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The Role of Community-Based Public Health Programs in Ensuring Access to Care Under Universal Coverage

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Policymakers today are working to develop and implement health reform that will improve the accessibility, affordability and quality of care, and contain health care costs. But while universal health insurance coverage is important, it does not guarantee access to care. Community-based public health programs help to prevent illness, disability and premature death and have an important role to play in reforms that expand and ensure meaningful access to coverage and care, especially for vulnerable populations. With an estimated 50 million Americans uninsured, and the numbers climbing every day, it will take considerable time and effort to ensure that individuals enroll in and maintain coverage, and obtain the health services they need. Community-based public health programs have a key role to play in engaging these individuals to make sure they continue receiving ongoing care and access to other health-related support services.

Programs such as the Breast and Cervical Cancer Early Detection Program, Title X Family Planning Programs, and the Ryan White HIV/AIDS Program provide critical services to vulnerable populations who lack access to health care, and who may be less likely to seek care. In addition to providing targeted clinical services, these programs provide outreach, health education, case management, and wrap-around services such as transportation—all of which improve access to care for millions of vulnerable individuals.

These evidence-based programs were developed and implemented based on the needs of local communities, and the services they offer are tailored to the target populations. Most programs, for example, provide culturally and linguistically appropriate services. The professionals who provide these services often resemble, understand, and reside in the communities they serve, allowing them to establish trusting, supportive, and continuous relationships with clients.

In an era of health reform and economic distress, there is great concern that funding for these and other successful community-based public health programs is in jeopardy of termination or, at minimum, dramatic reduction. This is due to a *perception* that these programs will duplicate services covered under a universal health insurance scenario, and thus are unnecessary. This paper explores that perception, and argues that when reforms are implemented, many vulnerable populations will continue to encounter barriers to care as they navigate the new insurance

and health care landscapes. These populations will continue to need the services provided by community-based public health programs in order to access care in a timely and appropriate manner and improve health outcomes.

Community-Based Public Health Programs: Playing a Critical Role in Serving Vulnerable Populations

Community-based public health programs were created to reduce disparities in health care access, quality and health outcomes. Many were designed to build capacity from within the community to enhance and sustain community health and wellness. While there are national program guidelines, these programs were designed to give states the flexibility to design and implement solutions based on local needs. Program services include culturally appropriate outreach, health education, case management, and wrap-around services to help ensure that vulnerable populations—with and without insurance—have timely and appropriate access to needed care. Some of these programs operate as independent non-profit organizations or freestanding clinics. However, most are located within community health centers, health departments, and hospitals which provide an array of clinical and social services, thereby creating multiple opportunities

Defining Vulnerable Populations

The term “vulnerable populations” often is used to denote the uninsured, low-income populations, or those at high-risk for a certain illness, condition, or adverse life situation. In the context of this paper, vulnerable populations refers to those who are at increased risk for poor health outcomes because of their economic status, place of residence, race or ethnicity, physical or medical condition, age, or functional status.

These populations are confronted with numerous barriers that adversely affect their health and their ability to access care. Many are uninsured and or lack a usual source of care, and therefore seek sporadic care in emergency rooms and from a patchwork of other safety-net providers in community health centers, health departments and public health programs. These populations often have low-incomes and reside in impoverished communities where there is scant access to affordable, healthy foods and recreational spaces,¹ and exposures to environmental hazards (e.g., poor air and water quality, and violence) are high.² These populations also have unmet psychosocial needs, including undiagnosed and untreated depression, mental health disorders, and substance abuse problems, and lack social support networks.



Photo Courtesy of the Indian Health Service/
U.S. Department of Health and Human Services.

Enrolled and Connected to Care: Special Considerations for Vulnerable Populations

Providing health insurance coverage is a critical *first step* in improving access, and ultimately health status, for vulnerable populations. However, for these populations, their use of health services is determined by a complex interaction of various financial, geographic, sociocultural, and environmental factors. Some challenges society faces in not only ensuring vulnerable populations, but also in maintaining their continuity of care are described below:

- **Getting them (and keeping them) enrolled.** Many vulnerable populations are considered “hard to reach” because the availability of coverage alone does not ensure enrollment. At least 25 percent of the uninsured are eligible for public insurance programs; this includes 66 percent of uninsured children who are eligible for Medicaid or the Children’s Health Insurance Program (CHIP).⁶ This lack of enrollment has been attributed to a number of factors including lack of information^{7 8 9}; lengthy application processes and documentation requirements^{10 11}; concerns about costs^{12 13}; and fear of punishment or deportation among those with family members who are undocumented immigrants.^{14 15 16} Many of the reasons that keep individuals from initial enrollment are the same reasons that prevent them from renewing coverage or re-enrolling.
- **Helping them navigate the health care system.** Choosing a health plan, finding a provider, and navigating a complex and opaque health care system can be especially intimidating for populations who have limited experience with health insurance and the health care system.¹⁷ Unaided and without sufficient information, these processes leave many vulnerable populations overwhelmed, confused, and frustrated, and can prevent them from seeking available health care services.
- **Ensuring needed care is covered and affordable.** For low-income populations, the cost of health care is particularly important. Many, when faced with even a modest copayment, will choose to forgo care.¹⁸ A recent survey found a large gap between what the uninsured are willing to pay for coverage and the actual cost of insurance premiums. Most of the uninsured surveyed were willing to pay \$25 to \$100 per month for coverage; 29 percent would pay \$200 per month, and only 6 percent would pay \$400.¹⁹ In addition, individuals avoid seeking certain health services because those services are not covered by their plan.
- **Addressing psychosocial and cultural barriers to care.** Racial, ethnic and sexual minority groups are more likely to encounter language and other cultural barriers, stigma and discrimination, and to receive lower quality care. As a result, these populations tend to distrust physicians and the overall health care system, which prevents them from seeking care.^{20 21 22 23}
- **Improving accessibility of care.** Some individuals face geographic or logistical barriers to care, such as residing in a rural or remote area, lacking transportation, and having limited sick leave, which prevents them from being able to seek care during standard operating hours.²⁴
- **Establishing clinically appropriate care patterns.** The longer an individual goes without care the chances that they have not received preventive services continue to increase. Research has found that with extended periods without coverage, at least two years may be needed to establish clinically appropriate care patterns for preventive services.²⁵ Lack of access, discontinuity of care, and distrust of providers also can contribute to inappropriate and inconsistent care patterns.²⁶

for these programs to engage vulnerable populations.

Many vulnerable populations have come to depend on safety-net providers and community-based public health programs not only for clinical care and social services, but also for emotional and community support. In addition to relying on degreed professionals (i.e., physicians, nurses, and social workers), community-based

public health programs place high value on the expertise and skills of community health workers, patient advocates and promotoras, trusted and knowledgeable members of the community.

The placement of these programs in vulnerable communities, the ethnically and linguistically diverse staff, and the substantial face-to-face time offered during appointments help to create an open and supportive environment conducive to

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establishing mutual trust and respect, and sharing of information. This helps to improve the patient satisfaction and quality of care. It also increases the likelihood that patients return for regular appointments and follow the prescription and treatment advice of the provider.^{3,4,5} In addition, these programs extend beyond institution walls, often conducting outreach and home visits, thereby engaging individuals that are harder to reach.

Unlike the traditional medical model, which is designed to diagnose and treat illness in *individuals*, community-based public health programs have a broader framework. With a bird's eye view, these programs identify and address a wide range of financial, physical, psychosocial, and environmental factors which adversely affect the health of the *community* in order to reduce and prevent illness, injury and premature death. This unique community-level perspective and the critical preventive health, social support and wraparound services provided by public health programs are complementary to, not duplicative of, traditional medical care.

Impact of Massachusetts Health Reform on Community-Based Public Health Programs and the Populations They Serve

Because the Massachusetts expansion has been noted as a model for health reform,²⁷ it is valuable to both note the successes and explore the challenges that could have implications at the national level. The following program overviews and findings were based on interviews with public health leaders, program directors, and advocates, who helped identify a wide range of financial, logistical, administrative and service delivery issues that have had an impact on community-based public health programs and the populations they serve.

OVERVIEW OF MASSACHUSETTS HEALTH REFORM

Prior to enactment of its landmark health reform law, Chapter 58, Massachusetts had several safeguards in place to help improve access to care for vulnerable populations. These included a

robust safety net comprised of community health centers, health departments and public health programs; comprehensive health benefits through the state's Medicaid program (MassHealth); and Medicaid coverage for low-income persons living with HIV (most states require a full-blown AIDS diagnosis). Still, many residents were uninsured, and there were large gaps in access and utilization.

Consequently, the state in 2006 launched four key initiatives to expand health insurance and increase the number of insured residents:

1. An expanded *MassHealth* to include additional low income residents;
2. *The Commonwealth Care Health Insurance Plan* to subsidize private coverage for low-income people ineligible for MassHealth or employer coverage;
3. *Commonwealth Choice*, which functions like an insurance exchange to provide individuals and small businesses with access to comparable insurance products; and
4. A requirement that both individuals and employers participate in the health insurance system or face penalties. Certain hardship exemptions are available to those who do not have access to and cannot afford to purchase insurance.

In addition, the Health Safety Net, which replaced the Uncompensated Care Pool, pays for services provided to uninsured (and underinsured) individuals at certain community health centers and acute care hospitals.²⁸

CONSIDERABLE SUCCESS, BUT ACCESS GAPS PERSIST

Since Chapter 58 took effect, 428,000 people have obtained health insurance, and the state touts one of the lowest uninsured rates in the country.²⁹ In addition, health care access and utilization have improved. According to the May 2009 report from the Division of Health Care Finance and Policy, 89 percent of residents have a personal care provider; 84 percent of women ages 40 and older have had a mammogram in the past two years; and 65 percent of adults ages 50 and older have had a sigmoidoscopy or colonoscopy in the past five years.³⁰

Despite these notable successes, many residents still face barriers to accessing care.



Ancedotal evidence indicates those who remain uninsured are from eligible but hard-to-reach groups. These populations tend to seek emergency room care only when there is a “crisis” such as life-threatening symptoms or intolerable pain.

- **The most vulnerable remain uninsured.** As of May 2009, an estimated 167,000 residents were uninsured. These are primarily individuals and families who are impoverished, geographically isolated, racial and ethnic minorities, and at high risk for poor health outcomes.³¹ Some of these individuals are undocumented immigrants who are ineligible for public coverage and do not have access to private insurance. Anecdotal evidence indicates those who remain uninsured are from eligible but hard-to-reach groups. These populations tend to seek emergency room care only when there is a “crisis” such as life-threatening symptoms or intolerable pain. To capture this population, the emergency room is a major site for insurance enrollment. When uninsured individuals come to the emergency room, they are referred to a financial assistant, who helps them apply for coverage. Coverage is not immediate, however, and they must wait to hear about their eligibility status. There is minimal follow-up to ensure that individuals are aware of their insurance eligibility once it has been determined; that they complete the necessary paperwork to enroll; or that they understand how to use available health benefits.
- **Many newly insured residents are confused about their health benefits and when and where to seek care.**³² State-funded outreach grants were provided to some community-based organizations and non-profit groups to help the newly insured apply for coverage and decipher their insurance benefits. One grantee received an average of 24,500 calls each month from residents needing assistance with insurance reform requirements.³³ Also, an informal survey by the Massachusetts League of Community Health Centers found that the newly insured were confused about when to go to a hospital emergency room for care.³⁴ One year into the expansion, emergency room use remained high among those newly covered by the Commonwealth Care plans. The rate was markedly higher among lower-income populations.³⁵
- **Cost remains a major barrier to care for many residents.** Overall, the cost of health care in Massachusetts is higher than the national average.³⁶ In 2008, Commonwealth Care enrollees faced a 10 percent premium increase at a time when unemployment was on the rise. For some, insurance premiums were no longer affordable; others

found that they had to pay for services that they had previously received for free or at minimal cost from safety-net providers.

- **Residents experience intermittent coverage.** Lapses in coverage have been attributed to several factors. Many newly insured are unaware that they must re-enroll or renew their benefits annually, or periodically verify their eligibility with Commonwealth Care plans; those who fail to complete this process are terminated from coverage. Also, more individuals and families are losing coverage because of job loss and their inability to pay premiums. Additionally, as income levels change, so does eligibility for subsidized products, and many residents are unaware of their change in eligibility. These individuals often are not officially counted as “uninsured,” because the state allows a 60-day grace period for interruptions in coverage. A pilot study of one of the state’s help lines found that 25 percent of newly insured adults experienced gaps in coverage during their first year of coverage.³⁷
- **Provider shortages reduce access to care.** The influx of newly insured individuals has put further strain on a health care system already fraught with provider shortages.³⁸ It has taken weeks for newly insured individuals to find doctors who will accept new patients, and many months longer to get an appointment. The previously insured face similar access issues.³⁹

EXPERIENCE OF COMMUNITY-BASED PUBLIC HEALTH PROGRAMS

In interviews with Massachusetts’ public health officials, directors and advocates, many indicated that Chapter 58 has improved access to insurance coverage for many of their clients, which in turn has increased their use of health services. Many clients still prefer to receive services from community-based public health programs. Volume at many family planning clinics, public health programs, and community health centers has remained steady, and in some cases, increased. Residents continue to seek health care through these providers for numerous reasons, including the established supportive and trusting relationships they have with providers and staff, the availability of bilingual providers or interpreter services, and evening and weekend operating hours. Furthermore, these patients already know how to access these providers and are able to get timely appointments.



Coverage for Legal Immigrants Nearly Eliminated

In the final FY2010 budget, funding was eliminated for the Commonwealth

Care Alien with Special Status (AWSS) program that provided insurance coverage to legal immigrants. However, at the end of August, Governor Deval Patrick announced a new plan to cover this group starting October 1, 2009. However, the new plan will not cover dental, vision, hospice, and skill nursing services, and will only be available to those legal immigrants who were covered under Commonwealth Care. Those who are newly eligible for AWSS will not be able to join the plan and must receive services through the Health Safety Net and Mass Health Limited (emergency care) programs.

However, several administrative barriers threaten the ability of community-based public health programs and providers to serve the newly insured.

Burdensome enrollment processes.

While some community-based public health programs received outreach grants from the state to educate and assist clients in the enrollment process, many others did not. Staff has had to spend substantial amounts of time to help patients with the lengthy enrollment processes, and provide information on plan options, benefits coverage, and re-enrollment assistance—often without any financial compensation. In a study of community health centers in Massachusetts, staff asserted that because of documentation requirements, it took an average of three encounters before patients completed applications for insurance.⁴² Furthermore, many of these programs lacked the resources and training to use the state’s Virtual Gateway, the major tool for determining insurance eligibility under health reform.

Lack of transparency about Commonwealth Care Plans. Under Chapter 58, most low-income residents obtained coverage through MassHealth or Commonwealth Care plans. However, consistent problems have been reported regarding the information provided about the various Commonwealth Care plans. A review of the plans websites found them confusing and difficult to navigate.⁴³ Overall, residents know little about the different plans and services covered. Once eligibility is determined, many do not choose a specific plan, and therefore are automatically assigned to a plan that may not provide the best coverage for their needs. In many cases, clients rely on the staff of community-based public health programs to inform them of the services covered under their health plan.

Billing challenges. Because many safety-net providers and community-based programs traditionally served the uninsured, they never instituted rigorous billing infrastructures, and thus, lack the technology, staff and other resources needed to bill numerous health insurance plans. In addition, a lack of clarity about covered benefits and varying paperwork requirements for different health plans have all hindered their ability to bill for services provided. As one family planning clinic administrator stated,

“We’ve had major struggles figuring out what they pay and why. For example, when we provide a client with a general exam that includes Pap smear, STD screening, maybe an HIV test, and say wart treatment, we can only bill for one of those services even though all four were provided that day.”⁴⁴

Existing statutory language threatens funding. Public health programs often are required by law to serve mostly uninsured populations. As more people gain insurance coverage—but continue to return to these trusted community-based providers—the proportion of insured to uninsured clients grows, and funding for specific community-based public health programs is jeopardized.

Less support for public health programs that serve people who are underinsured. The perception that health reform has addressed the full range of health needs for the uninsured and underinsured has weakened programs that provide uncovered wraparound support services, or services that are not covered or inadequately covered, such as substance abuse treatment, dental services, or family planning.

Shrinking funding for public health programs. In a difficult fiscal environment, public health programs have been under increased scrutiny by the Massachusetts Legislature and many have experienced dramatic cuts in funding. From fiscal year 2009 to 2010 funding for overall public health programming decreased by 14%. Programs disproportionately hit include:

- Youth violence prevention (-63%)
- Smoking prevention (-61%)
- Family health services (-39%)
- Early intervention services (-40%)
- Health promotion and disease prevention (-50%)

Specific examples of the impact of Massachusetts health reform on community-based public health programs:

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MASSACHUSETTS BCCEDP AND WISEWOMAN

Initially, in Massachusetts, the BCCEDP and WISEWOMAN programs fell under the Women's Health Network (WHN). However, around the same time that Chapter 58 took effect, the WHN underwent a major overhaul when it combined with the Men's Health Partnership to form the Care Coordination Program. The purpose of the transformation was to provide more comprehensive coordination of care and improved compliance of preventive health services for adults ages 40–64. With a focus on prevention and early detection of cardiovascular disease and breast, colorectal and prostate cancers, the program provides preventive screenings, risk reduction education, patient navigation, case management and community based lifestyle interventions to encourage healthy choices about nutrition, physical activity and tobacco use. The program operates within community health centers, hospitals, and visiting nurse centers. Funding comes from a combination of state and federal sources.

From FY2008 to FY2010 Health Promotion and Disease Prevention Programs in the Department of Public Health were cut by 50 percent. The Care Coordination Program has been moderately shielded from those cuts, largely because of federal matching requirements. However, *two statutory requirements threaten the program's ability to receive NBCCEDP and WISEWOMAN federal funding*, which then puts state funding at-risk.

- Programs must serve uninsured and underinsured women.** Since the enactment of Chapter 58, fewer women in Massachusetts are uninsured. Many former Women's Health Network participants found that they had to use providers in their new insurance plan's network. As a result, program participation declined by approximately 50 percent. However, little is known about if, where and when former program participants are receiving health services. The concern remains that these high-risk and hard-to-reach women are not receiving the health services they need.
- At least 60 percent of federal funding must be spent on direct clinical services.** This leaves 40 percent for the non-clinical services (outreach, prevention education, patient navigation), which are the crux of the Care Coordination program. In addition, a maximum of 10 percent (of the remaining 40 percent) can be spent on administrative expenses. The reorganization of the program has resulted in more comprehensive care for participants. However,



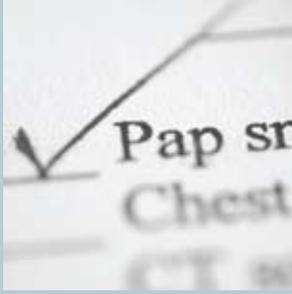
National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and WISEWOMAN

Low-income and minority women have higher rates of death from breast and cervical cancers because they are more likely to be diagnosed at later stages of the disease. Lack of access to screening services, lower rates of follow-up for abnormal results, and receipt of less aggressive treatment all have been cited as contributing factors to these disparities.^{45 46} The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) aims to bridge the gaps in access, follow-up and treatment by offering free or low-cost clinical breast exams, mammograms, pelvic exams and Pap tests; providing diagnostic follow-up for abnormal results; furnishing referrals for treatment; connecting women with other available health and social services. While the program serves all eligible non-elderly adult women, it aims to reach high-risk women 50–64 years of age who have not had breast and cervical screenings for five years, as well as certain racial and ethnic minorities.

Since 1991, NBCCEDP has served 3.2 million women; provided 7.8 million screenings; diagnosed 35,000 cancers; and detected 100,000 pre-cancers.⁴⁷ Currently, NBCCEDP funds services all 50 states, the District of Columbia, 5 U.S. territories, and 12 American Indian/Alaska Native tribes. In addition, 21 states receive funding to provide high-risk women ages 40–64 years with chronic disease risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease through Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN).

FUNDING FOR CARE COORDINATION PROGRAM FY2009-10		
Source	FY2009	FY2010
State (Health Promotion and Disease Prevention)		
Women's Health Services	\$5.3 million	\$3.2 million
Men's Health Services	\$2.2 million	\$1.4 million
Total state funding	\$7.5 million	\$4.6 million
Federal		
NBCCEDP	\$2.6 million	\$2.6 million
WISEWOMAN	\$1.1 million	\$900,000
Colorectal Cancer Prevention	---	\$1 million (new)
Total Federal funding	\$3.6 million	\$4.5 million
Total Funding for Care Coordination Program	\$9.5 million	\$8.5 million

For NBCCEDP and WISEWOMAN states must match at least \$1 for each \$3 in federal funding.



Title X Family Planning Program

Teens and young adults are the major users of family planning services. While these groups are more likely to engage in behaviors that put them at high risk for illness, injury and premature death, they have lower rates of health care utilization.^{48 49 50} The reasons for this include lack of insurance, concerns about confidentiality, and a lower perceived need for health services.^{51 52} Title X Family planning programs are uniquely designed to serve these populations by providing comprehensive and confidential reproductive health care. In addition to clinical services (i.e. gynecological screenings, pregnancy testing, STD testing and treatment, and contraceptive supplies) family planning programs provide individual counseling on reproductive and sexual health, conduct outreach and education to local communities, and furnish clients with invaluable tools, such as contraceptive education, condom negotiation, and parenting skills.

Most people receiving Title X family planning services are low-income and/or uninsured.⁵³ In 2007 alone, family planning programs served 5 million people and performed 2.5 million Pap smear tests, 2.4 million chlamydia tests, and 764,126 HIV tests.⁵⁴ Family planning services are also critical for reducing unintended pregnancies.⁵⁵ For many, especially low-income teens and young adults, these programs are their only access to primary care.⁵⁶ The services are confidential and voluntary, which encourages individuals fearing stigma or punishment to seek diagnosis, treatment and counseling, thereby helping to prevent poorer health outcomes. This is especially important for teenage girls, who, even if their parents have insurance, will not seek these services via their parents' coverage. In addition, family planning staff are especially skilled at helping individuals cope with difficult situations, including abuse and teen pregnancy.

as the program serves fewer people who are uninsured and provides fewer clinical services, its ability to receive reimbursement for the non-clinical services provided is limited by the statutory requirements of BCCEDP and WISEWOMAN.

Without changes to the language that authorizes funding, the Care Coordination program is in jeopardy of losing funding for services that are particularly critical to helping vulnerable populations navigate the health system and improve coordination and continuity of care

MASSACHUSETTS FAMILY PLANNING PROGRAM

Massachusetts has a robust public health infrastructure for family planning services, which includes free standing clinics and community health centers, many of which receive a combination of state and federal funding, as well as reimbursement from MassHealth. Since the enactment of Chapter 58, family planning programs have found that the populations they serve has remained the same, mainly low-income women and teens, both with and without insurance. Many clients still prefer family planning centers because they are a familiar and confidential source of care, conveniently located, and often have alternate evening and weekend hours. As one focus group participant of a family planning study noted, "I know the clinic a lot better at this point than I know my own insurance."⁵⁷

Staff agrees that health reform has increased access to care for the clients it serves, however it has also created a new set of problems. Because family planning is largely a clinical model, it has come under great scrutiny from legislators who believe its services are now covered under the health insurance expansion reform. This presumption, along with fiscal pressures, has resulted in a 40% cut in state funding (from \$7.6 million in FY 2009 to \$4.6 million in FY2010). However, the demand for services has not waned, and family planning programs continue to be critical component of the public health's responsibilities by:

- *Providing care to those who fall through the cracks.* Family planning programs continue to be a source of care for those who remain uninsured, underinsured, experience lapses in coverage. A number of newly insured residents seek care through family planning clinics because they have problems finding a provider that will accept their new insurance. Also coverage of family planning services under the Commonwealth Care and Common-

Since Chapter 58, some of the newly insured have found that they now have to pay high out-of-pocket costs for services they once received for free or at low-cost. For example, the costs for contraceptive pills at a pharmacy range from \$20 to \$60, while the maximum cost at a family planning clinic is \$20.

wealth Choice plans vary. Plans for young adults and the self-employed often do not cover family planning services.

- *Assisting clients with enrolling in and understanding health insurance plans.* Family planning sites have spent considerably more time helping clients apply for, enroll in, and maintain coverage, as well as decipher benefits. This has resulted in extending appointments times, expanding clinic hours, hiring more staff, and creating walk-in clinics.
- *Mitigating barriers to family planning services, especially contraceptives.* Since Chapter 58, some of the newly insured have found that they now have to pay high out-of-pocket costs for services they once received for free or at low-cost. For example, the costs for contraceptive pills at a pharmacy range from \$20 to \$60, while the maximum cost at a family planning clinic is \$20. Faced with a higher cost of care, some chose to forgo care altogether. These costs are mostly troublesome for women at the top of eligibility for Commonwealth Care plans (near 300% FPL). Also, clients used to receiving low-cost bulk supplies of contraceptives at family planning sites now have to take their prescription to a pharmacy to obtain a one-month supply and return monthly for refills. This is especially problematic for clients in rural areas and has impacted individuals' ability to stay on contraception.⁵⁸

Despite continuing and evolving demands for services, family planning sites have encountered major administrative barriers, particularly with the Commonwealth Care plans. Developing contracts with the plans was labor intensive, and not being able to contract with certain plans reduced access to family planning services in certain geographic areas. Staff also noted that tedious billing processes, lower reimbursement rates (than Department of Public Health or MassHealth), or lack of coverage of certain services have increased the financial and administrative burden on their sites.⁵⁹

Lessons from Massachusetts Have Implications for National Health Reform

During our interviews, Massachusetts public health officials and program staff indicated that the state's health reform initiative was largely concentrated on expanding and financing insurance coverage. Funding for outreach and assistance focused mostly on enrollment, with less attention to developing a system to help individuals maintain coverage, access appropriate health services and improve coordination of care. Although public health officials were very involved in planning and executing Chapter 58, they did not anticipate many of the issues that have arisen and adversely affected public health programs.

These issues and the experiences of community-based public health programs are summarized here with the objective of informing policymakers and public officials of lessons learned, potential consequences, and identifying opportunities to address them before they impact vulnerable populations.

Lesson 1: Despite extensive efforts to increase coverage, some will inevitably fall through the cracks.

As evident in Massachusetts, even with near-universal insurance coverage, there will be individuals and populations who remain uninsured, underinsured, and experience lapses in coverage for various reasons. Also, economic climates and life events (e.g., job loss, death of a family member) can result in gaps in coverage. A safety net of services will continue to be needed to provide care for these groups.

Recommendation: Preserve funding for programs and services for those who remain uninsured or underinsured, or experience intermittent coverage.

Lesson 2: Community-based public health programs ease gaps in access.

Insurance coverage is an essential first step, but does not guarantee access to care. Given predicted and actual physician shortages, an influx of new insurance recipients is likely to overwhelm many health care systems. Public health and

safety net providers must be included in health insurance plan networks not only to improve access to care in underserved areas, but also to ensure that vulnerable populations can choose to receive care from trusted providers in their communities.

Recommendation: *Require health plans to contract with public health and safety net providers to help ensure access to care.*

Lesson 3: Newly insured populations require support services to effectively navigate the health care system.

Insurance coverage expansions under national health reform will largely target low-income and vulnerable populations. Given the complex financial, geographic and psychosocial issues that affect these groups, concentrated and innovative methods will be needed to reach them and help them apply for coverage. These populations also will require help to decipher their eligibility paperwork, and to understand and use their benefits. Community-based providers including community health workers can provide application assistance, explanation of coverage, provider selection, prevention education, and reminders for appointments and re-enrollment. These workers also can connect newly insured patients with other available health and social services to help improve access and bolster health outcomes.

Recommendation: *Expand and sustain funding for staff of community-based public health programs, including community health workers and other patient advocates, to conduct ongoing outreach, enrollment and continuity-of-care assistance, and to help the newly insured navigate the health system.*

Lesson 4: Many community-based preventive and support services are not covered by health insurance and should continue to be funded as a part of health reform.

Preventive services, such as risk reduction counseling, tobacco cessation services, and healthy home visits, and support services such as transportation and prescription drug assistance are just a few services that many low-income and vulnerable populations need to access care and improve health outcomes. In addition, these ser-

vices are essential to sustaining positive outcomes over time, a clear goal of health reform.

The cost of expanded coverage should not be used to justify decreasing the investment in core and community-based public health services.

Recommendation: *Assess gaps in insurance coverage of preventive services and maintain commitment to core public health programs that focus on improving health outcomes through prevention.*

Lesson 5: Failure to anticipate and prepare for administrative issues could inadvertently impede expansion efforts.

Community-based public health programs and safety net providers who previously served mostly uninsured and underinsured populations, will need training, additional staff, technology and other resources for billing, filing claims and referral systems as they begin to serve more newly insured populations.

Recommendation: *Provide infrastructure grants for states to evaluate the capacity of the public health and safety net systems to support health insurance expansion efforts and to develop and implement plans to address gaps in technology, staff, and other resources.*

Lesson 6: Overlooking statutory requirements and federal funding formulas could interfere with the provision of critical public health services.

The experience of the Massachusetts' BCCEDP and WISEWOMAN programs support the need to examine current statutory language dictating funding and implementation of public health programs in anticipation of changes under health reform as they relate to the nature of needed services, client insurance status, and interaction between public and private providers. The goal is to ensure that community-based public health providers will continue to function as trusted and confidential sources of care and will be reimbursed for services provided.

Recommendation: *Evaluate, and revise as necessary, statutory language dictating the funding and implementation requirements of community-based public health programs to ensure their viability under health reform.*

Preventive services, such as risk reduction counseling, tobacco cessation services, and healthy home visits, and support services such as transportation and prescription drug assistance are just a few services that many low-income and vulnerable populations need to access care and improve health outcomes. In addition, these services are essential to sustaining positive outcomes over time, a clear goal of health reform.

Conclusion

The experiences of Massachusetts community-based public health programs and the populations they serve offer several lessons and warnings for policymakers as they consider the implementation of national health reform. Despite strong support for public health, the cost of health insurance expansion and the economic recession prompted legislators to identify areas to reduce spending. As a result, public health programs and services which appeared to duplicate benefits covered by insurance were reduced or eliminated. This is particularly disconcerting because, some of the new insurance plans do not cover, or provide limited coverage of, primary preventive services. Without adequate funding, community-based public health programs are unable to fill gaps in access to preventive services, leaving many vulnerable communities with no alternatives for services such as tobacco cessation and weight reduction.

In addition, it is important to note that, even prior to Chapter 58, Massachusetts had one of the lowest uninsured rates in the country, comprehensive Medicaid coverage, and a robust public health system. The impact of insurance expansions on residents and the public health system will vary across the states based on numerous issues including proportion of uninsured, organization of public health infrastructure and political and fiscal climates. It will be critical for public health advocates and policymakers in those states to “make the case” to their legislators for continued investment in community-based public health, safety net and prevention programs, as *an integral component of reform*, to protect vulnerable populations and safeguard opportunities to prevent disease and disability.

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