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Health Resources in Action (HRiA) is a national non-pro t 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.

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Universal Health Insurance Access Efforts in MA: A Literature Revie

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I. Executive Summary

The federal Patient Protection and Affordable Care Act (ACA), passed in 2010, as largel 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 bet een the ACA and MA's health care reform efforts, the lessons learned from MA's e perience are • aluable 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 identi es 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 ndings 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

- 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

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 Td [(inmvty)]2k in Td [(u(ino)15.9(vide ia(vide ia(viddv)6.1(e me

III. Qualitative research approach

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted to address the gaps identi ed in the literature review and to gain qualitative rst-hand insight into the process and impacts of the implementation of Chapter 58. Key informants were strategically targeted based upon the areas identi ed 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 ndings 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.

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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

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However, because many of them were involved in subsequent health care reform efforts in MA, interviewees often struggled to limit their comments

IV. Context of health care reform in MA

The follo ing section pro• ides highlights from the literature re• ie describing Massachusetts's unique conte t and public health enterprise. For further

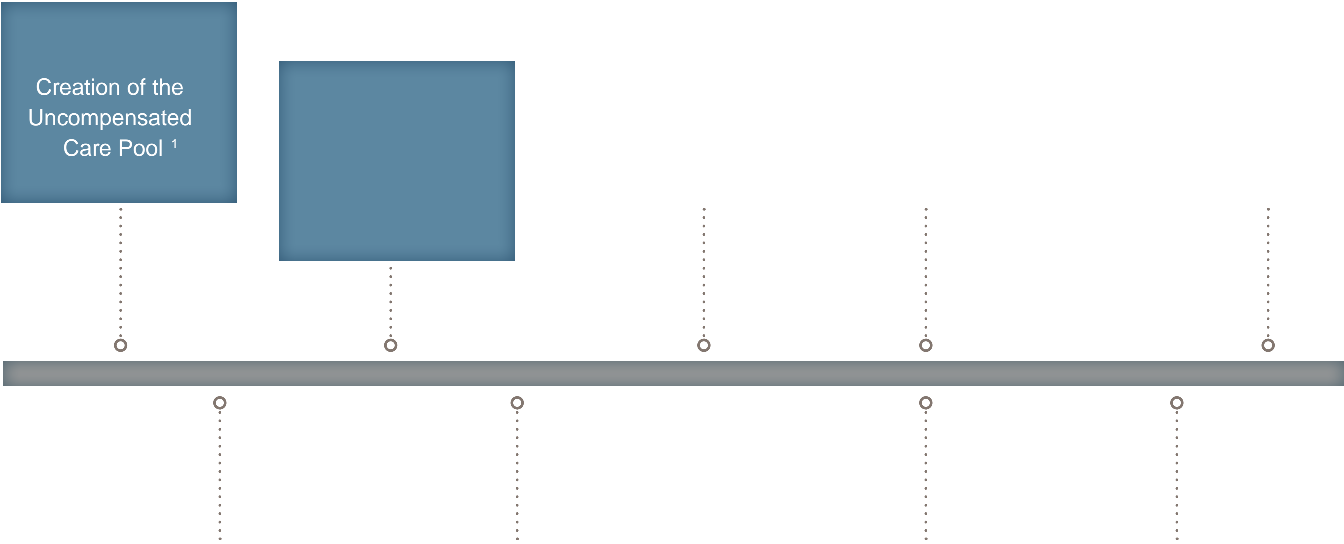
Creation of the Uncompensated Care Pool [1]

TABLE 1:

An Act Providing Access to Affordable, Quality, Accountable Health Care[1]	2006 *An Act to Prun.1 TfO -1.222mgO -1.222 TD[(14pna -)Tj/T13 1 TfO -1.222 TD[TfO -1.222mgO -1N Mžienc*
An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care[2]	
An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses[3]	
An Act Impro ing the Qualit of Health Care and Reducing Costs through Increased Transparenc , Ef cienc and Inno ation[4]	

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The MA E ecuti e Of ce of Health and Human Ser ices (EOHHS) created a t o- ear pilot program to be included ithin its MassHealth (Medicaid) ser ices.

- Nicotine replacement therap
- Other e idence-based pharmacologic aids for smoking cessation
- Accompan ing counseling b a ph sician, certi ed tobacco cessation counselor, or other quali ed clinician.

- Number of enrollees ho participated in smoking cessation ser ices
- Number of enrollees ho quit smoking
- E penditures tied to tobacco use b enrollees

This program as allocated $7 million per ear for 2007 and 2008 from the Health Care Securit Trust, hich as the trust that had duciar responsibilit for an monies recei ed b the Common ealth from the Master Settlement Agreement.

This bene t demonstrated success ith a 26% drop in smoking pre alence among MassHealth participants and a return on in estment of $2.12 for e er $1.00.[20]

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 of cials 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*

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These observations of MA's experience with Chapter 58 led interviewees to recommend ensuring that public health of cials 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, nancing, and the speci c 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?*

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.

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."*

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:

> Acti ists orked ith insurers, pro iders and go ernment of cials. The all listened to and respected each other e en if the disagreed. This led to compromise and illingness to seek collecti e solutions. All parties could agree that there ere 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 re ected that the strong and uni ed 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.

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

- „ 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.
- 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.'"*

One interviewee felt that Chapter 58's implementation could have been somewhat better coordinated in a uni ed 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

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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.

» 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 bene ted from the free care pool that could be used for targeted noti cation 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.

» ˆ 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 bene ts 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."*

Ÿ 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 de nitive 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

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."*

- ‹ ˆ ‘ ˆ – With the passage of Chapter 58, MassHealth (the MA version of Medicaid) was mandated to provide smoking cessation services to bene ciaries. However, MassHealth anticipated an in ux 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 bene t programs would run smoothly, rather than on educating the public about a single bene t. One state public health leader said, *"We wanted to demonstrate the meaningful role that public*

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]

This assumption led to cuts to some MDPH safety net services, which actually were not covered by insurance bene ts. 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 signi cant obstacle to care for individuals desiring addiction treatment who were unable to afford copayments (see £ ˆ † Š Š p. 28, for more detail). This situation and other stories of speci c 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

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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 ful ll 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 in uenza 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 to ns]... hich means each to n and localit has its o n health department. That means that ou get a fe that are larger and ha e some resources...then ou get man that ha e no resources. [All health departments] still ha e the responsibilit for doing a hole range of things. Some...ma onl focus on septic s stems, because that’s all the ha e time for and that’s the thing that’s most important for them...So, hen it comes to adding things like thinking about pre enti e care, chronic care ser ices...man just don’t ha e the time or the resources to actuall do it and their to n administrators don’t prioriti e them.

Another public health leader con rmed 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 speci c 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 reall mo ed a a from clinical ser ices. Kno ing that uni ersal health insurance as the primar goal of [Chapter 58], hich then as supposed to trigger an in u of patients into primar care and other health care ser ices... e didn't ha e a major role in

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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]

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 bene cial 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 signi cantly 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-pro ts, and unions formed to push for health care reform in MA, recalled:

Chapter 58 asn't [BPHC's] top priorit . Other things like substance abuse funding, treatment funding, clean needle legislation these ere higher public health priorities. I as de nitel still learning about health care nancing, but I felt a little bit like a square peg in a roundcannu4]TJ[9.9s

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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 con dential environments.[26,27]

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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 in ux 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 ser ices e pre iousl pro ided, e [onl] charged a $25 administration fee for each accine. We eren't set up to do Medicare or Medicaid or reimbursements, that asn't our model.

IMPACT ON MA'S SAFETY NET

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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 nancing dif culties 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.

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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 follo ing stor :

The Women's Health Net ork (WHN), a program of the Centers for Disease Control and Pre ention (CDC), pro ides free annual breast and cer ical cancer screening for poor and uninsured omen. The legislati e language that began the WHN states that the program is for uninsured and underinsured omen and also requires at least 60% of federal funding go to direct clinical ser ices (ith the remaining 40% able to be spent on non-clinical ser ices such as outreach, pre ention, education, and patient na igation).[28]

MA's WHN historicall as er strong and had high participation rates. Ho e er, ithin three months of Chapter 58's implementation, the participation rate dropped b 50% due to ne l obtained insurance. In addition, an one ho came for a ser ice ould be unable to return for follo -up as WHN staff ere charged ith guiding patients to enroll in insurance during their isits, and once insured, these clients ould no longer meet WHN ser ice criteria. Ho e er, though ne l insured, it as unclear hether former program participants ere recei ing health ser ices else here, and concerns e isted that these high-risk and hard-to-reach omen ould not follo up on screening results b seeking out the necessar health ser ices.

Because CDC's funding assistance as based on the WHN caseload, the funding stream for the WHN drasticall decreased, putting jobs and ser ices for omen in jeopard . Additionall , ith the o erall funding decrease, there as reduced capacit to pro ide the nonclinical ser ices essential to helping ulnerable populations na igate the health care s stem and impro e coordination and continuit of care. MDPH spoke ith 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 ne circumstances but ere ultimatel unable to do so.

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.

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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 signi cantly impacted MA's CHC system over the course of the second and third year of

These aren’t the populations that the ork ith. We ha e onderful hospitals, but the do not all ha e the abilit to ork ith some of the complications that come ith indi iduals ho are challenged b po ert and language.

Further af rming the literature, interviewees reiterated that the funding for safety net hospitals was cut

Consensus was also reached around the idea that improving health outcomes is complex and multi-factorial; 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 insuf cient condition to produce statistically signi cant changes in population health.

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 in uence decisions to access care. As one state public health leader stated:

Just because people are co ered doesn't mean e er one has access to care. Insurance co erage access does not actuall 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-certi cation.

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.

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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.[3] 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.

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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 signi cant 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 speci c 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-speci c expertise compromise appropriate treatment and follow-up and thereby allow greater TB transmission to occur.

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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.

- MDPH as directed to conduct a comprehensi e state ide stud of CHWs and pro ide recommendations for

Finall , Section 110 as seen as a model for the language included in the ACA, ith national reform as a polic indo of opportunit to integrate CHWs into the health care s stem. 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."*

MA's CHWs pla ed a highl isible and integral role in enrolling more than 200,000 uninsured residents in health insurance programs b 2010.[33] A chief state ide public health of cial described insurance outreach and enrollment ser ices b CHWs as a critical role for public health to take on and a lesson for other health departments under the ACA. Shortl after Chapter 58's passage, a state public health leader described the e olution of public health's role in enrollment and CHW engagement as follo s:

"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."

Proacti el , MDPH trained all contracted agencies ith client contact in the speci cs of the insurance e pansion. Pre-e isting grants funded outreach b CHWs and non-CHWs ho had client contact and MDPH pro ided speciali ed training for CHWs in insurance enrollment.[33]

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In contrast to the ACA, MA's Chapter 58 legislation does not speci cally 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 quali ed 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). £ ˆ • „ ’ p. 39, illustrates further complexities introduced upon implementation of Chapter 58 in MA.

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

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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 u 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-speci c visit. Interviewees pointed out the need to make sure that providers and the state Medicaid of ces are aware of this change.

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,

- *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 ve 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 noti cation 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-speci c prescriptions or with actual pills for their partners. MDPH has worked with pharmacists on this issue, but billing and con dentiality issues regarding blind prescriptions remain.

- *Partner notification:* DPH continues to provide partner noti cation services th( )Tjgp(toue of thest7h8c

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).

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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 con dentiality when seeking family planning services, a signi cant 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 bene ts (EOB) to the policy subscriber. Given the need to maintain con dentiality, 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 " ˆ †) 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

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 con dentially 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 con dential 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-ef cient 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 ef cacy 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 £ ˆ ‰ ” ˆ Š , p. 48, for more detail.

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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.

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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 uni ed research approach with dedicated resources. State and federal public health professionals could de ne 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 identi ed, isolated, and quanti ed 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 ne

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 count health departments' role is in understanding ho population health has changed as a result of medical care reform. This is here all [health departments] and the [federal go ernment] can contribute e pertise in nding a set of measures e pected to change hen people ha e better co erage and guring out ho to monitor that and see if it's actuall happening. That's hat public health should do.

One MA interviewee advises other states to 1) look rst 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.

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- 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.

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I think e need to keep our e es on the pri e. For me, that’s impro ing the health of our communities. Medical care is an important piece, but not the ans er.

“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 Of cials (ASTHO) and the Council of State and Territorial Epidemiologists (CSTE) are working on this at a national level.

VI. Summary of qualitative ndings and associated recommendations

THE ROLE OF PUBLIC HEALTH IN HEALTH CARE REFORM

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- Health care reform conversations during the formation and passage of Chapter 58 often ˆ š The public health tenets of ’ 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 ˆ ‘ or an overarching and uni ed public health message when Chapter 58 was being created.
- • were included in Chapter 58 to explore ‘ ¥ 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 for vulnerable populations, ˆ about new bene ts, and ˆ Ž ˆ 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 ˆ ˆ ˆ ‘ in state health care reform efforts.[33]
- Collecting and ˆ resulting from expanded access were instrumental in gaining public approval and achieving success in health care reform endeavors.
- The 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.

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- ˆ to public health departments and safety net providers needed 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 nancial 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.
- „ ˆ Ž 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 con dentiality 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.
- Ÿ – of LHDs and coordinate efforts with other community programs. In tight economic times, LHDs and the broader public health eld should • ‘ to 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 ef ciently and at a lower cost than what the LHD can provide.

SAFETY NET

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- There continues to be an essential ˆ .
- post-Chapter 58 at community health centers.
- ¢ ’ š
- ˆ in anticipation of universal coverage and reimbursement for services.
- With expanded coverage, revenue from billable services did increase, although insurance š
- Š (i.e., those performed to meet the complex needs of the safety net population).
- A signi cant proportion of safety net š
- The ˆ were not suf ciently recognized.

- 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 speci cally on the group of newly insured individuals.
- It is of increased coverage and access as disease development and behavioral changes take many years to manifest.

- Ensure that and integrated into the management of the health insurance exchanges.
- Create secure systems to – š MA advocacy organizations are currently trying to promote new policies to avoid automatic generation of EOBs to enable con dential 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.
- ™ ˆ – ˆ to ensure that diseases with population impacts will be addressed according to evidence-based prevention and treatment guidelines.
- Use the larger ¦ to understand how to truly reform health, health care, and impact individual outcomes. A ˆ of health and changing cultural norms around health and behavior are required to truly impact population health outcomes.
- Develop an • ˆ ¦ and a long-term monitoring system to assess the impact of health care reform at the 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

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 in ux 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 ef cacy 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 identi ed 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 bene t 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 of cials 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.

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IX. Appendices

APPENDIX A: EXECUTIVE

- 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

APPENDIX B: KEY INFORMANT INTERVIEW GUIDE

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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.

- 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 ndings from literature review and initial interviews.
- Expand list of informants as time allows as new relevant stakeholders are identi ed.
- Analyze interview notes to identify and extract emergent themes.
- Summarize emergent themes and delineate lessons learned.

Note: See belo for draft ke informant intervie guide.

Health Care Reform in MA: Qualitati e Inter ie s

KEY INFORMANT INTERVIEW GUIDE

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[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.]

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- 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 speci cally 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 ll 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, of un1.89 ( )miss, fehe gr r¬n¥’ÝîÞïïð-B Ý "L ¨ïïð p The CDC, via the Nation[lasAny T*6(ei2 Tdbted ,

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