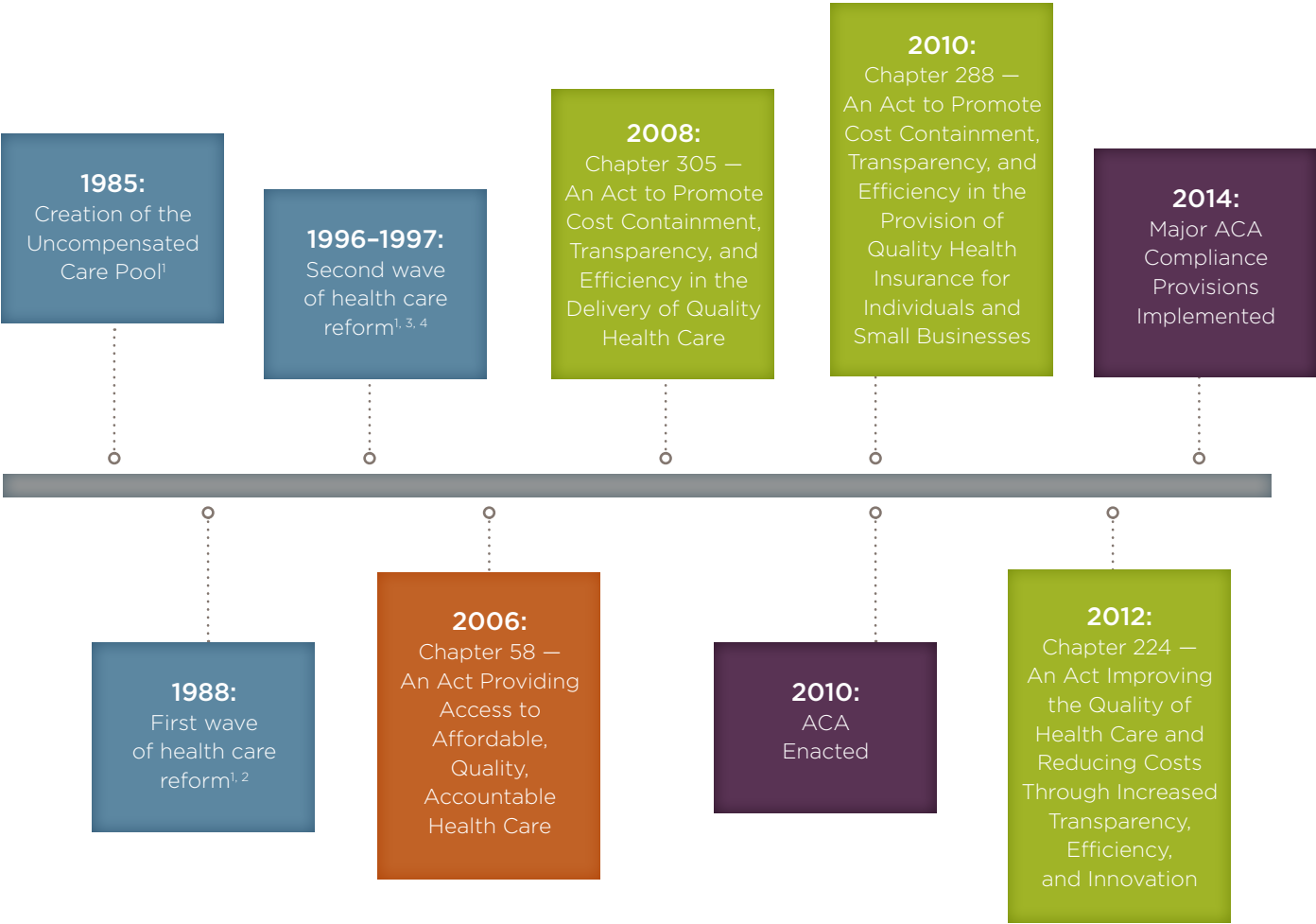
Additionally, while Chapter 58 addressed affordable insurance expansion, Massachusetts has also since passed legislation every two years addressing issues of health care cost and quality and building up the health care workforce.

These legislative reforms include Chapter 305 passed in 2008, *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care*; Chapter 288 passed in 2010, *An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses*; and Chapter 224 passed in 2012, *An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation*. Of particular interest to MA's public health system, Chapter 224 sought to tame health care cost growth through innovations such as the establishment of a Prevention and Wellness Trust Fund, administered by the MA Department of Public Health (MDPH) in collaboration with the Prevention and Wellness Advisory Board created by the law. The expected funding of the Prevention and Wellness Trust is about \$60 million from 2013 to 2016, and all activities paid for by the fund must address public health prevention activities with at least one of the following aims: reduce the rate of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and build the evidence base on effective prevention programming.⁹

See **Figure 1** and **Table 1** for a timeline and descriptions of Massachusetts's health care reform efforts to date.



FIGURE 1. MILESTONES OF HEALTH CARE REFORM IN MASSACHUSETTS



¹ McDonough et al., 2006

² An attempt to achieve universal health care through a “play-or-pay” employer mandate

³ Wachen & Leida, 2012

⁴ Expanded eligibility for MassHealth and the Children’s Medical Security Plan. Passage of the Non-Group Health Insurance Reform Act.



TABLE 1: CHAPTER 58 AND SUBSEQUENT HEALTH CARE REFORM EFFORTS IN MA

MA Legislation	Year	Description
Chapter 58: <i>An Act Providing Access to Affordable, Quality, Accountable Health Care</i> ¹	2006	This legislation aimed to provide near-universal health coverage for MA residents through shared individual, employer, and government responsibility. Its components include: Medicaid (known as Mass Health) expansion; establishing a health insurance exchange (known as the Commonwealth Health Insurance Connector) to enable residents to access both subsidized and non-subsidized private health insurance; introducing insurance market reforms; and establishing requirements for individuals and employers. It also included a number of prevention and wellness promotion components, including increases to the MA Department of Public Health's budget in such areas as tobacco prevention and control; a mandate to provide tobacco cessation services as part of MassHealth; and a call for a study and recommendations to investigate the use of community health workers.
Chapter 305: <i>An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care</i> ²	2008	The passage of Chapter 58 and the expansion of health insurance magnified the challenge of cost containment. Chapter 305 aimed to improve quality and contain costs through requiring electronic health records; streamlining insurer and provider billing and coding; recruitment and retention of primary care providers; instituting marketing restrictions on pharmaceutical companies; and commissioning various studies on cost containment and quality improvement measures.
Chapter 288: <i>An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses</i> ³	2010	This legislation aimed to build on Chapter 305's cost containment measures to further improve quality and contain costs through creation of a group wellness pilot program; analyzing mandated insurance benefits; requiring health care providers to track and report quality information; requiring health insurance carriers to calculate and report detailed financial information, including medical loss ratios; requiring hospitals to report all costs; establishing a single all-payer database; encouraging providers and payers to adopt a bundled payment system; reviewing small group insurance rating factors; requiring health plans to offer selective or tiered network plans; simplifying payer claims processing; establishing small business group purchasing cooperatives; promoting provider payment transparency; preventing certain carrier-provider contracting practices; and establishing a special commission on provider price reform.
Chapter 224: <i>An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation</i> ⁴	2012	This legislation aimed to further improve quality and contain costs by establishing a health care cost growth benchmark tied to the growth rate of the gross state product; requiring providers to report financial data; implementing consumer price transparency measures; requiring state approval for certain health care infrastructure changes (hospital mergers, construction of new health care facilities); changing Medicaid reimbursement rates; creating a new process for certifying Accountable Care Organizations; reforming medical malpractice; developing certification standards for patient-centered medical homes; and creating new funds for prevention through the Prevention and Wellness Trust Fund (PWTF). Of particular interest to public health, monies from the PWTF are to be used to reduce the rate of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and/or build evidence on effective prevention programming. Allocating an ample and protected budget for prevention and health promotion efforts is an important vehicle for addressing population and community health issues.

¹ <https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58>² <https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter305>³ <https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>⁴ <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

The Massachusetts public health enterprise

MA's unique public health enterprise is important to consider when drawing lessons from MA's experience for other public health systems across the country. The structure of the Massachusetts governmental public health system differs from most other states.^{10,11} The majority of other states' public health infrastructures are organized at the county or regional level; exceptions include large cities, such as New York City, Houston, and Detroit, which support their own city health departments, and some city and county collaboratives such as Seattle/King County, which jointly operates the health department.¹⁰ By contrast, MA's public health system is highly decentralized, where funding and the provision of local public health services are primarily the responsibility of individual local town and city governments. Thus, with 351 cities and towns, MA has more local health departments (LHDs) than any other state in the U.S.^{11,12}

In general, each of these LHDs functions autonomously, as they are governed by home rule legislation, with the majority having a local board of health that oversees the provision of public health services.¹¹ With the exception of the few larger cities, LHDs are sparsely funded, have few to no full-time staff, and only have the capacity and expertise to enforce sanitary and food codes or other basic functions. As a result, LHDs contract with individuals and agencies to provide mandated public health services such as public health nursing and inspection services. Municipal funding is the primary source of revenue for local public health departments, with additional revenue coming from fees, fines and/or surcharges, service contracts, and local, state, federal, and private grants.¹¹

Because local health department units are small with few staff and little funding, MDPH contracts out many public health services and functions to area non-profit organizations, such as community-based organizations (CBOs) and community health centers (CHCs).¹⁰ LHDs are often required to compete alongside private providers for state funds.

Massachusetts's safety net

Pre-Chapter 58 reform, MA was known for having one of the best health care access systems in the U.S. for low-income, uninsured populations.¹³ Compared to other states, MA had a robust safety net comprised of safety net hospitals, public health-funded clinics, and the oldest and most extensive network of community health centers (CHCs) in the nation.^{8,14} Also, dating back to 1985, Massachusetts established a "free care pool" known as the statewide uncompensated care pool (UCP) as a financing mechanism to distribute the burden of bad debt and free care provision more equitably among acute care hospitals.¹⁵

Through Chapter 58's legislation, the UCP was replaced with a smaller Health Safety Net (HSN) Trust Fund that pays community health centers and safety net hospitals for essential health care services provided to the reduced number of low-income uninsured and underinsured residents.¹⁵ As a payer of last resort, the HSN does not pay for any claims covered by private insurance, Medicare, or Medicaid. The HSN is funded through a combination of hospital assessments, payer surcharges, and government payments, and ensures that safety net providers caring for uninsured or underinsured patients receive some compensation for the services they provide.^{6,8}



While the term “safety net” can have varied definitions depending on context, Massachusetts’s safety net system, as defined for this study, is comprised of both comprehensive primary care services available for people who have no other source of care as well as public health services for treatment and containment of infectious diseases and preventive services, including:

- Providers at community health centers (CHCs) and “safety net hospitals,” which provide health care services to low-income residents;
- The Health Safety Net (HSN) Trust Fund that compensates certain community health centers and hospitals for services provided to the uninsured and underinsured;
- Medicaid coverage through “MassHealth”;^{13,16–18} and,
- Public health departments and programs that assure care for vulnerable populations around health issues such as sexually transmitted diseases (STDs) and tuberculosis (TB), and provide services such as immunizations, smoking cessation, family planning, and breast cancer screening.

According to MA public health experts, governmental public health in Massachusetts provides fewer direct safety net services when compared to other state and local health departments nationwide. Thus, this study primarily examines the impact of Chapter 58 on non-governmental safety net providers. Many of the lessons learned in the private safety net sector, however, can be applied to public health safety net providers.



V. Findings from stakeholder interviews

THE DEVELOPMENT OF CHAPTER 58: REFLECTIONS ON THE ROLE OF PUBLIC HEALTH

Overview

Chapter 58 and the expansion of health insurance access was propelled by an idiosyncratic feature of MA that has no parallel at the federal level.⁵ Starting in 1997, MA operated its Medicaid program through a federal Section 1115 waiver, which provided the state with dedicated funds for key safety net provider systems. The purpose of this waiver, first granted by the Clinton administration, encouraged state experiments in increasing access. However, in 2004, the state learned that these subsidies would end soon. Thus, Governor Mitt Romney and Senator Edward M. Kennedy negotiated with federal officials to allow MA to redirect the funds to provide insurance subsidies for income-eligible individuals. This agreement, made in January of 2005, was conditional upon MA enacting and implementing its near-universal coverage scheme by July 1, 2006.⁵ If this condition was not met, MA would face the loss of more than \$1 billion in federal subsidies over three years.⁵ For this and other reasons, health care access through insurance expansion was the primary focus of Chapter 58. Prevention was a more peripheral issue.

Public health involvement in shaping Chapter 58

During the process leading up to the passage of Chapter 58 in mid-2006, MDPH and other public health advocates were active supporters of health care reform and understood the value of expanding insurance access in promoting health, preventing disease, and reducing health disparities. At times, they

weighed in on the importance of considering broader population health issues within the deliberations. However, public health was not the central focus of the health care reform conversation. According to one state public health leader,

“There was little discussion about prevention and about the promotion of wellness as a component of health reform. We tried to make those cases, but we understood that this was not the main focus of the debate.”

Thus, the public health field was only peripherally involved in the health care reform conversation. Many public health advocates also deprioritized Chapter 58 advocacy in the face of other pressing issues. One public health advocacy leader recalled: *“I think we public health advocates had other priorities higher on our agenda. [Chapter 58] was on the agenda purely for its health care access reasons. We didn’t see it as a potentially transformative vehicle for leveraging money for primary prevention or any of those things. Public health folks were fighting hard around other public health issues on the policy front. Especially [for] funding, which is ironic of course, because tons of money was going to be going into health care.”*

In addition to public health not being a primary focus for Chapter 58, and thus not a top priority for public health advocates, this interviewee also talked about the cynicism that some public health practitioners felt about Chapter 58 because it did not focus on primary prevention.



In this person's words: *"It [was felt that Chapter 58] didn't get at the root of public health problems... It was missing the opportunity to really make the case about prioritizing public health primary prevention, health outcomes, and the health care system."*

Public health provisions in Chapter 58

Because Chapter 58 was primarily focused on health care access, population health goals were not a major consideration during the legislative process and debates informing Chapter 58, except insofar as it was believed that expanded insurance access was good for the overall population and its health. Regardless, some advocates asserted that Chapter 58 should more vigorously address population health and health disparities and thus there was some recognition by the legislature of the importance of population health. As one state public health leader described,

"There were [public health] people who advocated that Chapter 58 should include more about public health and prevention. The legislature felt that it was a complicated enough bill... but [wanted to] acknowledge that [public health] needed to be attended to at some point."

Though public health was not the focus of Chapter 58, the involvement of public health leaders resulted in some key provisions contained in the legislation. These significant provisions included the commissioning of a formal study of the potential role of community health workers (see "An in-depth look: Community health workers"); the establishment of the MA Health Disparities Council and requirements around collecting data on race and ethnicity; and a one-time \$12 million increase to public health line items, such as tobacco control.

One of the most significant public health victories of Chapter 58 was the requirement that MA's Medicaid program, MassHealth, provide a smoking cessation benefit to enrollees. This benefit is a prime example of how public health was able to integrate its goals of promoting population health into the expansion of insurance coverage.

While these were important stepping stones, the conversations surrounding these decisions did not always include public health stakeholders. For example, regarding the line item increases, the former MDPH Commissioner reflected: *"The decision about what new funding to give the Department of Public Health wasn't the result of a substantive conversation about where funding was needed. It was more a reflection of the fact that the legislators thought, 'Since the public health people have been saying to us that health care reform should deal with prevention, let's bump up a few line items as a way of saying 'we heard you.'"* But there wasn't a process to think through what services would best complement insurance expansion or be most beneficial for the health of the public."



Smoking Cessation Benefit Provisions: Section 108 of Chapter 58¹⁹

The MA Executive Office of Health and Human Services (EOHHS) created a two-year pilot program to be included within its MassHealth (Medicaid) services.

Benefits included:

- Nicotine replacement therapy
- Other evidence-based pharmacologic aids for smoking cessation
- Accompanying counseling by a physician, certified tobacco cessation counselor, or other qualified clinician.

MassHealth was required to report:

- Number of enrollees who participated in smoking cessation services
- Number of enrollees who quit smoking
- Expenditures tied to tobacco use by enrollees

This program was allocated \$7 million per year for 2007 and 2008 from the Health Care Security Trust, which was the trust that had fiduciary responsibility for any monies received by the Commonwealth from the Master Settlement Agreement.

This benefit demonstrated success with a 26% drop in smoking prevalence among MassHealth participants and a return on investment of \$2.12 for every \$1.00.²⁰

Furthermore, there was no coordinated state public health strategic plan or approach for public health stakeholders to rally around. While both governmental and non-governmental public health practitioners may have focused their attention upon particular public health issues, there was not a unified approach to advocacy. Thus, it was not always clear what the public health “ask” should be. One public health advocacy leader reflected,

“We pushed for public health funding and for public health to be more a part of [Chapter 58], but overall, there was not really a coherent public health ask.”



Public health involvement in Chapter 58's implementation

Similar to the experience during the shaping of Chapter 58's legislation, public health was not a central player in the implementation process, which began in 2007. Again, because Chapter 58 was primarily focused on health care access and seemingly had little to do with population health, public health struggled to identify its role. This lesson was articulated by John Auerbach in his published article, *Lessons from the Front Line*: *"It was obvious to me that I had a front-row seat at a historic event with meaningful implications for the nation as well as our state. What wasn't so obvious was what the Department of Public Health and I had to do with all this. We were watching all the action but confined to the sidelines. Could public health assist in the implementation of health care reform? Even more important, would health care reform change the role and the work of public health?"*²¹

Furthermore, while health care access organizations knew how to speak the language of health insurance and thus represented the medical consumer voice well at the health care reform table, many public health practitioners faced the challenges of not knowing how to speak the language of health insurance and having a lack of clarity as to what public health officials should advocate for. One state public health leader said: *"You almost have to be an insurer to understand how health care reform works... even just thinking about how the regulatory system works. What's the role of the Department of Insurance versus [MA's health insurance exchange — the Commonwealth Health Insurance Connector] versus the hospital versus public health? It's just complicated."*

In Auerbach's article, *Lessons*, this sentiment is echoed:

*"For the most part, people from public health were not invited [to health care reform planning meetings]. And when we were, we often felt like the children who had been allowed to dine with the adults. The discussions were largely over our heads: detailed conversations about insurance coverage with insider talk about benefits packages, rates of reimbursement, risk pools and utilization review. When we offered input, we probably sounded naive and idealistic, well meaning but unfamiliar with the challenges of real-world delivery of care.... However, we learned the hard way that if we didn't fight for a seat at the table and struggle to demonstrate our value, others who were there would make decisions that affected us.... We needed to understand the basics about insurance, including technical language and detailed concepts. Since no one is going to teach us, we had to determine how to educate ourselves."*¹⁹



Opportunities and challenges for public health in the national health care reform environment

Getting a seat at the table

These observations of MA's experience with Chapter 58 led interviewees to recommend ensuring that public health officials represent population and prevention priorities at the health care reform table and, that in order to do so, public health professionals become knowledgeable about health care systems, financing, and the specific role they can play in achieving the triple aim of improving population health, improving care, and lowering costs.

By being at the table, public health then has the opportunity to speak to its priorities. As one local public health leader put it, *"Sometimes public health just has to [be there] to ask the questions. How do we make sure that while we increase access, we are also doing things to keep people healthy overall? How do we make sure that we are increasing the number of smoking cessation programs and implementing programs that keep people from having asthma attacks? That's the public health concern and that's how I'd want [public health] to push the conversation. [Public health] has to be a part of the overall picture."*

In order for public health to be an active and informed player at the health care reform table, it is also important that public health practitioners learn the language of insurance and health care access in order to bridge public health priorities with the overall goal of health insurance expansion. A public health advocacy leader said:

"You need a cadre of public health people that can represent public health and form relationships across the health care divide. You have to have translators who have the conceptual ideas to understand the levers of [integrating public health into health care focused conversations]."

A number of other interviewed public health leaders echoed this need for translators to bridge public health and health care, and named it as a needed competency for public health.

Messaging and advocacy for public health

During MA's burgeoning health care reform conversation, public health as a field struggled to articulate its message within the larger conversation around health care access. Numerous people interviewed mentioned the need for defining a coordinated, persuasive, and powerful public health message to represent community and population health interests at the health care reform table.

A public health advocacy leader voiced, *"Public health advocacy organizations needed to do better at coordinating a united voice of shared priorities that is higher than any one particular disease or issue that people can work for together."*



Such observations led interviewees to make the following recommendations for public health messaging in the context of national health care reform. Practically speaking, the public health message should include:

- **A global focus on health promotion including the importance of prevention:** As captured in the previous quotation, numerous interviewees spoke to the need for breaking out of the silos of health care, insurance, and public health. One public health leader stated, *“When I think about health care reform, [health care delivery and prevention] are all wrapped in together. Health care reform pushed us to think about not only providing better access, but also how we actually can provide better preventive care as well. Public health needs to make sure that it’s looking at the overall picture [of health].”*
- **Public health’s economic value and return on investment:** While public health has a powerful social justice message, in the health care reform environment public health also needs to make its business case. One public health advocacy leader said, *“Public health as a justice issue, an issue of fairness - that’s your rally. But then, we need to be also ready to say, ‘Here’s what we need. We need a minimum of \$10 per person per year for meaningful prevention and here’s the baseline and the data that backs it up.’ [This] business and political negotiation ability ... is how public health can participate in these conversations in a way that’s analogous to what the hospital and insurer players are able to do. It’s the dominant language.”*

Another health care advocacy leader echoes this point as a way to reach and persuade legislators. Policymakers have *“short-term bias, while public health has longer-term rewards. Public health needs to sell itself by showing how it reduces overall costs.”*

Data collection to document the return on investment of prevention activities is critical. In Lessons, Auerbach reminds the public health field that practitioners need to be disciplined in collecting data to back up claims around the cost savings associated with prevention activities. For example, he cites a resource-intensive utilization review of Medicaid’s tobacco cessation benefit that demonstrated a statistically significant short-term savings because of fewer heart attacks and reduced emergency department utilization for respiratory illnesses.¹⁹ More data collection such as this is necessary for public health to demonstrate its value.

- **A clear vision and ‘ask’ combined with political savvy:** Many interviewees mentioned that public health activists are often viewed as “naive” or “idealistic,” and thus are not included as partners in the health care reform conversation. One public health advocacy leader stated, *“You have a lot of activists and idealists in public health who didn’t want to play once it wasn’t single payer. I think we also need more incrementalists in public health who are willing to get their hands dirty in imperfect negotiation with the end goal in sight, knowing that next year, you push for single payer, or what have you. You keep pushing while you negotiate this bill. Public health has a great vision and great activism, but not necessarily great savvy and sophisticated participation in the political process.”*
- **Education about what the public health field does:** In order to build the demand for public health, the sector needs to raise awareness about the need for its programs and services. One public health leader stated, *“We have not done a good job in getting the message out about what we do. We need to educate municipal leaders, state leaders and obviously, the public, about just what laws public health is responsible for enacting and enforcing.”*



In the words of one local health department official,

“Public health’s role is to remind stakeholders that [public health provides] an ‘assurance function’ that requires — regardless of ability to pay — that the air is clean, the water is clean, the systems are here to promote and protect the health of all residents, workers and guests.”

Building a stronger lobby for public health

Following the passage of Chapter 58, the strength of the health care and insurance lobbies dwarfed the public health voice. To address this, one health care advocacy leader recommended, *“Public health needs a stronger lobby. Lobbying forces behind medical care are so enormous and public health just doesn’t have a constituency. Virtually every state [representative] has a hospital in his/ her jurisdiction, and the hospital is typically the largest employer in the area... with a board that includes the civic leaders in that town. This gives hospitals an enormous lobbying advantage.”*

Similarly, another public health advocacy leader suggested, *“Public health needs to be better organized politically. Public health should donate money to political action groups that can work for candidates on behalf of public health, so that there’s a sense of an organized public health constituency that elected officials are accountable to. [Even if you have your message], the message doesn’t get across if you don’t have political power to make the message heard. We need the muscle behind the message.”*

Forging partnerships to create the conditions for future action

A key lesson that one health care systems leader took from the process of forming Chapter 58 was that *“the passage and implementation of health care reform should not be viewed as an end in itself but rather as a process to improve health. It wasn’t necessary to get everything right in the bill because its passage created conditions that allowed many other positive things to happen that wouldn’t otherwise have occurred, such as the Prevention and Wellness Trust.”* Thus, the importance of public health being at the health care reform table is critical to forge partnerships that can lead to future public health endeavors.

From another standpoint, one state legislator who came into office after Chapter 58 was passed and played a critical role in the passage of Chapter 224, said, *“It makes sense to first invest in making the ground fertile for new ideas. The history of positive public health work in Massachusetts [through efforts such as Chapter 58] laid the groundwork [for the Prevention and Wellness Trust]. It is important to be flexible about the legislative language and be willing to broaden its appeal.”*

The previously quoted health care systems leader also talked about the necessity of having a broad and multi-sector coalition in the passage and successful implementation of Chapter 58, including health care and insurance providers, employers and businesses, and other community stakeholders. As a result of the personal and professional relationships that were built through the coalition, *“People could [often] put aside their organizational self-interest and compromise for the greater good.”*



Another health insurance leader echoed this sentiment:

“Activists worked with insurers, providers and government officials. They all listened to and respected each other even if they disagreed. This led to compromise and willingness to seek collective solutions. All parties could agree that there were problems related to conditions in the communities that affected health.”

Not only was it critical to build a multi-sector coalition for the passage of Chapter 58, it was also important to maintain the coalition after its passage for the implementation process and for future efforts. One health care advocacy leader reflected that the strong and unified coalition that was formed during the passage of Chapter 58 could have easily ended once it passed. But Health Care For All, a grassroots health care access organization that brings the consumer voice to the table, and several other organizations agreed to stay at the table. This helped ease some of the issues that arose in the implementation process. For example, expertise from multiple sectors was needed to identify vulnerable populations in need of outreach and to analyze insurance cost assumptions.

Health care reform implementation

Key parties who were involved in the implementation of Chapter 58 identified the following strategies as instructive to other states:

- Implementation timeline:** Implementing Chapter 58’s provisions quickly after its passage was a successful strategy to minimize public
- opposition and quickly show the positive impact of the legislation (e.g., the immediate uptick in insurance enrollment). As a result, new supportive constituencies were created to help facilitate buy-in for current and future health care reform efforts.
- Tell success stories early and often:** The success and public approval of Chapter 58 was facilitated in part by the collection and telling of success stories. One health care advocacy leader stated, *“The stories that people needed to hear early and often had a message like, ‘I never had health insurance before. After I got it, I went to a doctor for the first time in years and he discovered I had a serious health problem. Because it was detected and treated early, I am alive today.’”*
- Central coordination of the state’s implementation:** One interviewee felt that Chapter 58’s implementation could have been somewhat better coordinated in a unified manner by the state. She indicated that there were some delays, uncertainties, and differing perspectives among agencies. There were times when one state agency passed reform-related regulations that required enforcement by another state agency, but the other agency was not always willing or able to do so. Without a centralized decision-making entity there was no easy way to resolve this.
- Identification of and outreach to the uninsured (enrollment strategies):** Identifying and enrolling uninsured individuals was a major task for the public health system once Chapter 58 was passed. The following were successful strategies and/or recommendations for other states as they enroll their uninsured population through the ACA.



- » **Develop strategic public education campaigns:** Funding was needed for a big public education initiative to reach high-risk populations without insurance after the passage of Chapter 58. Both public (state dollars) and private (insurers and foundations) funding was used to do a high visibility campaign in MA. Initially, this was intended to build support among the public so the bill would not be overturned. However, once support seemed solid, these funds were used to help with enrollment. Since a key target population over-represented among the uninsured were young men, the Red Sox was perceived as an important partner. Focus groups indicated that the Red Sox image associated with groundskeepers and ticket takers was more effective than using highly paid, well-known players. Funding was used to create both a top-down media campaign, and a bottom-up approach through the awarding of \$50,000 grants to many grassroots community agencies (such as churches, neighborhood associations, and ethnic and cultural organizations) to do outreach and enrollment.
- » **Create a shared database for outreach:** An active participant in the process said there needed to be an easy way to identify the uninsured and to coordinate outreach efforts between agencies. In Massachusetts there was a database with those who benefited from the free care pool that could be used for targeted notification and outreach regarding the new insurance options. This interviewee said close communication and coordination between the insurance exchange and the Medicaid program also was necessary at the outset of implementation to maximize the success of enrollment efforts.
- » **Patients need navigation assistance:** Patient navigators were critical to help individuals to access and enroll in insurance and navigate the new insurance marketplace. Furthermore, it was equally important to ensure that they would be equipped to maximize the benefits and opportunities of the health care system to improve health. One public health leader said, *“We did a good job with our navigation system in trying to get insurance for people, but it was about enforcing the law instead of emphasizing that if you have insurance, you can get a physical every year, learn tips on nutrition from your doctor, or get help quitting smoking. We didn’t connect the health benefits to the law. We spent so much time on the fact that it’s a law now and not on the benefits and why it’s going to be really good for you.”*
- **Data collection:** Stakeholders interviewed mentioned the importance of collecting baseline information regarding the impact of Chapter 58 on health care enrollment, utilization, and cost at the outset of implementation and establish procedures to monitor progress regularly. Blue Cross Blue Shield Foundation successfully sought a Robert Wood Johnson grant to co-fund the Urban Institute to do baseline and annual reports on the progress being made with Chapter 58. In MA, these have become the definitive reports that were later complemented by the reports of the Division of Health Care Finance and Policy (DHCFP).^{22,23}



One public health leader cited a missed opportunity for data collection, stating, *“While these reports were very focused on health insurance and access, we know health insurance is insufficient to achieving better health. It was an oversight to not include indicators of improved health in these reports or others. This means that health impact was not consistently measured.”*

Under the ACA, it will be important to not only measure health insurance access and care utilization, but also health outcomes, racial and ethnic data to address health disparities, and the quality of health care delivered.

Furthermore, interviewed stakeholders spoke of the need for agencies to enter into data sharing agreements. Because of the numerous stakeholders and agencies involved in the implementation of Chapter 58, it was important for agencies to develop memoranda of understanding (MOU) and get legal assistance to ensure that progress could be measured. For example, in order to monitor the impact of Chapter 58, the Division of Health Care Finance and Policy and the Department of Revenue needed to share information related to the penalties for non-compliance. Under the ACA, opportunities for collaboration and data sharing between departments should be identified and MOUs forged in order to ensure that programs and policies can be evaluated to show the impact of health care reform in their local context.

IMPACT ON THE STATE PUBLIC HEALTH SYSTEM’S STRUCTURE AND FUNCTIONS

Overview

With the increased access to health insurance following the passage of Chapter 58, Massachusetts was poised to reach near-universal coverage.

However, as the main intent of the landmark legislation was health insurance expansion, it was not immediately clear how MA’s public health system would be impacted.

Massachusetts was embarking upon uncharted territory; yet, it was an exciting time where there was a new health care reform initiative with some new public health provisions, as listed in the previous section. The following section details the opportunities and the approach that the MA Department of Public Health (MDPH) took to navigate the new health care reform landscape, as well as the unanticipated challenges that public health encountered due to the lagging economy and assumptions made about the need for services.

Opportunities

At the outset of health care reform implementation, MDPH focused on promoting three major activities mandated by Chapter 58. These activities included the following:

- **Facilitating outreach and insurance enrollment for vulnerable populations:** An immediate role for MDPH to engage in was educating agencies, community partners, and community health workers who served vulnerable populations that were disconnected from the health care system about the new insurance benefits available and the enrollment process. These vulnerable populations included homeless individuals, non-English speakers, those with mental health and/or substance abuse disorders, and others. As one public health leader stated, *“This was just one of the most concrete things people were working on in terms of public health that had a connection to health care coverage.”* As one state public health



leader further described: *“MDPH held a series of trainings for the contracted agencies across the department, regardless of [their] subject matter. If they did AIDS outreach or diabetes reduction... we brought them all in and made sure that every community-based agency [got] training in what health care reform was all about, what the Connector is, how to use the website, [etc.]. [This] made a difference in reaching [vulnerable] populations.”*

- **Educating Medicaid recipients about the smoking cessation benefit:** With the passage of Chapter 58, MassHealth (the MA version of Medicaid) was mandated to provide smoking cessation services to beneficiaries. However, MassHealth anticipated an influx of new enrollees in a short period of time. Thus, their efforts focused primarily on ensuring that people could enroll in the plan and that the administrative, billing, and reimbursement processes of the new benefit programs would run smoothly, rather than on educating the public about a single benefit. One state public health leader said, *“We wanted to demonstrate the meaningful role that public health could assume; namely, alerting the public and providers about some of the specific benefits that were more population-based or public health oriented. We hoped our actions would add value that might not have been recognized by insurers.”* Thus, public health officials embraced the role of informing current and future MassHealth members that tobacco cessation strategies were newly covered services, and urging physicians to offer these benefits to patients. To accomplish these goals, MDPH led outreach and advertising campaigns, and ran a telephonic quit line with coordinated messages that complemented the campaigns.

- **Collectively envisioning and internally strategizing (within MDPH) about the effects of Chapter 58:** In 2006, MDPH had 3,000 employees and over one hundred programs. One state public health leader recalls, *“It was a major task to make sure that [all of the] programs actually knew what health care reform was about. I would say that the majority of those programs thought that it had nothing to do with public health and that it wasn’t going to affect them one way or the other. So, our role was helping them understand its impact and to think it through.”* Though the thinking around Chapter 58 varied across the departments at MDPH and Chapter 58’s impact remained to be seen, this leader reflects on this exercise as an important one for health departments to undertake as a part of health care reform.

While public health was not the central focus of Chapter 58, the aforementioned three functions that MDPH undertook are roles that other health departments can consider under the ACA.

Unanticipated challenge: The economy

While the components of Chapter 58 were being ramped up and MDPH was adapting to its role within the new health care reform environment, an economic recession hit. As a result, there were overall cuts to the state budget and the MDPH line item that resulted from the need to pass a balanced budget at the start of each fiscal year.

Further exacerbating these more traditional cuts, beginning in 2007 (the same year health care reform went into effect) MDPH had to undergo “9C cuts.”



9C cuts are abrupt budget reductions made in the middle of a fiscal year by the administration without legislative input. Such cuts were so named because they were allowed as a result of Section 9C of Chapter 29 of the Massachusetts General Laws, requiring that when projected tax revenue is less than projected spending, the Governor must act to ensure that the budget is brought into balance.²⁴ As a result, massive mid-year program cuts and layoffs repeatedly occurred at the state public health department. Between 2007 and 2012, there were eight rounds of budget cuts and layoffs as a result of the 9C and annual budget reductions. MDPH was faced not only with the challenge of interpreting and redefining its programs and roles within the new health care reform context; it also had to adapt to constant economic uncertainty as well. A statewide public health leader recalled:

“We’d say to the programs, ‘Unfortunately your budget has been cut by 10% and you have to lay off a third of your staff. And while you are absorbing those reductions, we need you to take a very thorough look at the impact of health care reform on your clients because you may want to do things differently.’ It was difficult for people to feel like they could put all of their energy into adapting for health care reform when they were facing wave after wave of cutbacks and layoffs.”

The annual and 9C budget cuts resulting from the economic recession undoubtedly played a large role in the program cuts that will be described in the next section. As Chapter 58 focused on insurance expansion through MassHealth and subsidized insurance, these costs consistently grew. However, many interviewees felt that the costs of implementing Chapter 58 may have inadvertently exacerbated cuts to the public health budget due to the misconception that many state-funded public health services would no longer be needed once universal coverage was achieved (e.g., family planning and infectious disease clinics; see health services section below for specifics). Interviewees talked about how these assumptions led to disproportionate cuts to the public health department as a whole, contrasted with more modest cuts to some other state departments. It is important to note that all stakeholders who were interviewed on this topic expressed that the impact of the recession and strategic cuts resulting from the costs of implementing Chapter 58 were inextricably linked and difficult to disentangle.

While the economic recession was the catalyst for cuts across the board, one interviewee talked about how Chapter 58 impacted the degree of those cuts to public health, since Chapter 58’s provisions were protected and “hardwired,” leaving the remaining programs more vulnerable. The lessons from Chapter 58’s approach undoubtedly informed public health’s approach to Chapter 224 several years later, which dedicated \$60 million in funds to primary prevention and health promotion through the Prevention and Wellness Trust Fund (described in **Table 1**).

Other interviewees recalled that public health programs that primarily served people without insurance were targeted for budget cuts because of the assumption that these safety net programs and clinical services would no longer be needed with universal coverage and access.



This assumption led to cuts to some MDPH safety net services, which actually were not covered by insurance benefits. For example, one MA Department of Public Health leader recounted that co-pays for substance abuse treatment programs were not covered and this created a significant obstacle to care for individuals desiring addiction treatment who were unable to afford copayments (see **Vignette 2: Substance Abuse Services**, p. 28, for more detail). This situation and other stories of specific cuts to public health programs with unanticipated consequences are detailed in vignettes in the section, “Impact on MA’s Safety Net.”

LOCAL PUBLIC HEALTH DEPARTMENTS

Impact of Chapter 58 on the role, function, and funding of local health departments

The general consensus among stakeholders interviewed was that nearly all MA local health departments (LHDs) experienced little to no direct impact as a result of Chapter 58. Only the largest city, Boston, experienced some related changes to a limited number of functions. As previously mentioned, MA’s 351 LHDs each function autonomously, as they are governed by home rule legislation. With the exception of a few larger cities, LHDs are sparsely funded (with communities of fewer than 5,000 people reporting an average annual budget of \$75,000 in 2005), have few to no full-time staff, and only fulfill basic functions.¹¹ In addition, prior to health care reform, MA boasted a strong health care system and relatively low uninsured rates. Free clinics or public health clinics run by LHDs are not the norm in Massachusetts as they are in other parts of the country. For the most part, MA LHDs did not have to rethink how to provide dedicated clinics, with the exception of influenza vaccinations and, in some cases, blood pressure checks.

Many interviewed local public health experts felt that MA’s decentralized local public health system did not have the capacity to address Chapter 58’s goals of greater medical access, especially in light of the uneven resource levels of LHDs across the state. One public health leader stated:

“Massachusetts has 351 cities [and towns]...which means each town and locality has its own health department. That means that you get a few that are larger and have some resources...then you get many that have no resources. [All health departments] still have the responsibility for doing a whole range of things. Some...may only focus on septic systems, because that’s all they have time for and that’s the thing that’s most important for them...So, when it comes to adding things like thinking about preventive care, chronic care services...many just don’t have the time or the resources to actually do it and their town administrators don’t prioritize them.”



Another public health leader confirmed this sentiment, referring to the large number of smaller LHDs (in cities/towns with fewer than 50,000 residents): *“There’s a saying in local public health that what we do is work on sinks and toilets. We don’t focus on prevention as much as we should or proactive policy work because we only have time and money for sinks and toilets. As a result, we’re not involved on a day-to-day basis in improving one’s health.”*

In terms of funding, interviewees explained that, on the whole, LHDs were not impacted by Chapter 58 because unlike most states, virtually none of the LHDs provide direct clinical services. And while DPH allocates some state and federal funding to certain LHDs or clusters of LHDs for specific purposes, it does not award the type of routine public health grants to Massachusetts LHDs that counties and regions in other states receive. The majority of core LHD functions, as well as other municipal services, are funded through a combination of property and commercial taxes.

While all stakeholders interviewed agreed that the vast majority of LHDs were not impacted by Chapter 58, many also hypothesized that larger, better resourced health departments may have been impacted. However, even a leader from the second largest LHD in MA remarked that Chapter 58 did not have any direct impact on their public health work.

Key informants contributing to this research also believed that Chapter 58 had minimal impact on the role and function of LHDs because *“there was precious little directly about local public health in Chapter 58.”* While MA’s later health care reform legislation offered opportunities for local health departments to engage in prevention work, particularly through the establishment of the Prevention and Wellness

Trust, Chapter 58 was viewed as primarily focused on health insurance, health care access, and clinical care and thus perceived as outside of the purview of public health. Because the vast majority of LHDs do not provide clinical services, Chapter 58 was not seen to be directly relevant to the services that LHDs provided. This was supported by two leaders of large LHDs:

“Our department has really moved away from clinical services. Knowing that universal health insurance was the primary goal of [Chapter 58], which then was supposed to trigger an influx of patients into primary care and other health care services... we didn’t have a major role in providing health care services outside of flu clinics and our travel clinic.”

“I suspect you’ll find [that most health departments] do not actually provide clinical services. So, we were less engaged in what actually happened. It was more on the advocacy side of supporting this kind of initiative as an important one to happen, more than on the delivery side of ensuring that it was implemented properly.”



Chapter 58 in Boston: Advocacy and unanticipated effects

Overview

The Boston Public Health Commission (BPHC) is the largest local health department in the state, with over 1,200 employees and a current budget of \$172 million. In addition to operating public health programs, BPHC provides oversight of Boston Emergency Medical Services (EMS), several substance abuse treatment facilities, and the second largest homeless services program in New England.²⁵

Advocacy

During the formation and passage of Chapter 58, interviewed stakeholders noted BPHC's support for the passage of Chapter 58 and advocacy for provisions regarding access and prevention. One of BPHC's priorities was expanding insurance for poor, low-income residents, and the leadership of BPHC recognized the beneficial impact that Chapter 58 would have in increasing health care access to this population. In addition, BPHC successfully advocated for provisions to require the collection of and reporting on race and language data and pushed for more public health funding overall. Even with this advocacy, however, the stakeholders interviewed acknowledged that BPHC was not significantly involved in the overall formation and passage of this legislation. A representative of BPHC on the Massachusetts Affordable Care Today (MassACT) Coalition, a diverse coalition of businesses, non-profits, and unions formed to push for health care reform in MA, recalled:

“Chapter 58 wasn't [BPHC's] top priority. Other things like substance abuse funding, treatment funding, clean needle legislation — these were higher public health priorities. I was definitely still learning about health care financing, but I felt a little bit like a square peg in a round hole for the [MassACT] Coalition. I didn't entirely know yet how to translate public health beyond health care coverage into this organization.”

This perspective illuminates the uncertainty that public health practitioners experienced as they sought to understand the implications that Chapter 58 would have upon the field both locally and statewide.

Unanticipated impacts

While numerous public health provisions were successfully included in the final legislation, BPHC experienced some unanticipated impacts. One particular example recounted involves the billing challenges that long-standing provider sites faced. These challenges, which pre-dated Chapter 58 but were exacerbated due to insurance expansion, included an inadequate infrastructure for insurance billing and reimbursement approvals.



One such example of this included BPHC-funded school-based health centers (SBHC). SBHCs are critical to providing health care, promoting disease prevention, and reducing health disparities for underserved and vulnerable youth. SBHCs are often environments where students might feel more comfortable seeking out services — particularly sexual health and sexually transmitted disease (STD) services — in confidential environments.^{26,27}

According to interviewees, in Boston, as in other localities, SBHCs already had limited billing capacity prior to Chapter 58. Following the passage of Chapter 58, SBHCs began to serve more students who were covered by managed care plans, thus creating new administrative billing headaches. Some of these plans created restrictions on providing reimbursements outside of the patient-centered medical home. BPHC wanted to negotiate reimbursement, but many patient-centered medical homes declined payment to BPHC for such services and insurers often would only pay a nominal \$35 for an \$80 visit. As a result, BPHC had to scale back SBHC services, such as conducting physicals or chronic disease management for students. Instead, they limited services to medications for acute conditions, mental health, family planning services, and peer-to-peer education.

Additionally, rather than a traditional medical model, BPHC uses more of a community-based approach to health improvement through the engagement of community health workers and other non-traditional community providers. However, post-Chapter 58, grants and funding levels for these services were cut, largely due to the recession. There were also some smaller cuts due to reductions of the MDPH budget that related to the assumption that they were no longer needed in the new health care reform environment.

BPHC has since struggled to reimburse for their evidence-based public health service models, even when a clear return on investment could be demonstrated. For example, BPHC facilitates a home visiting program for high-risk pregnant women that results in better birth outcomes. However, even when BPHC offered to receive payment only when an improved birth outcome resulted, patient-centered medical homes were unwilling to support home visits to their patients through payments. Similar experiences have arisen with cost-effective public health interventions for asthma, falls among the elderly, and immunizations.

Chapter 58 in Worcester: Shifting priorities and finding the identity of local public health

Overview

Worcester, MA is located in the middle of the state and is the second largest MA city, after Boston. Like most LHDs in MA, Worcester's Division of Public Health (WDPH) moved away from providing clinical services over a decade ago with the transfer of approximately 45 public health nurses to Worcester Public Schools Department of Nursing. Following this move, WDPH provided limited clinical services, with public health nurses only operating a biweekly immunization clinic, Senior Center clinics, Worcester Housing Authority clinics, and seasonal flu clinics. As a result, even with the passage of Chapter 58 in 2006, there was no perceivable influx of patients to the clinics in spite of the expanded insurance coverage.

However, the economic downturn of 2008-2009 led to shifts in priorities for WDPH. While these changes did not directly result from Chapter 58, the approach that WDPH took to reprioritize its resources within the context of Chapter 58's expanded insurance access may be instructive for LHDs across the country.



Economic downturn and reprioritization

The struggling economy and subsequent budget cuts spurred WDPH to reexamine the LHD priorities and role. One interviewee recalled this time as follows:

“When [MDPH] in the 2008-2009 economic downturn was determining services and programs in which they could cut with minimal impact, they chose areas where services would still exist through other access points in the community, such as immunization services. And so, the WDPH did realize cuts in the flu vaccine allocation and other childhood vaccines because of these decisions. I would say that was a direct correlation to health care reform because 95% plus of people are now covered [and] can go get these immunizations through their primary care or services such as limited service clinics.” This interviewee recalled that the prevailing wisdom was that, “WDPH should not be competing with the clinical providers in the community. Let the clinicians do the clinical work, and let the health department do the prevention work. [Because] we have a wealth of hospitals, health centers, and community-based organizations providing clinical services...why does the health department have to continue to do that when we should really be encouraging our residents to connect into the health care system?”

In this context, WDPH ceased its immunization services and became a referral link to other clinical providers in the community. WDPH also undertook community education to inform the public about the changes to its services and now provides a directory of clinics. While other LHDs across the country could look to the influx of newly insured patients as an opportunity to expand services and get reimbursed, that was not the philosophy in Worcester due to the lack of billing infrastructure.

This was described as follows:

“The services we previously provided, we [only] charged a \$25 administration fee for each vaccine. We weren’t set up to do Medicare or Medicaid or reimbursements, that wasn’t our model.”

IMPACT ON MA’S SAFETY NET

Overview

Universal Health Insurance Access Efforts in MA: A Literature Review details the evidence in the literature around the necessity of maintaining a strong safety net system, even after health care reform.

Challenges to upholding the safety net that have been documented in Massachusetts post-Chapter 58 include financing difficulties for safety net providers (due in part to inadequate levels of subsidized funding via Medicaid payments); physician shortages; the effect of the economic downturn; and perceptions by lawmakers that certain safety net services may no longer be needed.

The Massachusetts experience shows how constant monitoring, mid-course adaptations, creative remedies, and collaborations have supported success in the health care reform context. The following section will focus on the impact of Chapter 58 on public health programs and safety net providers.



Impact upon state-funded public health direct service programs

As previously mentioned, public health faced funding threats not only due to the lagging economy, but also as a result of the perception that such programs would be unnecessary or duplicative under universal health coverage.

In addition to direct budget cuts impacting programs, other MDPH programs were subject to legislative impacts due to near universal health care coverage. The vignettes below demonstrate the unintended consequences on safety net programs resulting from the erroneous assumptions about their continued roles under universal health insurance coverage.

Vignette 1: Women's Health Network

A MA Department of Public Health leader recounted the following story:

The Women's Health Network (WHN), a program of the Centers for Disease Control and Prevention (CDC), provides free annual breast and cervical cancer screening for poor and uninsured women. The legislative language that began the WHN states that the program is for uninsured and underinsured women and also requires at least 60% of federal funding go to direct clinical services (with the remaining 40% able to be spent on non-clinical services such as outreach, prevention, education, and patient navigation).²⁸

MA's WHN historically was very strong and had high participation rates. However, within three months of Chapter 58's implementation, the participation rate dropped by 50% due to newly obtained insurance. In addition, anyone who came for a service would be unable to return for follow-up as WHN staff were charged with guiding patients to enroll in insurance during their visits, and once insured, these clients would no longer meet WHN service criteria. However, though newly insured, it was unclear whether former program

participants were receiving health services elsewhere, and concerns existed that these high-risk and hard-to-reach women would not follow up on screening results by seeking out the necessary health services.

Because CDC's funding assistance was based on the WHN caseload, the funding stream for the WHN drastically decreased, putting jobs and services for women in jeopardy. Additionally, with the overall funding decrease, there was reduced capacity to provide the nonclinical services essential to helping vulnerable populations navigate the health care system and improve coordination and continuity of care. MDPH spoke with CDC to inform them of the dilemma, and also communicated that *"this will send a message to other states that if they expand insurance opportunities, the federal government will cut their money. This will be a disincentive for health care reform."* In collaboration, MDPH and CDC attempted to adapt the program to the new circumstances but were ultimately unable to do so.



Vignette 2: Substance abuse services

A MA Department of Public Health leader recounted the following story:

MDPH has long provided tens of millions of dollars in grants to community-based substance abuse providers to buy detoxification (detox), residential, and other services for clients who lacked insurance. After Chapter 58 passed, MDPH assumed that those contracts could be reduced for detox services since more people would have insurance and insurance always covered detox. The remaining grant funding was mandated as the “payer of last resort.” Almost immediately, however, the flaws in that approach became clear. Within six to nine months, the detox directors raised their concerns. They had seen an increase in clients with insurance, as expected, but each insurance plan required a co-pay in order to access care.

Most clients who sought detox were penniless at the point they entered care. The facilities were in a bind: they didn’t want to turn anyone away but they couldn’t afford to waive the co-pays either. The providers had found it easier in the pre-Chapter 58 days when they could bill MDPH for the total cost of care for an uninsured patient. MDPH and the providers tried unsuccessfully to advocate for a global insurance policy to eliminate co-pays for detox. As a result, the detox facilities incurred greater debt. This was an example of an unintended and unwanted consequence.

Impact on community health centers

Client volume and capacity increased

According to one community health center (CHC) leader, “*There was a presumption...that people would leave community health centers now that they had coverage and they could get private doctors. That did not happen.*” In fact, there was an overall increase in patient volume of 12% within the first year of Chapter 58’s implementation among federally qualified CHCs (FQHCs) in MA. In 2007, FQHCs in MA served 483,000 patients, the equivalent of approximately one in every 13 MA residents and one in four low-income residents.²⁹

This is consistent with the literature that describes that previously uninsured patients served by the safety net system prefer care from facilities such as CHCs due to their convenience, affordability, availability of services other than medical care (e.g., transportation services), availability of appointments, and linguistic capabilities.¹⁷ According to one CHC expert, some of this increase was due to expanded capacity at CHCs enabled by federal expansion dollars that had come through the Massachusetts League of Community Health Centers. Using these funds, health centers instituted loan repayment programs that were effective in increasing physician recruitment.



This initiative is detailed in *Universal Health Insurance Access Efforts in MA: A Literature Review*. As patient volume increased, the CHC system increased capacity; however, interviewed stakeholders stated that the situation is too complex to attribute these changes solely to Chapter 58.

New revenue offset by increasing administrative burdens

MDPH contracts with community organizations and CHCs for the provision of direct clinical and ancillary support services through competitive state grant funding. Pressure from the economic recession led to cuts of over \$18 million in state direct service grants that significantly impacted MA’s CHC system over the course of the second and third year of Chapter 58 implementation. These extreme reductions in state grants were the result of the assumption that as more people became insured, CHCs would be able to replace this revenue by billing insurers. While billing revenue did increase, Medicaid reimbursement rates for services were considered low. In addition, some services needed by and delivered to the safety net population were not billable (e.g., outreach, navigation, translation) and not all patients were insured. Over time, some of the budget cuts were restored and there were some increases in reimbursement rates. The overall financial impact was not easy to track and not clearly attributable to one cause, as the issues are multifactorial.

One budget flow example highlighted by a statewide program administrator was that health centers had difficulty financing the purchase of child and adult immunizations. Although the immunizations were reimbursable, CHCs did not have the funds to purchase them up front. The MA League of CHCs created a purchasing group as part of a solution. It took four to five years to implement a work-around for this problem.

Changes in coverage and client mix

The statewide average of uninsured clients across the 34 Federally Qualified Health Centers (FQHCs) in MA (many of which operate multiple sites) declined from 36% to 26% one year after Chapter 58 went into effect. CHCs were still left with a significant portion of uninsured clients, particularly undocumented immigrants for whom CHC or emergency departments (EDs) may be the only settings available for health care. Some individual CHCs still have uninsured rates close to 40%. Payer mix among CHC clients across the state showed some shifts. While the Medicare and private insurance percentages remained relatively constant, the proportion covered by Medicaid or the Children’s Health Insurance Program (CHIP) increased from 38% to 42%. Commonwealth Care, MA’s subsidized insurance program for adults who meet income and other eligibility requirements, and other new public insurance options benefited 5% of the CHC population by 2007.

TABLE 2: CHANGES IN INSURANCE TYPE AMONG MA FQHC PATIENTS, PRE- AND POST-CHAPTER 58²⁹

Insurance type	2005	2007
Uninsured	36%	26%
Medicaid/CHIP	38%	42%
Commonwealth Care/ other public insurance	<1%	5%
Private	19%	19%
Medicare	7%	8%

Source: MA Uniform Data System (UDS) from USHHS, Bureau of Primary Health Care



Patient enrollment

CHCs trained staff to be diligent about enrolling newly eligible patients into insurance plans. CHCs worked with MDPH, hospitals, and other safety net providers to design educational materials with a simple message: health care is available; talk to the financial counselor at your community health center or hospital. Administrative staff navigated patients through this process and directly enrolled them into health insurance using the state's online enrollment system. CHCs recognized the need to put supports in place to prevent staff burnout. One CHC leader pointed out that the brunt of the work burden fell upon the enrollment workers and front desk workers in clinics and medical practices. This person aptly said, *“Keep calm, be very, very good to your front desk and enrollment people, because they're going to be in amazing states of burnout. We advise people — schedule overtime, schedule pizza delivery, because your staff is going to be in need of support.”*

Provider and facility contracting

Upon implementation of Chapter 58 in MA, health centers sought contracts with all insurers in their areas, including newly created public insurance products as well as private payers. Once contracted with a managed care organization (MCO), all of the CHCs' clinical providers then had to apply to become credentialed as contracted providers. As MCOs were swamped with provider credentialing requests, this process led to considerable delays in provision of patient care. According to executives at the MA League of Community Health Centers, it was this credentialing delay that was primarily responsible for long wait times for new appointments rather than any scarcity in provider supply.

It is worth noting that for some MCOs, the limited network of contracted facilities inconvenienced patients and/or deferred their care. For example, there were cases of patients in central or western MA who were required to travel to Boston for hospital-level care, as their insurer(s) did not contract with local hospitals.

Clinical community linkages

A CHC interviewee mentioned that bridges are being built and fortified between CHCs and public health-oriented community-based resources to link individual care with community health. These growing partnerships align with recommendations shared by other public health informants as well. Community transformation funds have been facilitating this process thus far.

Impact on safety net hospitals

Due to the extensive research available in the literature, the experience of safety net hospitals was not a research focus of this report. However, insights from the interviews support the literature's assertion that utilization of safety net hospitals increased in part because safety net patients continue to go where they are comfortable or have existing relationships.¹⁷ One public health leader noted:

“People loved to say that [with the passage of Chapter 58], all these poor people were going to be able to go to any hospital; but, I don't think that happened. People go where they feel comfortable, and some of our big teaching hospitals are not opening up their arms and saying, ‘give me your tired and your poor.’”



These aren't the populations that they work with. We have wonderful hospitals, but they do not all have the ability to work with some of the complications that come with individuals who are challenged by poverty and language.”

Further affirming the literature, interviewees reiterated that the funding for safety net hospitals was cut with the expectation that safety net patients would go elsewhere once they had insurance — an assumption that created tremendous financial problems.^{17,18,29}

CLINICAL AND PUBLIC HEALTH SERVICES: ASSESSING ACCESS, OUTCOMES, AND OVERALL HEALTH IMPACT

Overview

To delve further into the impact of Chapter 58 on population health outcomes and the processes of tracking and measuring those impacts, interviews were conducted with informants who oversee prevention, treatment, and/or surveillance of infectious diseases, chronic conditions, and reproductive or other health conditions statewide in MA. This section includes findings on general effects on health outcomes and clinical services; health care access; immunization, infectious disease, and family planning programs; health care utilization; quantitative data collection; and evaluation efforts and community health.

General impact on clinical services

MA relies on its robust network of community health centers to deliver many of the clinical services that fall under the purview of local and county health departments in other states. Thus, changes in clinical service delivery are likely to be more dramatic elsewhere in the country as a result of the ACA.

It is important to note, however, that prior to the passage of Chapter 58 in 2006, an array of categorical clinics were funded by MDPH for sexually transmitted diseases (STDs), tuberculosis (TB), and family planning. To some extent, after Chapter 58 was implemented, people began to use their health insurance for these and other clinical services that were traditionally provided through public health, as described in the following subsections.

Long-term effects on health outcomes

The stakeholders interviewed universally reiterated that, while more immediate changes in health care access behaviors may be monitored, it is difficult to assess whether there are attendant improvements in population health. The major limitation highlighted in terms of evaluating the impact and outcomes of Chapter 58 is time. As many risk factors accumulate and medical conditions develop over decades, it is too soon to detect long-term health outcomes. In addition, the systems and resources necessary to monitor such long-term outcomes do not exist. Individual understanding of new benefits and resultant behavioral changes in terms of care seeking require time to progress as well. Furthermore, existing health status data are often two or more years behind the current date due to the time it takes to gather, analyze, and report the data to the public.



Consensus was also reached around the idea that improving health outcomes is complex and multifactorial; numerous variables affect health outside of medical care. These additional variables, such as socioeconomic status, confound the relationship between expanding insurance access and changes in health outcomes. It may be that health insurance is a necessary but insufficient condition to produce statistically significant changes in population health.

Access to health care

A recurrent theme across key informant interviews was that although universal insurance coverage is an important step to increasing access, it does not guarantee universal access for everyone, especially vulnerable populations. There are two main reasons for this. Not everyone is eligible for, or desires to purchase, insurance. In addition, there are cultural and other factors at play that influence decisions to access care. As one state public health leader stated:

“Just because people are covered doesn’t mean everyone has access to care. Insurance coverage access does not actually equal health care access.”

Informants pointed out that certain subpopulations still remain uninsured, largely consisting of young adults, Hispanics, some Asian subgroups, and undocumented immigrants. Other groups that remained uninsured and/or struggled with gaining access to care include substance users and homeless individuals. In addition, coverage is not continuous. Gaps occur as people move between jobs and/or miss timelines for re-enrollment or re-certification.

Several informants suggested that systems be put in place to prevent coverage gaps and/or to ensure continuity of care during these gaps. In addition, patient navigation was noted to be a vital service that needs support. Even with patient navigators in place, many non-U.S.-born patients, such as those at high risk for TB, do not access care due to cultural stigmas and distrust of government services based on experiences in their native countries. As another state public health leader explained, *“If we really want to improve the quality of care, we need to be able to provide care that understands the context of people’s lives.”*

Additionally, informants highlighted the importance of maintaining quality clinical public health services. Several interviewees stressed the critical need to help primary care providers gain the expertise necessary to address diseases with population health implications (e.g., infectious conditions such as TB) and the particular needs of the populations who previously received services through the public health-funded clinics.

Impact upon clinician capacity

Key informants indicated that Massachusetts had been struggling with a physician shortage long before the law’s implementation. Thus, from their vantage point, Chapter 58 had no clear direct effects on provider supply. It was also noted that Chapter 58 included measures that expanded nurse practitioner (NP) use. Thus, NPs and other mid-level practitioners (i.e., physician assistants) offered additional capacity to provide primary care services in many settings.

Numerous sources in the literature have indicated that MA has the highest physician-to-population ratio of any state in both primary care and overall.^{30–32}



Seemingly conflicting, the Physician Workforce Study produced by the MA Medical Society (MMS) reported long wait times for appointments and “critical” or “severe” shortages in the fields of internal medicine and family medicine.³¹ An MMS informant attributes this discrepancy to the fact that MA’s physician registry counts not only medical doctors who work as health care providers, but also the many academic researchers or private industry consultants who rarely or never engage in clinical work. This lack of categorization of practice time percentage can distort the picture of clinician availability. In addition, a health care expert said:

“Whatever the reality around physician supply is in MA, it is very difficult to know and findings would not be generalizable because MA is a very specialist-heavy state. With all of the teaching hospitals, the biomedical industry, and the pharmaceutical industry here, Massachusetts is an outlier.”

While there does seem to be a shortage of clinically available physicians in MA, interviewed experts doubt that Chapter 58 had any direct effect on the situation. An expert on the topic stated:

“It would be hard to conclude that there’s been any change as a result of Chapter 58. We haven’t seen a particular spike in trends... Physician shortages in MA have been going on for a long time.

Increasing from 93% [health insurance] coverage to 98% is not going to significantly impact supply.”

In addition, while health care reform was being implemented in Massachusetts, both state and federal funds were targeted towards workforce expansion. For example, one informant said the University of Massachusetts began a loan forgiveness program. In parallel, informants echoed what was mentioned in detail in the literature review and recapped above: the infusion of federal dollars enabled the MA League of Community Health Centers to start a special workforce initiative to support loan repayment for primary care physicians who would be willing to practice in local community health centers.¹⁷ This incentive program has been successful in recruiting primary care physicians for the CHC system, thus expanding primary care capacity.

Similarly, interviewees did not believe there has been any physician flight as a direct result of expanded insurance access and the subsequent influx of patients to primary care practices. One health care expert commented, *“Covering more people is not the reason they leave the state. There may be other reasons, but not universal coverage. The percentage of doctors who say they’ll leave because conditions are difficult hasn’t changed much. They might leave if the practice environment, including regulations, salaries and administrative burdens, were to worsen. [For example], we are [now] concerned that the regulatory burdens associated with Chapter 224 will force more consolidation and result in either physician flight or early retirement. Massachusetts is, however, a rich academic and research state where people often want to live and practice.”*



On the whole, while physician supply was and continues to be an issue in medical care access, all interviewed stakeholders felt that this challenge preceded Chapter 58's legislation and was not negatively impacted by health care reform.

Wait times

Despite the assertion that physician supply was not depleted as a direct result of Chapter 58, several informants shared the perception that many of those who are newly insured have had to wait significant periods of time to be assigned to primary care providers and for appointments. It was acknowledged that this belief is based on anecdotal evidence due to the lack of a coordinated effort to monitor wait times. Estimates of this appointment time lag range from three weeks to three months. One attempt underway to document such delays was described by an interviewee: MA CHCs are using length of time until the “third next available appointment” as a proxy measure for wait periods.ⁱ However, quantifying this measure is currently problematic as the variable recorded is not specific to newly insured individuals and aggregate data are not available.

However, it is important to note, as mentioned above, that at least for the MA League of Community Health Centers, executives attribute long waiting periods for appointments to the time-consuming process of getting CHC clinicians added to insurance networks in order to provide reimbursable care under the new coverage plans.

ⁱ Per MA League of Community Health Centers: Third next available appointment is considered a more reliable reflection of the system's availability. First and second available dates are more likely due to last minute cancellations, random events, or held for urgent conditions.

One interviewee pointed out the geographic variability in wait times, noting that in rural areas, access can be compromised by a lower density of providers than in urban areas. In contrast, an unpublished internal study of Greater Boston CHCs, cited by an informant, showed a relatively short wait time of several hours to three days for a medical visit for established patients, while the wait time for new patients varied across CHCs with an average of approximately three weeks. All CHCs do reserve urgent care appointment slots that can be made available daily for individuals with pressing medical concerns.

The timeliness of treatment is particularly important in transmittable diseases, such as TB. Primary care is limited in many geographic areas where TB cases are clustered, yet a patient with active TB needs to begin treatment urgently. Long waits for appointments due to scarce physician supply and lack of disease-specific expertise compromise appropriate treatment and follow-up and thereby allow greater TB transmission to occur.

Dental health

Another health care leader lamented: “*Since CHCs are one of the few places adult Medicaid patients can get dental care, they are in complete overload right now,*” as Medicaid has eliminated dental coverage. For adult Medicaid patients in MA, only CHCs offer dental services, covered under safety net funding. This informant estimated the wait time for dental services as approximately six months. It is important to note that Chapter 58 did not include dental services.



An in-depth look: Community health workers

Definition and history

As adjuncts to and facilitators of direct clinical care, community health workers (CHWs) are defined as front-line, non-clinical, public health workers who promote full and equal access to necessary health and social services by applying their unique understanding of the experiences, languages, and cultures of the communities that they serve.^{29,30} CHWs can serve as outreach workers, patient navigators, or in other capacities. Prior to Chapter 58 legislation, support for CHWs in MA was incubating. Among the efforts that contributed to this were:

- *An Office of CHWs within MDPH:* Starting in 1995, MDPH convened an internal CHW Task Force to research the current and potential impacts of CHWs on the health care system and make recommendations for how MDPH could support and promote CHW programs. The Office of CHWs was established in the mid-1990s and conducted research and encouraged action steps to make CHW funding sustainable. In different programmatic areas within MDPH, grants were provided to support the work of CHWs, including the provision of high quality training.
- *The MA Association of Community Health Workers (MACHW):* One of the nation's first statewide professional organizations for CHWs, the MACHW was founded in 2000 to conduct education, research, policy development, and advocacy to promote the CHW workforce and define and strengthen the profession of community health work.

Legislation and advocacy

Despite an unsuccessful push for Chapter 58 to mandate insurers to reimburse for CHW services, the legislation included two key policy provisions for CHWs under section 110. Section 110 was originally part of a stand-alone bill coauthored by the MACHW and the Massachusetts Public Health Association (MPHA) that aimed to validate CHWs as a profession that can bridge population health and clinical health. The collaborative dialogue between MACHW, MPHA, and MDPH resulted in a robust CHW policy agenda, where *“legislative successes emerged from a shared commitment among all partners to prioritize and promote CHW perspectives and interests while protecting the integrity of the field.”*³⁵

With the increased focus upon Chapter 58, a modified CHW bill was incorporated into the larger health care reform package as a health disparity provision but only went so far as to mandate a study and support the potential utility of CHWs, rather than directing reimbursement for such services.³¹ In the words of one policy maker, the goal of the CHW provisions was *“to acknowledge the value of CHWs; document their efficacy in addressing health disparities, increasing access to health care, and managing chronic disease; and to require the state Department of Public Health to convene a multi-sector commission that would develop a sustainable program utilizing CHWs in MA.”*



The provisions included in Section 110 of Chapter 58 included the following:

- MDPH was directed to conduct a comprehensive statewide study of CHWs and provide recommendations for building a sustainable workforce; and,
- MACHW was given a seat on the state's expanded Public Health Council, an organization that advises MDPH on major policy decisions.³³

These provisions were considered by interviewed stakeholders to be 1) important stepping stones for public health to have a voice in Chapter 58 implementation; 2) supportive of CHWs who were integral to the success of Chapter 58's effort to expand insurance to the previously uninsured population; and 3) the genesis of the movement toward integrating CHWs into the national health care system through the ACA. As one public health leader stated: *"It was clear that [the] expansion of coverage for low-income folks alone [would] not be enough to provide care; community health workers were going to be an essential ingredient in promoting equity."*

In the words of another public health leader, the CHW provisions addressed health disparities by *"not just connecting residents to insurance but by promoting connectivity to different systems, primarily health care."*

The state-mandated CHW committee reviewed the existing literature on CHWs. It identified instances where CHWs increased access to primary care through culturally competent outreach and enrollment

strategies and improved the quality and cost-effectiveness of care by assisting patients with self-management of chronic illnesses, medication adherence, and health care system navigation. The study also found instances where CHWs had become important members of teams that delivered patient-centered primary care. The report recommended:

- A "professional identity" campaign to increase recognition and understanding of the CHW role;
- Expanded training programs for the workers and supervisors, with related certification;
- Financing to pay for CHWs including third party payments; and,
- The establishment of an expanded state Office of Community Health Workers to do workforce surveillance, research, coordination of training and career pathways, and policy development.^{29,31,32}

Recognition and professionalization of CHWs were seen as the most tangible and sustainable benefits of Section 110. As one public health leader put it, *"The community health worker model was not established by Chapter 58 but was, in my opinion, catalyzed by Chapter 58."* Another state public health leader interviewed stated, *"Ten years ago, not many knew what [CHWs] were. Now so many people know! Because of public awareness, people who were doing the work previously are now doing it under [the] title of [CHW], defining an emerging profession."*



Finally, Section 110 was seen as a model for the language included in the ACA, with national reform as a policy window of opportunity to integrate CHWs into the health care system. A state public health leader stated, *“There are a lot of ripple effects of [Section 110], including the national impact. CHWs are now seen as an essential portion of health care reform in Massachusetts, which contributed to its inclusion in the ACA.”*

CHW role in enrollment and access

MA’s CHWs played a highly visible and integral role in enrolling more than 200,000 uninsured residents in health insurance programs by 2010.³³ A chief statewide public health official described insurance outreach and enrollment services by CHWs as a critical role for public health to take on and a lesson for other health departments under the ACA. Shortly after Chapter 58’s passage, a state public health leader described the evolution of public health’s role in enrollment and CHW engagement as follows:

“There was concern at the state level that there were going to be high-risk eligible clients — who because they were disconnected from health care delivery previously — [would] not even know they were eligible for health insurance. One successful way to reach them was by tapping the experience and skill of the community health workers and other grant-funded employees with client contact. CHWs often interacted with those community members who were disconnected from health care. They knew who they were and how to reach them.”

Proactively, MDPH trained all contracted agencies with client contact in the specifics of the insurance expansion. Pre-existing grants funded outreach by CHWs and non-CHWs who had client contact and MDPH provided specialized training for CHWs in insurance enrollment.³³



Immunization program

Childhood vaccines

In contrast to the ACA, MA's Chapter 58 legislation does not specifically require insurers to cover immunization. However, achieving high childhood vaccination rates has long been a priority in Massachusetts with dedicated state funding complemented by federal funding via two mechanisms: 1) a federal grant (for low-income children who qualified for the federal Vaccines for Children (VFC) program) and 2) a state legislative line item of more than \$50 million for children above the federal income guidelines. MDPH pooled the funding and purchased the vaccines for children of all income groups and distributed them to the state's pediatricians. This eliminated the need for the pediatricians to incur additional costs or keep complicated inventory records. By simplifying the process for the pediatricians and guaranteeing vaccines for all children, MDPH contributed to MA's long-standing track record of very high vaccination rates. Concurrent with implementation of Chapter 58, provision of childhood immunizations became complicated as the economy plummeted, prices rose, and new vaccines were added to recommended regimens. Neither the state nor federal funding for immunizations kept pace with the rising cost of vaccines or with recommendations for additional vaccinations. Given these budget constraints, MA went from being a universal vaccine state to a "universal select state" in that some vaccinations were not covered (e.g., human papilloma virus or HPV) and many were only covered when administered "on schedule" (i.e., at the recommended age).

Vignette 3: Childhood Immunizations, p. 39, illustrates further complexities introduced upon implementation of Chapter 58 in MA.

Adult vaccinesⁱⁱ

As newly insured individuals connected with primary care providers, the likelihood of appropriate adult

vaccinations increased but was not guaranteed. Adult primary care providers may not stock all recommended adult vaccines and have historically felt that they were not sufficiently reimbursed for this service. Re-training and creating systems to support administration and billing of recommended immunizations by adult providers is a process MDPH is addressing.

Although prior to Chapter 58, MDPH provided some adult vaccines to public providers (LHDs and CHCs), legislators assumed insurers would be billed upon implementation of Chapter 58. Therefore, fewer vaccines were provided to LHDs and CHCs with the expectation that only the small population of uninsured adults would need them. However, in many cases, LHDs did not have the capacity or established contracts to bill for these services.

ⁱⁱ *Adult vaccines may include: influenza, pneumococcus, varicella, zoster (shingles), Tdap (tetanus, diphtheria, pertussis), hepatitis A, hepatitis B, HPV (human papilloma virus), and/or MMR (measles, mumps, rubella).*

Immunization reimbursement solutions

The following are two models for immunization reimbursements:

- *An intermediary model for LHD immunization reimbursement — Commonwealth Medicine:* In MA, almost 200 local health departments administer at least flu vaccines. Most of them are very small and do not have the capacity to contract with and bill all the health plans. Health plans do not want the administrative burden of contracting with 200 health departments, each of which serves very few members of each health plan. To address this issue, MDPH collaborated with UMass Medical School in 2009 through an intermediary, Commonwealth Medicine, to contract with all the health plans for coverage of flu vaccines, and in parallel, to contract with all the local health departments to deliver flu vaccines. All reimbursement claims go through Commonwealth Medicine for a 10% commission.



Vignette 3: Childhood immunizations

Former Commissioner Auerbach recounted the following story:

Here is an example where I totally understood the state legislature's rationale. The legislature looked at the fact that we had a state line item for childhood immunizations of \$52 million. Yet health care reform had assured that almost 100% of children in Massachusetts had health insurance and the insurers all included childhood immunizations as covered benefits. The Legislature understandably thought the \$52 million line item was no longer necessary and cut it to zero.

We soon found out that this budget cut was very problematic. The Massachusetts Chapter of the Academy of Pediatrics explained how complicated it would become for the pediatricians without such funding. They would need to bill for the vaccines and keep separate inventories based on the payer. They would have to incur the cost of vaccine purchase until they were able to recover those costs from the insurers. This was such a new approach that the insurers had not yet provided vaccine billing forms.

Plus, pediatricians would still get free vaccines for low-income children from the federal government. Under the old system, vaccines were provided with pooled federal and state funding eliminating the need for separate tracking systems. Under the new system, they had to purchase two separate refrigerators and develop two separate inventory systems, one that met the federal

requirements and one that met the insurers' rules. The doctors would have to be careful that they never pulled the vaccine for a child with insurance from the refrigerator for the uninsured children. And this came at a time when they were being asked to take on more patients as insurance coverage expanded.

As a result, pediatricians started saying that they would have to begin setting limits on the vaccines they would offer. The best, most dedicated doctors were saying, 'My practice is either going to close or I will have to start setting limits on the care I provide.'

Fortunately, we had several months before the new rules would go into effect. Together with the pediatricians, we convened a series of meetings with the insurers and with legislative leaders. The solution turned out to be a change of law. The state law assessed the insurers for the cost of the vaccines and pooled the funding in a trust to be administered by MDPH. That way we got the \$52 million back and were able to re-constitute the longstanding system of providing the pediatricians with vaccines for all children regardless of the payer.

The lesson for the ACA is 'beware of unintended consequences and, whenever possible, develop innovative approaches that minimize their impact.'



While local health departments still need to pay the up-front cost to obtain the vaccines, over \$800,000 went back to local health departments in reimbursements for flu vaccines in 2012.

This model may prove to be effective in other states where local health departments provide more extensive clinical services and may not be able to purchase vaccinations without assurance of reimbursement. Such an intermediary body could potentially negotiate with health plans to reimburse other services provided by local health departments.

- *Medicaid “bump up”*: The ACA provision that “bumps up” Medicaid reimbursement rates to higher Medicare rates for preventive services (including immunizations) from 2013-2014 has been a huge incentive for health care providers. In addition to the rate increase, this change allows pediatric and adult providers to charge separately for the vaccine itself and for the service of administering the vaccine. Previously, providers were not reimbursed for vaccination service if administered during a general medical visit; reimbursement occurred only if the vaccine was delivered during a vaccine-specific visit. Interviewees pointed out the need to make sure that providers and the state Medicaid offices are aware of this change.

Cancer screening

While a feasibility study demonstrated that it is possible to extract information to detect changes in cancer screening rates as well as trends in the timing of cancer detection from existing databases, this assessment has not yet been conducted on a broad enough scale to yield definitive results. Key informants did not share new information beyond what was presented in the literature review.

Infectious diseases

Concern that it may be difficult to transfer appropriate care for infectious diseases with public health significance to the primary care setting was a recurrent theme across interviews of state researchers and epidemiologists. It was noted that for some diseases (e.g., hepatitis C) people are gaining coverage for laboratory testing and treatment. However, particular infectious diseases require specialty clinical and public health expertise often not available through primary care medical homes. As one state public health leader explained:

“If we really want people to be in a medical home, then ultimately we have to figure out how to provide not just patient-oriented services, but population-oriented services.”

To illustrate this issue, key informants shared their experiences with the impact of Chapter 58 on STD and TB clinics, as detailed below.

Sexually Transmitted Diseases (STDs)

In 2008-2009, on the heels of Chapter 58 implementation, MA’s few remaining public STD clinics were effectively defunded. This decision was a result of economy-driven budget cuts and the expectation that many of these services would shift to the private sector. However, the desire and need for confidentiality for many patients seeking STD screening and treatment made this clinical service unique and not readily transferable to the private sector. While it is too early to see the impact of STD clinic closure on disease trends, a study on utilization trends is underway at Boston Medical Center (by Dr. Katherine Hsu).



- *Unintended consequences:* Getting urgent appointments with providers equipped to manage individuals exposed to STDs was sometimes problematic. MDPH clinics were able to arrange next-day appointments. However, for private providers, the wait time for a new appointment could be three to five weeks — not within acceptable clinical treatment guidelines for someone with an active STD or their contacts. While CHCs offer expanded hours and accommodate walk-in patients, individuals potentially exposed to STDs may be unaware of these options or of the urgency of treatment. Maintenance of public health-oriented STD clinics could ensure more timely treatment and prevent further transmission of infections.

Another unintended consequence was that immediate treatment of syphilis became compromised. Although the prevalence of syphilis is much lower than Chlamydia or gonorrhea, CDC's evidence-based guidelines indicate that, in addition to laboratory testing, it is critical to treat a patient with syphilis symptoms or exposure, and their sexual contacts, with the long-acting antibiotic Bicillin LA (penicillin G benzathine) as soon as possible. However, emergency departments and private providers were not fully aware of these guidelines and did not generally stock Bicillin LA. These alternate sources of care tended to wait for laboratory results before initiating treatment, leading to delays and increasing the potential for transmission. In response to this barrier, MDPH found out where Bicillin LA was available and, through the existing partner notification program, began to refer individuals at risk to those service locations. In addition, MDPH had some capacity to get Bicillin LA delivered to providers to meet the needs of contacts, simultaneously giving providers the message that patients were being referred for preemptive treatment (in addition to testing).

MDPH also addressed providers' training needs by disseminating evidence-based guidelines for STD treatment. One issue that MDPH focused on was expedited partner therapy. MDPH increased training and disseminated guidelines and brochures in order to raise awareness that clinicians can provide patients with non-specific prescriptions or with actual pills for their partners. MDPH has worked with pharmacists on this issue, but billing and confidentiality issues regarding blind prescriptions remain.

- *Partner notification:* DPH continues to provide partner notification services through integrated counseling, screening, and testing sites (for HIV, STDs, and hepatitis C). Although this integration was mainly driven by budget restrictions, rather than by Chapter 58, it has been helpful in making the transition to private sector care. Non-clinical disease information specialists, primarily located in health centers and hospital clinics, conduct interviews, notify partners of potential exposure, and refer individuals to clinical services.

Tuberculosis (TB)

MDPH is responsible for preventing the transmission of TB as well as for preventing the emergence of antibiotic resistance. Very few infectious disease specialists, and even fewer private clinicians, have expertise in treating TB, as the prevalence is low. However, appropriate treatment is crucial to maintaining population health and preventing the emergence of drug-resistant TB. Although a state infectious disease official described significant pressure to close public TB services and consider alternate models, all 21 of these safety net clinics across the state remain open. While primary care is well delivered through a medical service model, TB requires a medical public health model.



There are many things that the public health sector is required to do by law that the private sector does not have the capacity to do: e.g., monitor patients monthly, assess adherence to treatment, do outreach, use incentives, do outbreak investigations, and identify contacts. Care needs to be delivered in conjunction with public health services to meet all these requirements, yet collaborative efforts are still being established. The state still funds TB clinics and contracts for TB services with hospitals, and to some extent, with community health centers and private providers who have the necessary expertise. MDPH is working to raise the awareness among private providers of the resources available to assist them with managing TB infections.

Prior to Chapter 58, most TB clinics did not ask for insurance information, even from those who had coverage, due to the concern that it would be a treatment deterrent. However, according to key informants interviewed, since 2006, asking clients to share insurance information for reimbursement purposes has not appeared to negatively impact care. Of note, the remaining uninsured population is disproportionately represented among TB clinic clients, as the demographics of MA residents remaining uninsured largely overlap with the population of TB patients (e.g., non-citizens, non-English speakers).

- *Opportunities:* Opportunities for TB and public health specialists to work with primary care providers and community health centers are growing. Funding is enabling the development and implementation of an integrated data system to facilitate case management and other functions.

- *Unanticipated consequences:* Using insurance coverage for TB treatment can pose some problems. Required co-pays can deter patients from complying with treatment, particularly for those individuals who are asymptomatic yet still require continuous monitoring and medication. Many of the TB treatment sites have contractual agreements with insurers that prevent waiving of co-pays. This problem has not yet been solved and MDPH is trying to bring national attention to the issue that copays are a disincentive to TB clinic attendance.

Furthermore, TB clinicians assumed that care would be uninterrupted once coverage was obtained, but that was not the case. Some patients enrolled to avoid tax penalties and then dropped coverage due to cost. Many switched among plans due to affordability of rates, resulting in gaps in coverage. As mentioned above under primary care, other subpopulations of TB patients - including non-U.S.-born, substance users, and homeless individuals — chose not to access health care due to various fears and stigma.

While TB clinics gained the opportunity to bill for services, more preparation could have been done. Providers faced challenges with reimbursement for TB care, as it was not included in the highest priority category in the most recent U.S. Preventive Services Task Force list. Other states, such as New Jersey, have been more successful in this area, and stakeholders interviewed suggested that it would be helpful for this issue to be addressed on a national level.

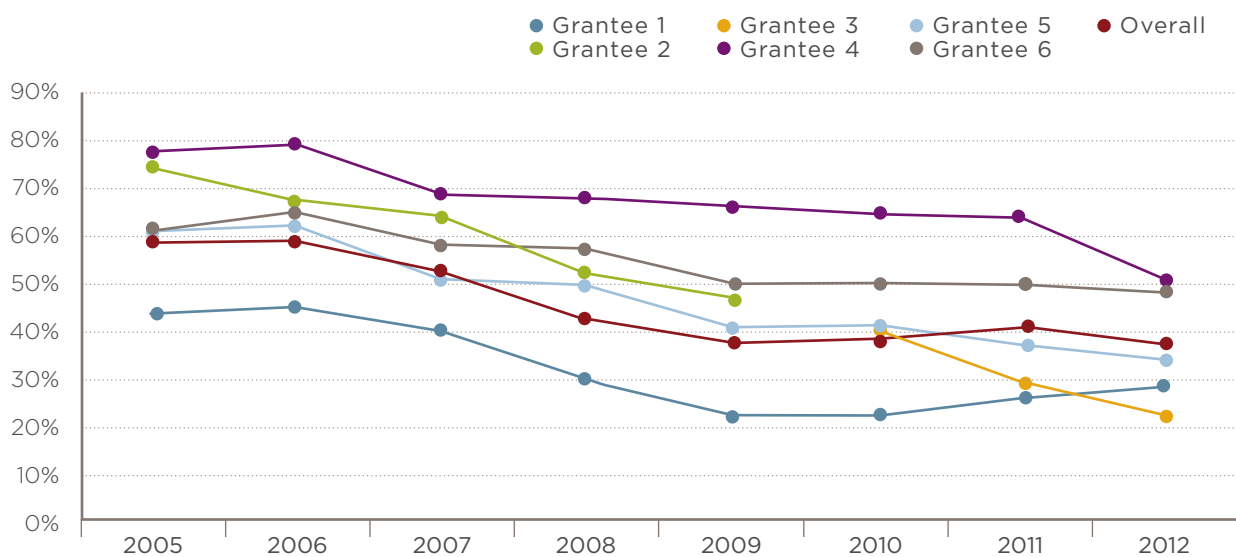


Family planning

Upon the implementation of Chapter 58 in MA, informants recalled that there was concern Title X family planning programs would be perceived as unnecessary given the expectation of universal coverage, despite their value as safety net services. Due to the desire and/or need for confidentiality when seeking family planning services, a significant number of people who use Title X services either do not have, or do not feel able to use, insurance. Billing insurers for family planning services automatically generates an explanation of benefits (EOB) to the policy subscriber. Given the need to maintain confidentiality, particularly for domestic violence survivors and adolescents, insurance is often not accessed. There is a need to put a system in place to prevent automatic EOBs for family planning as well as other sensitive conditions such as STDs.

Data collected across the geographically diverse MA Title X grantees between 2005-2012 (see Figure 2) demonstrates a steady decline in clients who did not have, or did not access, insurance coverage, after the implementation of Chapter 58. As the population of uninsured residents in MA fell to nearly 3%, the percent uninsured among Title X service users declined, as well. However, the proportion of clients reporting that they “did not have insurance that would cover them for primary health care” remains significantly larger than the MA population (from 27% to 52% in 2012, across grantee sites).

FIGURE 2: PERCENT OF UNINSURED PATIENTS AMONG MA TITLE X GRANTEES



Source: DHHS Region I, Family Planning Annual Report, 2012

Notes: Grantee 3 replaced Grantee 2 in 2010. “Overall” reflects the average trend across the grantee sites.



Groups more likely to remain uninsured are overrepresented among family planning clinic clients. Individuals who use family planning services include undocumented immigrants who often fall through the cracks, low-income populations, and many who do not understand insurance very well. In addition, after the closure of MA's STD clinics, more individuals seeking those services confidentially are turning to family planning clinics. In many cases, disease screening is part of family planning care. However, as a stand-alone service, such visits would not be covered under Title X and private reimbursement is not yet recoverable in a confidential manner.

While providers have been able to get reimbursed for services administered to patients who shared their insurance information, the expenses of developing billing processes and contracting with insurers have offset this revenue. Title X family planning grantees have not been successful in contracting with all insurers for several reasons. Some smaller insurers are staff models that offer covered services only when delivered by clinicians they employ and do not contract out for services they provide under their own umbrella. Others will not reimburse for services provided by mid-level practitioners, so the cost-efficient family planning care delivery model has been a barrier. Insurance turnover and gaps in coverage have also been challenging to navigate. The administrative burden of billing an array of plans and tracking the shifting insurance status of clients required additional resources. This was an unanticipated consequence of Chapter 58.

One of the advantages of expanded coverage has been the increased access to higher cost, longer-acting contraceptive methods that are more effective in preventing pregnancy. Yet gaps in coverage affect the efficacy of family planning services.

If an individual loses coverage, medications for contraception will no longer be covered. Such interruptions in contraceptive compliance greatly reduce their value in pregnancy prevention.

See **Vignette 4: Family Planning Services**, p. 48, for more detail.

Chronic disease management

Key informants agreed that it is too soon to see a measurable impact on chronic diseases tied to Chapter 58. The data that is currently accessible is population-based, allowing only for a broad aerial view. In order to discern any movement in this area, a mechanism would need to be created to isolate trend data to newly insured individuals.

Data collection: Future opportunities

Key informants share a concern that the population health impact of Chapter 58 has not been examined closely enough. While short-term impact on service utilization can be documented, longer-term health impacts are still evolving.

Several interviewed stakeholders envision the development of a unified research approach with dedicated resources. State and federal public health professionals could define a set of measures to monitor. Data on utilization patterns and health outcomes focused solely on the group of newly insured individuals need to be identified, isolated, and quantified in order to assess the effects of MA and/or federal legislation. Given the high rate of health insurance coverage in MA prior to reform, the population of newly insured individuals may not be large enough to detect shifts in health outcomes a mere five to six years post-Chapter 58. There is much greater potential to identify health impacts in states with larger increases in access under the ACA.



Vignette 4: Family planning services

Massachusetts has a robust family planning services infrastructure, including free-standing clinics and community health centers. Under health care reform, the demand for family planning clinics has not waned; many clients prefer family planning centers because they are familiar and confidential sources of care, conveniently located, and often have alternate evening and weekend hours.²⁸ A state public health leader shared the following story that occurred in 2007 during the first round of 9C cuts:

“People had the best of intentions and the legislators and governor’s office had impossible jobs as the recession had just hit. Elected officials proposed cutting certain state-funded services in the hope that health care reform would make them less necessary. One such cut involved the grants given to the state’s family planning centers. It had been historically used to provide free services to people who didn’t have insurance or couldn’t afford it.

The assumption of the legislature was that after Chapter 58 many more people would be able to have their services paid for by insurance.”

However, the family planning agencies analyzed their patient characteristics and demonstrated that a third of the people who were getting free services had insurance coverage but were afraid to use it. These patients included teenagers who were on their parents’ insurance plan but didn’t want their parents to know they were using birth control. It also included people who were in relationships where they were worried about violence or abuse if their partner knew of their use of reproductive services. An additional percentage of the clinics’ clients were a disproportionate number of the state’s remaining uninsured.

The family planning providers went to the legislators with the client information and said, *‘It doesn’t seem like expanded insurance coverage is going to justify this extent of a cut.’* The legislators listened and restored the line item.



A state public health researcher asserted:

“State, local, and county health departments’ role is in understanding how population health has changed as a result of medical care reform. This is where all [health departments] and the [federal government] can contribute expertise in finding a set of measures expected to change when people have better coverage and figuring out how to monitor that and see if it’s actually happening. That’s what public health should do.”

One MA interviewee advises other states to 1) look first at process measures to assess access; 2) be strategic about the data to be examined and how to use it; and 3) think about repurposing existing data to try to look at health impact. The Behavioral Risk Factor Surveillance Survey (BRFSS) can be very useful in this endeavor as the survey pre-dated the ACA and can serve as a key data source in all states. Initiatives to supplement the survey to look at coverage issues are underway. Medicaid data may provide a window into the utilization patterns and health outcomes of newly covered individuals. A national study of this data could yield informative results, if supported by collaborative efforts and appropriate resources.

Suggestions of interviewed stakeholders for specific data variables that would be useful to track to assess health care reform’s impact include:

- Data on utilization shifts, i.e., where people seek care in lieu of their health department clinics. Such information could help LHDs target educational interventions to gain provider support and buy-in with public health imperatives.
- Assessment of the extent of absorption of public health functions in clinical settings.
- Infectious disease rates and evidence-based treatment. For example, time to treatment for TB cases to assess whether treatment is delayed as care shifts to primary care providers without the requisite TB expertise.
- Sub-acute ED visits and ED visits for asthma exacerbations and other chronic yet manageable conditions.
- Amenable, or preventable, hospitalization and re-hospitalization rates.
- Long-term health outcomes by monitoring rates and appropriate management of potentially preventable conditions such as heart disease, obesity, etc.
- Health care quality.
- Health care costs.
- Use and impact of CHW, care coordination, and patient navigation services.



Informants stressed that a unified coordinated approach would be an enormous contribution and would greatly advance national understanding of the impacts of health care reform. As a state public health researcher suggested:

“Throughout this country, we should begin pulling together the resources to create meaningful, longitudinal research and evaluation of the community health impacts of medical payment reform.”

Continued roles for public health

Concerns about cuts in public health budgets and services under Chapter 58 were universally voiced. As mirrored in the literature review, stakeholders interviewed underscored the importance of maintaining core public health functions that will not be absorbed by the private sector. A state public health researcher stressed that *“State and local health departments’ traditional roles need to be re-emphasized, not diminished, in medical payment reform.”*

One interviewee went further to suggest that these services would benefit from visible advocacy and marketing. These core functions include:

- *Assessment* - including disease surveillance, epidemiology, outbreak investigation, and targeted screening.
- *Assurance* – specifically that people get the appropriate care from practitioners with specialized knowledge, including outreach, case management, and follow-up.

- *Policy development* – e.g., new laws, guidance, and education.

Key informants frequently stressed the importance of the health department’s role in providing a safety net and facilitating access to care for the highest-risk populations. These interviewees issued frequent reminders that increasing insurance coverage does not mean that everyone has universal access to care. Another important role for the public health system is to expand educational efforts to train primary care providers about the special needs of newly insured populations with attention to population health impact, evidence-based guidelines, and culturally sensitive approaches. There was consensus around the need for support and guidance at both state and national levels, as well as a good marketing strategy, to preserve these critical public health functions.

Improving community health

As previously mentioned, the impact of Chapter 58 and the lagging economy on public health functions and services catalyzed some public health practitioners to reexamine the priorities and role of the field. According to one state public health leader interviewed, *“Public health officials can expect disruptions in services and threats to funding for services that may not be fully covered by insurance, especially for poorly understood services directed to specific vulnerable populations. But there are also opportunities to shift costs and rationalize clinical service delivery so that public health care can focus increasingly on prevention.”*



Another state public health leader contextualized:

“I think we need to keep our eyes on the prize. For me, that’s improving the health of our communities. Medical care is an important piece, but not the answer.”

Several stakeholders interviewed pointed out the need to match population health strategies with the provision of individual medical care. One state public health leader described the need to address community health as follows:

“Segregation of community-oriented health departments and patient-oriented providers is problematic. Prevention and evidence-based care of individuals with conditions that have public health implications should be part of the job of clinical providers and accountable care organizations. ACOs are key. Accountable care organizations should be accountable for the population health of the community they provide services to. They can’t really be responsible to their patients if they allow them to be exposed to tuberculosis. [They] have to see the context of the community those people are living in, and if [ACOs] don’t contribute to that, [they’re] not going to be successful in taking care of those patients in the way that the whole ACO concept is supposed to do.”

This informant asserted that public health participation should be integral to ACOs and encourages national-level attention to the issue of addressing community health. He noted that the Association of State and Territorial Health Officials (ASTHO) and the Council of State and Territorial Epidemiologists (CSTE) are working on this at a national level.



VI. Summary of qualitative findings and associated recommendations

THE ROLE OF PUBLIC HEALTH IN HEALTH CARE REFORM

Findings:

- Health care reform conversations during the formation and passage of Chapter 58 often **focused on insurance coverage and health care access**. The public health tenets of **prevention and health promotion were not prioritized** in initial health care reform discussions. Chapter 58 was seen as a missed opportunity for public health to leverage and/or advocate for dedicated funds to support primary prevention and public health.
- Public health did not have a **strong, coordinated ask** or an overarching and unified public health message when Chapter 58 was being created.
- **Limited public health measures** were included in Chapter 58 to explore **community health workers**; establish the MA Health Disparities Council; require data collection to address health disparities; require smoking cessation coverage for Medicaid patients; and allocate a one-time increase to public health line items.
- Facilitating **outreach and insurance enrollment** for vulnerable populations, **educating populations** about new benefits, and **facilitating multi-sector strategy sessions** were key roles for public health to play following the passage of Chapter 58.
- Creating a strong and sustained collaboration of diverse stakeholders to develop, promote, and implement CHW-related policies was important to successful advocacy efforts and effective policies. Broad-based policies (e.g., MDPH-supported training and services for CHWs and state contracting policies requiring employers to support educational opportunities and provide supervision for CHWs) combined with consistent and powerful advocacy from the leaders of the CHW workforce and state public health partners **secured the ongoing integration of community health workers** in state health care reform efforts.³³
- Collecting and **sharing success stories** resulting from expanded access were instrumental in gaining public approval and achieving success in health care reform endeavors.
- The **economic recession confounded** the ability to ascertain the impact of Chapter 58 on the structure and function of health departments and programs.
- A set of metrics, to understand if and how health care reform impacts population health outcomes, is needed.
- Safety net services may become vulnerable under health care reform because of a lack of understanding of the important continued role of such services.



Recommendations:

- **Insert population health and prevention into the health care reform conversation.** The public health field needs to ready itself to **speak the language** of insurers and clinicians, identify **collaborative public health priorities**, and work towards **coordinated and feasible appeals**.
- **Break down silos** between health issue areas and multi-disciplinary sectors from a public health perspective to develop non-traditional partnerships in order to create a robust, strategic approach to health care reform implementation.
- **Expand public health departments' community health worker workforce** and engage and train CHWs and other paraprofessional community providers to **provide outreach** to and facilitate enrollment and navigation for vulnerable populations. Mobilization of the CHW workforce is an essential and cost-effective strategy for public health to address health disparities and promote health equity.
- **Demonstrate the value of prevention** through collecting data to document the **return on investment** for prevention efforts and emphasize its potential to reduce overall health care costs.
- **Message public health** as an important strategy for overall health care cost reduction.

LOCAL HEALTH DEPARTMENTS

Findings:

- **Local health departments (LHDs) were not involved** in the formation and, for the most part, implementation of Chapter 58.
- Due to the unique structure of MA's LHD system, Chapter 58 **did not impact the majority** of MA's 351 small LHDs, as most do not provide significant clinical or safety net services. The biggest effect on LHDs was the reimbursement potential of flu clinics. Only **the largest** LHD, Boston Public Health Commission, with robust programs for vulnerable populations, **reported tangible impacts** due to the legislation.
- LHDs and safety net providers **do not have the infrastructure or administrative resources** necessary for insurance contracting and billing. One informant noted that online toolkits are now being developed to assist with training around billing for reimbursable services.
- **School-based health centers (SBHCs)** are still a critical entry point in providing care to underserved and vulnerable youth, but **face challenges** in the new health care reform environment.
- Information and documentation on the impacts of reform on LHDs remain scarce.



Recommendations:

- **Provide resources, training, and the infrastructure** to public health departments and safety net providers needed to **bill insurers** for previously state-funded services. LHDs need to become savvy about contracting and reimbursement. If local health departments continue to provide billable services, they will need to arrange for appropriate reimbursement systems or contract with external billing services. LHDs should build their own internal capacity, work with other providers to prepare for the increase in patient volume, and develop, or contract with, billing systems to maximize resources and identify which services are reimbursable. Improvements to billing infrastructures would support financial sustainability. LHDs should reach out to accountable care organizations and hospitals to promote prevention efforts and identify ways to be reimbursed for prevention. The National Association of City and County Health Organizations (NACCHO) has information on public health departments becoming billable providers.
- **Integrate school-based health centers into systems of care** in the community (e.g., the patient-centered medical home) and work with accountable care organizations (ACOs) to incorporate SBHCs into their scope of practice and develop the necessary protections to confidentiality for youth services. The ACA's emphasis on enhancing the role of primary care through the patient-centered medical home model provides an opportunity for SBHC integration into systems of care in the community.²² Furthermore, LHDs can work with ACOs to help them incorporate SBHCs into their practices. If SBHCs are recognized as part of an ACO and can document their effectiveness in promoting the health and wellness of their enrollees through care delivery, they may have

the potential to obtain part of the reimbursement that the health care system receives from the insurance company.

- **Define the core mission** of LHDs and coordinate efforts with other community programs. In tight economic times, LHDs and the broader public health field should **reexamine their scope of work to streamline resources and eliminate duplication** of services, particularly in the context of near-universal health insurance. In the new health care reform environment, assessing the clinical and preventive services landscape for other strong community partners could provide LHD services more efficiently and at a lower cost than what the LHD can provide.

SAFETY NET

Findings:

- There continues to be an essential **need for public health services and safety net programs.**
- **Client volume and capacity increased** post-Chapter 58 at community health centers.
- **Utilization of safety net hospitals increased.**
- **Budget cuts were severe** in anticipation of universal coverage and reimbursement for services.
- With expanded coverage, revenue from billable services did increase, although insurance **reimbursement rates were perceived as low.**
- **Some services delivered were not billable** (i.e., those performed to meet the complex needs of the safety net population).
- A significant proportion of safety net **patients remained uninsured.**
- The **cost and burden of enrollment efforts and billing processes** were not sufficiently recognized.



- Insurers were **swamped with provider credentialing requests**, resulting in delayed patient care.
- **Electronic health records provide the capacity** to automate support of evidence-based clinical preventive services.
- Bridges are beginning to **link individual care with community health**.

Recommendations:

- **Maintain a safety net, which is essential** to care for uninsured and vulnerable populations.
- Begin the process of **securing contracts and credentialing with all MCOs as early as possible** to minimize delays in a provider's ability to see new patients.
- **Coordinate efforts in approaching health plans** to pay for preventive, public health, and safety net services through CHCs and LHDs. Working with someone who can facilitate relationships with high-level executives at the health plans is key.
- **Track the administrative cost** in staff time to do patient enrollment and quantify costs to enroll one patient. This data is useful when negotiating rates with insurers.
- **Put supports in place to prevent burnout** among administrative and enrollment staff.
- **Retain grant funding** to cover gaps in insurance payments and underpayments.
- **Formalize collaborations** between private primary care providers, safety net providers, and community public health services by creating mutual agreements about how services can interface, support, and complement one another.

CLINICAL AND PUBLIC HEALTH OUTCOMES

Findings:

- **Coverage does not equal care.** Many vulnerable populations are unaware and/or wary of enrollment systems. Gaps in coverage, co-pays, and formulary restrictions interrupt care continuity.
- **Physician supply** was noted as a **pre-existing deficit** and was **not further depleted** as a result of expanded insurance coverage. In fact, in some areas, physician capacity increased as a result of loan repayment/forgiveness programs. For the most part, wait times for appointments were not related to physician supply or patient influx but rather due the administrative bottleneck of health plan credentialing.
- Accessing health **insurance coverage creates a barrier for those seeking treatment for sensitive issues** (such as STDs, HIV, family planning, and mental and behavioral health) due to the automatic generation of explanation of benefits documentation to policyholders. Previously, under certain conditions, subcontractors provided these services anonymously with state funding.
- Many primary care providers **do not have the expertise to address some diseases with population health significance** (e.g., TB) and/or do not have the support staff or cultural capacity to meet the needs of some vulnerable, previously uninsured subpopulations.
- Chapter 58 health care reform legislation **did not address primary prevention, social determinants of health**, nor population/community health issues.



- **Coordinated efforts to evaluate** many process and outcome measures of health care reform have not occurred. The few studies that have been conducted have been population-based rather than focused specifically on the group of newly insured individuals.
- It is **too soon to detect impacts** of increased coverage and access **on health outcomes** as disease development and behavioral changes take many years to manifest.

Recommendations:

- Ensure that **public health interests are considered** and integrated into the management of the health insurance exchanges.
- Create secure systems to **protect confidentiality of treatment**. MA advocacy organizations are currently trying to promote new policies to avoid automatic generation of EOBs to enable confidential access to coverage under certain circumstances (e.g., STDs, family planning, school health clinics, mental health, and substance use). There may be value in continued provision of certain services by public health if the use of insurance poses genuine barriers. Careful and thoughtful consideration must be given as to where and when this is needed.
- **Offer significant provider education and training** to ensure that diseases with population impacts will be addressed according to evidence-based prevention and treatment guidelines.
- Use the larger **lens of population/community health** to understand how to truly reform health, health care, and impact individual outcomes. **Addressing social determinants** of health and changing cultural norms around health and behavior are required to truly impact population health outcomes.
- Develop an **explicit research agenda/protocol** and a long-term monitoring system to assess the impact of health care reform at the **national level** and allocate appropriate resources for ongoing implementation.



VII. Conclusions: Lessons learned for the nation

Massachusetts's experience with Chapter 58 is unique in many ways due to the structure of MA's public health enterprise as well as the focused scope of the legislation upon health insurance coverage and access. Yet, in reflecting upon the lessons learned from MA's Chapter 58 experience, all stakeholders interviewed had reflections to share with public health departments, providers, and practitioners across the nation. The high-level lessons learned are discussed in this section.

SHIFTING ROLES FOR PUBLIC HEALTH AGENCIES: EMERGING AND EXPANDING OPPORTUNITIES

As clinically-oriented services shift to more traditional (public and private) primary care realms, new gaps that the public health system can fill are becoming evident. Newly emerging and expanding roles for the public health sector include opportunities to engage in the political process; convene non-traditional partners; empower consumers through outreach, enrollment, and navigation; provide education and training for clinicians; and monitor and evaluate the process and outcomes of health care reform efforts.

ENGAGING IN THE PROCESS TO DESIGN AND IMPLEMENT HEALTH CARE REFORM: GETTING A SEAT AT THE TABLE

The critical nature of ensuring that the public health sector gets a seat at the table and learning the language necessary to engage as a full partner in the health care reform conversation was a unanimous theme that emerged. As one interviewee advised, public health's attitude at the health care reform table should be as follows: *"Get in there. Get to the table as a full partner and know that you've got a role."*

Being a key player in health care reform and negotiating compromises is also essential to forging important partnerships that can lead to future and even more progressive public health endeavors.

COORDINATING THE PUBLIC HEALTH MESSAGE AND DEVELOPING THE POWER TO BE EFFECTIVE

Collaboration across public health silos is crucial to build and present a coordinated public health message to represent community and population health interests at the health care reform table. The public health message should focus on education about the public health mission and the importance of incorporating prevention and health promotion goals in the reform process, as well as public health's economic value in terms of return on investment. The public health message is best delivered with a clear, coordinated vision, well-crafted proposals, and a strong, unified voice.



CONVENING AND MAINTAINING MULTI-SECTOR COALITIONS: PUBLIC HEALTH AS THE CHIEF HEALTH STRATEGIST

This research affirmed the literature’s assertion that under MA and national health care reform, new opportunities exist for public health departments and the broader public health field to be “the chief health strategist in communities” and to assume “greater accountability for the design and development of the overall strategic plan for improving health in communities.”³³ A broad and multi-sectoral coalition was key in the passage and successful implementation of Chapter 58 and the public health sector is poised to facilitate and sustain such collaborations. Forming multi-sector coalitions in other states may be a challenge since such coalitions may not have existed before the passage of the ACA. Yet it is important for the public health system to recognize and seize the opportunity to play a key role in convening non-traditional partners in the new health care reform environment.

EMPOWERING CONSUMERS THROUGH OUTREACH, EDUCATION, AND NAVIGATION

The public health sector can take the lead in establishing and implementing straightforward collaborative methods to identify uninsured individuals and coordinate outreach efforts across agencies to maximize efficiency and efficacy. Public health professionals can raise consumer awareness of enrollment benefits by facilitating public and private funding to develop and launch highly visible media campaigns as well as by engaging community agencies to reach vulnerable populations.

As demonstrated through MA’s successful community health workers initiative catalyzed by Chapter 58, patient navigation is an immediate role that public health can play in promoting individual coverage and health. Patient navigation by non-traditional providers increases the likelihood that beyond enrolling in insurance plans, people are equipped to maximize the benefits and opportunities of the health care system to improve their health.

PROVIDING EDUCATION AND TRAINING FOR CLINICIANS

As primary care clinicians take on patients from vulnerable populations and are tasked with treating diseases that impact population health, they will benefit from the expertise of public health professionals. The public health sector can provide training to enhance sensitivity to the psychosocial and cultural needs of newly insured individuals. Public health specialists can provide guidance on the implications of medical conditions with public health significance and can disseminate and reinforce evidence-based treatment protocols. Capitalizing on the resources dedicated to electronic health records, these tasks can be facilitated by utilizing automated tools to systematize alerts and educational materials targeted to specific public health issues and clinical preventive services.



PROACTIVELY PREVENTING WORKFORCE SHORTAGES AND DELAYS IN CARE

As insurance coverage expands, it is important to ensure that there is an adequate supply of physicians and ancillary health care providers to accommodate the likely influx of patients seeking services. This is particularly important in light of pre-existing nationwide primary care physician shortages and in states that will experience even greater increases in newly insured residents than in MA. Workforce expansion initiatives, such as loan forgiveness programs to entice health care providers to work in underserved areas and community health centers, can be effective. Furthermore, training and expanding the use of mid-level practitioners and community health workers can not only increase capacity and cut down on appointment wait times, but can also effectively reach the most vulnerable populations. Pre-enrolling or expediting provider credentialing processes by all area insurers, as well as allowing temporary or retroactive provisions for providers waiting to get credentialed, can also prevent delays in care by enabling providers to see patients expeditiously, regardless of who the payer is.

COORDINATING DATA COLLECTION, MONITORING, AND EVALUATION IS KEY

Collecting baseline information at the outset of ACA implementation and establishing procedures to monitor the process and outcomes of health care reform efforts regularly is critical to developing an understanding of the efficacy and impact of these efforts. Developing and pursuing this research agenda on a national level would be ideal.

As more individuals across the nation enroll in health insurance plans, it will be important to not only measure health insurance access and care utilization, but also health outcomes and racial and ethnic data to address health disparities. Opportunities for collaboration and data sharing across state and local departments should be identified and memoranda of understanding forged in order to ensure that evaluation of programs and policies show the impact of health care reform in national, state, and local contexts.

CONTEXTUALIZING REFORM THROUGH A POPULATION HEALTH LENS

Attention to population and community health should be integral to health care reform efforts. Beyond covering individuals, managed care and accountable care organizations would reduce costs and maximize revenue by investing in prevention and health promotion initiatives that have broad community impact. Through Chapter 58, one of public health's biggest wins in terms of integrating population health into health care reform was the inclusion of the mandated pilot tobacco cessation benefit under MA's Medicaid program, MassHealth, and its striking success. National level attention to addressing prevention, wellness, and community health would send a powerful message to payers, providers, consumers, and state government officials and would ultimately reduce costs and improve individual and population health status.



PREVENTION AND WELLNESS TRUST FUND

Established via Chapter 224 and administered by the MA Department of Public Health in collaboration with the Prevention and Wellness Advisory Board, monies from the Prevention Trust are to be used to: reduce the rate of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and/or build evidence on effective prevention programming. Allocating an ample and protected budget for prevention and health promotion efforts is an important vehicle for addressing population and community health issues. MA's innovative Prevention and Wellness Trust Fund is a model that can be replicated on a broad scale.

LOOKING FORWARD

Lessons learned from the MA experience with the initial stages of implementing the health care reforms mandated by Chapter 58 serve as instructive messages for states across the nation. Further experiences with subsequent reforms in MA that expand upon Chapter 58's provisions (e.g., Chapters 305, 288, and 224) can enrich the examples of this model. States embarking on health care reform can embrace the findings and recommendations of this qualitative research to inform their strategies and efforts, avoid pitfalls, and increase the likelihood of successfully expanding access and improving individual and community health.



VIII. References

- ¹ Graves JA & Swartz K. Health care reform and the dynamics of insurance coverage — Lessons from Massachusetts. *New Engl J Med*. 2010; 367(13): 1181–1184.
- ² Henry J. Kaiser Family Foundation. Massachusetts health care reform: Six years later. [Internet]. 2012. Retrieved from <http://kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later/>
- ³ Long SK. What is the evidence on health reform in Massachusetts and how might the lessons from Massachusetts apply to national health reform? [Internet]. 2010. Retrieved from <http://www.urban.org/publications/412118.html>
- ⁴ Long SK, Stockley K, & Dahlen H. National reform: What can we learn from evaluations of Massachusetts? [Internet]. 2011. Retrieved from <http://www.shadac.org/publications/national-reform-what-can-welearn-evaluations-massachusetts>
- ⁵ Patel K, McDonough J. From Massachusetts to 1600 Pennsylvania Avenue: Aboard the health reform express. *Health Aff (Millwood)* [Internet]. 2010 Jun;29(6):1106–11. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20530338>
- ⁶ Raymond AG. Lessons from the implementation of Massachusetts Health Reform [Internet]. 2011 Mar. Available from: <http://bluecrossmafoundation.org/publication/lessons-implementation-massachusetts-health-reform>
- ⁷ Auerbach J. *Health Care Reform and Public Health*. New Orleans, LA; 2013.
- ⁸ McDonough JE, Rosman B, Phelps F, Shannon M. The third wave of Massachusetts health care access reform. *Health Aff*. 2006;25(6):w420–w431.
- ⁹ Gosline A, Rodman E. Summary of Chapter 224 of the Acts of 2012 [Internet]. 2012. Available from: <http://bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012>
- ¹⁰ Wall S. Transformations in public health systems. *Health Aff* [Internet]. 1998 May [cited 2013 Jul 2];17(3):64–80. Available from: <http://content.healthaffairs.org.ezproxy.bu.edu/content/17/3/64>
- ¹¹ Hyde J, Tovar A. Strengthening Local Public Health in Massachusetts: A Call to Action [Internet]. 2006. Available from: http://sph.bu.edu/images/stories/scfiles/strength_lph_6_06.pdf
- ¹² U.S. Census Bureau. State Population-Rank, Percent Change, and Population Density [Internet]. 2010 [cited 2013 Aug 28]. Available from: <http://www.census.gov/compendia/statab/2012/tables/12s0014.pdf>
- ¹³ Hall M. The costs and adequacy of safety net access for the uninsured. Robert Wood Johnson Found [Internet]. 2010 [cited 2013 Sep 6]; Available from: <http://www.newpublichealth.org/content/dam/supplementary-assets/2010/06/safetynetmass201006.pdf>
- ¹⁴ Henry J. Kaiser Family Foundation. Consumers' experience in Massachusetts: Lessons for national health reform [Internet]. 2009 Sep. Available from: <http://kff.org/health-costs/report/consumers-experience-in-massachusetts-lessons-for-national/>
- ¹⁵ Cunha G. Ongoing Analysis of the Health Safety Net Trust Fund: MassHealth's New Prepayment Obligations, March 2013 - health-safety-net-march-2013.pdf [Internet]. Boston; 2013. Available from: <http://www.mass.gov/ig/publications/reports-and-recommendations/2013/health-safety-net-march-2013.pdf>
- ¹⁶ American Public Health Association. The role of community based public health programs in ensuring access to care under universal coverage [Internet]. Washington, DC; 2009 Oct. Available from: <http://www.apha.org/advocacy/Health+Reform/>
- ¹⁷ Ku L, Jones E, Shin P, Byrne FR, Long SK. Safety-net providers after health care reform: Lessons from Massachusetts. *Arch Intern Med*. 2011;171(15):1379.
- ¹⁸ National Association of Public Hospitals and Health Systems. Massachusetts health reform: Lessons learned about the critical role of safety net health systems [Internet]. 2009 Apr. Available from: <http://www.naph.org/Homepage-Sections/News/Announcements/MA-Reform-Paper.aspx>
- ¹⁹ Blue Cross Blue Shield of Massachusetts Foundation. Section 108: MassHealth Tobacco Use Cessation and Prevention Program [Internet]. 2012 [cited 2013 Dec 17]. Available from: <http://bluecrossmafoundation.org/content/section-108-masshealth-tobacco-use-cessation-and-prevention-program>
- ²⁰ Land T, Warner D, Paskowsky M, Cammaerts A, Wetherell L, Kaufmann R, et al. Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in smoking prevalence. *PLoS One*. 2010;5(3):e9770.



- ²¹ Auerbach J. Lessons from the front line: The Massachusetts experience of the role of public health in health care reform. *J Public Heal Manag Pract* [Internet]. 2013 Jun [cited 2013 Dec 20];19(5):488–91. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23760308>
- ²² Long SK, Stockley K. Sustaining Health Reform In A Recession: An Update On Massachusetts As Of Fall 2009. *Health Aff* [Internet]. 2010 Jun [cited 2013 Mar 5];29(6):1234–41. Available from: <http://content.healthaffairs.org/content/29/6/1234>
- ²³ Urban Intitute Health Policy Center. Massachusetts and Health Reform: Papers, Policy Briefs, and Research Reports [Internet]. 2012 [cited 2013 May 23]. Available from: http://www.urban.org/health_policy/Massachusetts-and-Health-Reform.cfm
- ²⁴ Massachusetts Budget and Policy Center. MassBudget Brief: What Are 9C Cuts? [Internet]. Available from: http://massbudget.org/report_window.php?loc=9CAuthority.html
- ²⁵ Boston Public Health Commission. Boston Public Health Commission: Our Mission [Internet]. [cited 2013 Nov 8]. Available from: <http://www.bphc.org/about/officedirector/Pages/Home.aspx>
- ²⁶ Keeton V, Soleimanpour S, Brindis CD. School-based health centers in an era of health care reform: Building on history. *Curr Probl Pediatr Adolesc Health Care* [Internet]. 2012 Jul [cited 2013 Apr 10];42(6):132–56; discussion 157–8. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22677513>
- ²⁷ Ammeran A. School Based Healthcare: Why it is common sense. *SouthEast Educ Netw* [Internet]. 2010; Available from: <http://www.seenmagazine.us/Sections/ArticleDetail/tabid/79/ArticleID/582/smid/403/reftab/317/Default.aspx>
- ²⁸ Taylor T. The Role of Community-Based Public Health Programs in Ensuring Access to Care Under Universal Coverage [Internet]. *American Public Health Association Issue Brief*. 2009 [cited 2013 Jun 27]. Available from: <http://www.apha.org/NR/rdonlyres/48621EFE-9732-4744-83A2-1389763D65D8/0/CommunityBasedReformupdtd.pdf>
- ²⁹ Ku L, Jones E, Finnegan B, Shin P, Rosenbaum S. How is the primary care safety net faring in Massachusetts: Community Health Centers in the midst of health reform [Internet]. *Community health centers in the midst of health reform*. Washington, D.C.; 2009. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7878.pdf>
- ³⁰ Goodman DC, Fisher ES. Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription. *N Engl J Med*. 2008 Apr;358(16):1658–61.
- ³¹ Massachusetts Medical Society. 2012 Massachusetts Medical Society physician workforce study [Internet]. 2012 Oct. Available from: <http://www.massmed.org/News-and-Publications/Research-and-Studies/2012-MMS-Physician-Workforce-Study/>
- ³² McDonough JE. *Inside National Health Reform* [Internet]. University of California Press; 2011 [cited 2013 Aug 28]. Available from: <http://books.google.com/books?id=0kAiLhlf6bUC&pgis=1>
- ³³ Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Willaert AM, Scott JR, et al. Community health workers: Part of the solution. *Health Aff (Millwood)* [Internet]. 2010 Jul;29(7):1338–42. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20606185>
- ³⁴ Massachusetts Public Health Association. Massachusetts Association of Community Health Workers [Internet]. 2006. Available from: <http://www.mphaweb.org/MACHW.htm>
- ³⁵ Mason T, Wilkinson GW, Nannini A, Martin CM, Fox DJ, Hirsch G. Winning policy change to promote community health workers: Lessons from Massachusetts in the health reform era. *Am J Public Health* [Internet]. 2011 Dec [cited 2013 Nov 10];101(12):2211–6. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22021281>
- ³⁶ Massachusetts Department of Public Health. *Community Health Workers in Massachusetts: Improving Health Care and Public Health: A Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council* [Internet]. 2009. Available from: <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf>
- ³⁷ Trust for America's Health. *A Healthier America 2013: Strategies To Move From Sick Care To Health Care In The Next Four Years* [Internet]. 2013 [cited 2013 Apr 28]. Available from: <http://healthyaamericans.org/assets/files/TFAH2013HealthierAmerica07.pdf>



IX. Appendices

APPENDIX A: EXECUTIVE SUMMARY OF UNIVERSAL HEALTH INSURANCE ACCESS EFFORTS IN MA: A LITERATURE REVIEW

The federal Patient Protection and Affordable Care Act (ACA), passed in 2010, was largely modeled after the Massachusetts (MA) 2006 Health Care Reform effort (Chapter 58) (*Graves & Swartz, 2012; Henry J. Kaiser Family Foundation, 2012; Long 2010; Long, Stockley, & Dahlen, 2011; Patel & McDonough, 2010; Raymond, 2011*). Entitled *An Act Providing Access to Affordable, Quality, Accountable Health Care*, Chapter 58 aimed to provide near-universal health insurance coverage for MA residents through shared individual, employer, and government responsibility (*McDonough, Rosman, Butt, Tucker, & Howe, 2008; Patel & McDonough, 2010*).

Title I of the ACA most closely resembles Chapter 58 and Massachusetts's previous insurance reform efforts, as they both primarily focus upon increasing insurance coverage for the population through insurance-market reforms, individual mandates, and insurance subsidies (*McDonough, 2011*). Given the parallels, the lessons learned from Massachusetts are valuable to inform the implementation of the ACA and its potential impact upon the public health enterprise throughout the United States.

The experience of Chapter 58's passage and implementation is unique in several important ways, which will be important to bear in mind when applying lessons learned in Massachusetts to the rest of the United States. Before reform, MA had a political environment that was particularly favorable to expanding coverage (*Patel & McDonough, 2010; Raymond, 2011a*); tightly regulated small-group and non-group insurance markets (*McDonough,*

Rosman, Phelps, & Shannon, 2006); a significantly lower insurance rate as compared to the rest of the nation (*Auerbach, 2013; McDonough et al., 2006*); and one of the best health care access systems in the U.S. for low-income, uninsured populations (*Hall, 2010*). Additionally, MA has a unique governmental public health system that is decentralized and much less likely than other states to directly provide clinical and safety net services.

This document reviews the existing body of peer-reviewed and grey literature to understand the impact of MA's health care reform efforts upon public health practice and population health outcomes. Specifically, this document describes the impact of Chapter 58 on health insurance coverage, access to care, chronic disease management, infectious diseases, utilization of emergency services, screening and preventive care, smoking cessation, safety net provider utilization, the role of safety net providers in enrollment, safety net finances, and public health programs.

In addition, lessons learned from the MA experience are described, addressing the following content areas:

- Successful strategies used by MA to enroll uninsured individuals and increase access to care;
- Identifying the remaining uninsured/underinsured populations and barriers to accessing care;
- The impact of health care reform upon clinical health and public health services; and
- The role of public health leadership in health care reform.



This literature review also identifies the following gaps in the literature to understand Chapter 58's impact in MA. These gaps include the following:

- The short-term impact of Chapter 58 on
 - » Provider supply and practice patterns;
 - » Local health departments in MA;
 - » The structure and funding of the safety net;
 - » The extent to which public health functions were absorbed into clinical settings;
 - » Certain health outcomes which have not been analyzed; and
 - » Health care quality and costs.
- The long-term effects of Chapter 58 on health outcomes and utilization.

These gaps were explored through qualitative interviews with key informants who were involved in the passage and implementation of Chapter 58. The findings from these interviews are detailed in a qualitative findings report. Highlights from both the literature review and the qualitative findings report were developed into a case study documenting MA's universal health insurance access efforts. The lessons learned from the MA experience were extrapolated to the national scale and presented in the case study to help other states anticipate the potential impact of the ACA in their own context.

Lastly, while the ACA focuses on affordable insurance coverage and expansion, it also includes areas that Chapter 58 did not address as extensively or at all. These areas, such as health care cost and quality and building up the health care workforce, were addressed through the following MA legislation: *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care* (Chapter 305) passed in 2008; *An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses* (Chapter 288) passed in 2010; and *An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation* (Chapter 224) passed in 2012. While analyzing the impact of Chapters 305, 288, and 224 on MA's public health enterprise goes beyond the scope of this literature review and the subsequent qualitative report and case study, future studies are recommended to more fully understand the impact of MA's health reform efforts to date and draw lessons learned for the rest of the country.



APPENDIX B: KEY INFORMANT INTERVIEW GUIDE

Qualitative Research Goals:

To identify and understand lessons learned from MA's Chapter 58 to inform other states in preparation for the implementation of the Patient Protection and Affordable Care Act.

Approach:

- Develop a list of questions informed by gaps revealed via the literature review.
- Develop an interview guide.
- Identify up to 35 key stakeholders in each of the following categories (approximate number in each category):
 - » State Health Department (4-6)
 - » Local Health Departments (3-4)
 - » Local Public Health Department Associations (3)
 - » Health Care and Public Health Associations (4)
 - » State Policy Leaders (2-3)
 - » Legislative Policy Leaders (4)
 - » Organizational Policy Leaders (2-3)
 - » Academic Leaders (3)
 - » Other Safety Net and Advocacy Leaders (3-4)

- Schedule and conduct interviews.
- Revise and add to interview questions as needed based on findings from literature review and initial interviews.
- Expand list of informants as time allows as new relevant stakeholders are identified.
- Analyze interview notes to identify and extract emergent themes.
- Summarize emergent themes and delineate lessons learned.

Note: See below for draft key informant interview guide.



Health Care Reform in MA: Qualitative Interviews

KEY INFORMANT INTERVIEW GUIDE

DRAFT: May 31, 2013

[NOTE: QUESTIONS FOR THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT AND WILL BE MODIFIED BASED UPON THE KEY INFORMANT BEING INTERVIEWED.]

I. BACKGROUND (5 minutes)

- Hi, my name is _____ and I am with Health Resources in Action. Thank you for taking the time to speak with me today.
- The CDC, via the National Network of Public Health Institutes (NNPHI), has engaged us to conduct quantitative and qualitative research to develop a case study of the impact of health reform, and specifically Chapter 58 in MA to serve as a learning tool for other states in planning for the implementation of the Patient Protection and Affordable Care Act.
- We are conducting interviews with governmental and non-governmental leaders to fill in the gaps in knowledge about the various impacts of the health reform process, implementation and outcomes. We are interested in your perspective, feedback, and insight. Your story will help us to develop a list of “lessons learned” from the MA experience.
- Our interview will last about ____ minutes [EXPECTED RANGE FROM 30-60 MINUTES, DEPENDING ON INTERVIEWEE]. After all of the interviews are completed, we will write a summary report of the general themes that emerged. We will not attach identifiers to specific quotes or feedback unless permission is granted. A list of interviewees will appear as an appendix to our report.
- Any questions before we begin our discussion?

II. QUESTIONS

A. *Connection to Chapter 58*

1. What has your connection been to Chapter 58 reform efforts - either during the passage or implementation?

B. *Planning and Preparation for Chapter 58*

1. Was there anticipation that previously or currently funded public health services would be paid for (or cut) after Chapter 58? If so, which?
2. Were there anticipated cost savings?
3. Were there anticipated changes in access to care?
4. Were there anticipated changes in quality of care?
5. How did your organization prepare for these changes? How was implementation handled?
(For organizations)
6. Who/what were your sources of information in anticipating or planning for Chapter 58 implementation?



C. Impact of Chapter 58

1. What was realized and what resulted to your knowledge?
2. Do you now believe that your expectations were an accurate assessment of the changes in:
 - a. Cost
 - b. Access
 - c. Quality?
3. What were the important unanticipated results of Chapter 58 (positive and negative) and how were they addressed?
4. In hindsight, how could these have been foreseen and/or planned for?

D. Role of Public Health and Safety Net Providers in Chapter 58

1. What role did DPH or local health departments play during the formation and implementation of Chapter 58? How helpful was it?
2. For state and local health departments or safety net providers:
 - a. Were there changes to the structure or function because of Chapter 58? How were they affected?
 - b. Were there any legislative changes or changes to regulations?
 - c. Were there any budgetary impacts? Financing or funding changes?
 - d. What lessons were learned during the implementation of health reform that might inform other states as they implement the ACA?

E. Lessons Learned

1. What were other ways you saw Chapter 58 affecting public health in MA?
2. What were the important unanticipated results of Chapter 58 (positive and negative) and how were they addressed?
3. In hindsight, how could these have been foreseen and/or planned for?
4. What might other states do to insure that public health has a voice in the planning and implementation processes?
5. Are there lessons learned from the experience that might be useful for other states that are implementing the ACA?
6. How can public health message itself to promote the need for public health services and funding in the health reform conversation?

F. Evaluation

1. Do you have access to data that might be helpful?
2. In hindsight, are there outcomes or data points that have not been tracked but would be helpful for states just embarking on ACA implementation to keep an eye on and use as measures/benchmarks?
3. Is there anyone else that you recommend we speak with?

III. CLOSING (2 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

Thank you again. Have a good day.



APPENDIX C: KEY INFORMANTS INTERVIEWED

Name	Organizational Affiliation(s) (relevant to Chapter 58)
Al DeMaria	MA Department of Public Health
Amy Whitcomb-Slemmer	Health Care For All
Barbara Ferrer	Boston Public Health Commission
Brian Rosman	Health Care For All
Bruce Cohen	MA Department of Public Health
Cheryl Sbarra	Massachusetts Association of Health Boards
Christie Hager	MA State Legislature, U.S. Health and Human Services
Claude Jacob	Cambridge Department of Public Health
Derek Brindisi	Worcester Department of Public Health
Donna Lazorik	MA Department of Public Health
Elaine Kirshenbaum	MA Medical Society
Gail Hirsch	MA Department of Public Health
Geoff Wilkinson	MA Department of Public Health
Harold Cox	Boston University School of Public Health
Jason Lewis	MA State Legislature
John Auerbach	MA Department of Public Health, Boston Public Health Commission
Justeen Hyde	Institute for Community Health
Kathleen Desilets	Department of Health and Human Services - Region I Family Planning
Kristin Golden	MA Department of Public Health, Boston Public Health Commission
Madeleine Biondolillo	MA Department of Public Health
Matt Fishman	Partners HealthCare
Nancy Turnbull	Harvard School of Public Health
Pat Edraos	MA League of Community Health Centers
Sarah Iselin	Blue Cross Blue Shield of MA
Sue Etkind and two colleagues	MA Department of Public Health
Susan Servais	Massachusetts Health Council
Valerie Bassett	MA Public Health Association, Boston Public Health Commission



For more information, please visit www.hria.org.
For inquiries, please email Brittany Chen, Senior Program Manager
at bchen@hria.org or call **617-279-2240 ext. 324**.



Health Resources in Action
Advancing Public Health and Medical Research