Health Centers' Role in Affordable Care Act Outreach and Enrollment: Experience from Kentucky and Montana

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Key Findings

- Kentucky and Montana Medicaid and exchange/insurance agencies cultivated important partnerships with PCAs and health centers to support outreach and enrollment assistance activities under the Affordable Care Act.
- PCAs and health centers play a central enrollment assistance role that has supported success in two states with top enrollment performance in the first two years of enrollment.
- PCAs and health centers are reaching beyond traditional health center populations and adopting innovative strategies and new partnerships to increase enrollment.
- Health centers in Kentucky, a Medicaid expansion state, shifted more of their patient population into coverage programs than health centers in Montana, possibly indicating an advantage for health centers in expansion states.
- Health center collaboration with state and federal agencies is central to effective outreach and enrollment activities and continued collaboration and funding can support future efforts.
- Low health literacy among the health center population poses a continuing challenge to supporting and retaining enrollment into new coverage programs.

Executive Summary

The Affordable Care Act created new opportunities for health centers and primary care associations (PCA) to play a leading role in supporting outreach and enrollment into new and expanded health coverage programs. Health centers and PCAs received new funding, sometimes from multiple state and federal entities, new training and tools, and a new mandate to find and enroll eligible individuals, both within their patient caseload and in the broader community. In undertaking this charge, many health centers and PCAs found themselves engaging new partners, building stronger relationships with state Medicaid and insurance or exchange agencies, and often playing a central role in coordinating outreach and enrollment activities in their state or community.

To better understand the new roles of these entities and identify promising strategies in their coordination with state Medicaid and insurance/exchange agencies, NASHP undertook a case study review of Kentucky and Montana, two states with strong enrollment performance where the state PCA and health centers played an important role. With support from the Health Resources and Services Administration's National Organizations of State and Local Officials Cooperative Agreement, NASHP interviewed representatives from the PCA, a health center, and a Medicaid agency in each state about their respective roles in and coordination of outreach and enrollment assistance during the first two years of Affordable Care Act implementation.[1] Findings from these interviews are summarized here, with case studies highlighting each state's circumstances and experiences, followed by a discussion of common themes relating to collaboration with state and federal agencies, lessons learned, and future priorities for outreach and enrollment work with states.

Background

The Affordable Care Act and related federal regulations created new national standards for enrollment assistance entities to support enrollment into new health insurance options. For Health Insurance Marketplace enrollment, new federal grants provided by the Center for Consumer Information and Insurance Oversight (CCIIO) at

the Centers for Medicare and Medicaid Services (CMS) funded assistance entities, called either in-person assisters (IPAs) in State-based Marketplace (SBM) states or navigators in federally facilitated marketplace (FFM) states.[2] (See Affordable Care Act Glossary in the Appendix for definitions of related terms.) Federal guidance also created other assistance entities to support enrollment into Health Insurance Marketplaces, Medicaid, and the Children's Health Insurance Program (CHIP), called certified application counselors (CACs). The general charge for these entities was the same: provide needed education about coverage options, answer questions, establish eligibility, facilitate completion and submission of applications, and support enrollment into coverage for eligible individuals.[3]

Recognizing that health centers could play an important role in identifying and enrolling newly eligible individuals, the Health Resource Services Administration (HRSA) awarded $150 million in grants under the Affordable Care Act annually to fund outreach and enrollment activities by federally-funded health centers, as stand-alone grants in the first year of open enrollment and as a component of annual funding for the second and future years.[4] These funds support a range of health center activities related to outreach and enrollment into new insurance coverage options.[5] HRSA has also provided $6.5 million annually to 52 state and regional PCAs to provide outreach and enrollment related engagement, technical assistance, and coordination support to health centers within their state or region.

Enrollment into new health coverage options created under the Affordable Care Act has been robust in the first two years. Estimates suggest that more than 16 million individuals have gained new coverage through Medicaid, CHIP, and the marketplaces, with coverage gains the strongest among low-and middle-income individuals and among subgroups of young adults, non-white, and Latino populations.[6] During the period since the Affordable Care Act was implemented, national uninsurance rates have dropped, from 17.1 percent in the first quarter of 2013 to 10.1 percent in the first quarter of 2015.[7]

Fig. 1.
Overview of Case Study States

	Kentucky	Montana
Medicaid Expansion Type	Expansion	Non-expansion*
Exchange Type	State-based Marketplace (SBM)	Federally facilitated Marketplace (FFM)
Total Enrolled: Medicaid/CHIP	548,102 (90.3% increase)	24,918 (16.7% increase)
Total Enrolled: Marketplace	FY 15: 106,330 (72% renewals) FY 14: 82, 747	FY 15: 54,266 (59% renewals) FY 14: 36,584
Primary Assistance Entities	In-person Assisters (kynectors) CACs[8] Agents/Brokers	Navigators CACs Agents/Brokers
Number of HRSA-Funded HCs	23	17
HRSA Grants Supporting HC Outreach/Assistance (Total/#)[9]	FY 14: $500,000/20 health centers Total (FY 13-14): $2,883,522	FY 14: $740,559/15 health centers Total (FY 13 -14): $2,217,598
HRSA Grants to PCAs[10]	$750,000	$148,730

* Expansion was legislatively approved in 2015 is pending implementation for FY 2016.

As the Affordable Care Act offers new health coverage options and incentives for enrollment, it is profoundly impacting health centers' business operations and patients' access to new coverage options.[11] Given the new federal and state funding opportunities and health centers' unique connections to local communities, many health centers are finding their roles shifting to focus more on educating and enrolling the communities they serve on coverage options and seeing an increase in patient caseload.[12] In addition, an increasing percentage of patients are now either eligible for or enrolled into a coverage program that pays for health services.[13] While this increase in coverage rates is providing new revenues for health centers, it also poses new challenges for patients that may be unfamiliar with traditional coverage and insurance rules, including eligibility and renewal requirements and rules about premiums, copayments, coinsurance, deductibles, and penalties. The Affordable Care Act is also presenting new opportunities for health centers to proactively collaborate with state Medicaid and insurance agencies in outreach and enrollment efforts. In some cases, state PCAs and health centers are taking on new leadership roles in their state or community to support other assistance organizations or stakeholders in coverage expansion initiatives.[14] This brief offers case studies to shed light on health center experience with enrollment efforts in two states during the first two years: Kentucky, a Medicaid-expansion state that hosted its own SBM, and Montana, a non-expansion state[15] that relied on the FFM.

Kentucky

Background

Kentucky opted to expand Medicaid coverage to 133 percent of federal poverty guidelines and to host its own state-based health insurance marketplace, called kynect. To support implementation of the Affordable Care Act's new coverage options, Kentucky built an integrated, automated enrollment system that provides an online platform for a consumer's enrollment experience and can manage determinations for all coverage programs, including Medicaid, CHIP, and qualified health plans (QHPs) offered through the exchange. Kentucky's enrollment efforts are led by the Kentucky Health Benefit Exchange, the state agency that oversees kynect. The exchange agency has worked collaboratively on all aspects of Affordable Care Act implementation, including enrollment efforts, with the Department of Medicaid Services (the state's Medicaid agency), the Department of Community-Based Services (the state's eligibility agency), and the Office for Administration and Technology Services.

The exchange and Medicaid agencies are leading initiatives to help the state identify and enroll hard-to-reach populations, including immigrants, justice-involved populations, and homeless individuals. Medicaid is also providing important funding support to sustain exchange operations in future years. Since kynect processes eligibility and enrollment for a large number of Medicaid applicants, approximately 75 percent of kynect's outreach and education costs are allocated to Medicaid. This allows the state to claim federal Medicaid matching funds. State officials also noted that Medicaid expansion has been a primary driver in Kentucky's enrollment success, with a majority of those gaining coverage enrolling in Medicaid.

Kentucky has seen a dramatic growth in coverage under the Affordable Care Act, signaled by a drop in their uninsurance rate from 20.4 percent in 2013 to 9.8 percent in 2014, making them the state with the second greatest coverage gain among all states.[16] Kentucky's Medicaid and CHIP enrollment has grown by 548,102 individuals since late 2013,[17] and exchange enrollment has grown to 106,330 in 2015 (see Figure 1 for more details).[18]

There are 22 health centers serving 340,614 individuals in Kentucky, located in urban and rural areas throughout the state. Kentucky's health center population is disproportionately low-income as well as racially and ethnically diverse, serving communities that are majority African-American and those with significant immigrant and refugee populations. Across the state, 62 percent of patients have incomes below the federal poverty level (FPL) and 84 percent are below 200 percent of the FPL. In terms of demographic makeup, health center patients are 84.5 percent white, 13 percent

African American, seven percent Hispanic/Latino, and roughly one percent Asian or mixed race identified. In 2013, about a third (34 percent) of Kentucky health center patients were uninsured, with another third (32.5 percent) enrolled in Medicaid or CHIP, about a quarter (23 percent) paid by a third party, and just over one in 10 enrolled in Medicare.[19]

Kentucky Health Center's Role in Outreach and Enrollment Assistance

Kentucky oversees three types of assistance entities that provide outreach and enrollment services for Affordable Care Act coverage programs: (1) in-person assisters, called "kynectors"; (2) certified application counselors (CACs); and (3) insurance agents and brokers.

The Kentucky exchange contracts with three organizations to represent the state and run regional kynector programs for state-certified and trained kynectors. Two of these organizations make grants to certified kynectors and provide oversight, assistance, and technical support. The Kentucky PCA is a leading kynector organization that makes grants to health centers, as discussed later. The exchange also certifies and trains certified application counselors, individuals who work with local organizations that provide assistance with Medicaid and CHIP enrollment. Health centers work as both kynectors and CACs throughout the state.

The Kentucky PCA received $1.17 million in fiscal year 2014-2015 under a contract with the exchange to serve as the lead kynector entity for Region 8, which covers a rural and mountainous area in southeastern Appalachia. The PCA subcontracted with six local organizations to serve as kynectors: five health providers (including four community health centers and one non-health center) and one legal aid organization. kynector funds are paid in fixed monthly payments with a 10 percent withhold to incentivize the PCA to reach monthly outreach and enrollment targets, including holding outreach events. In 2013-2014 the PCA also received $750,000 from HRSA to provide technical assistance and support to all health centers in the state, including federally qualified health centers (FQHCs) and rural health centers, in the first year of open enrollment and has received comparable increased funding in its base grant. In that role, the PCA's functions have included dissemination of information to all health centers, representing health centers' views in communication with state agencies on implementation and participation on relevant subcommittees and in coordination meetings. In Region 8, the PCA relied on 17.2 full-time equivalent staff to support its outreach and enrollment assistance work for fiscal year 2014-2015. Kentucky health centers provided a total of 195,550 enrollment assistance contacts with consumers between July 1, 2013 and March 31, 2015.[20]

The health center interviewed for this case study operates in multiple locations in an urban area in Kentucky, serving over 25,000 patients annually representing at least 17 languages and cultures. Staff at the health center are certified by the state to provide kynector and CAC functions and have played a significant role in enrollment efforts so far, with 12,500 enrollments and 38,000 points of contact in the first two years of implementation. The health center also oversees some of the enrollment activities in the area, providing outreach and "inreach," which is outreach to existing patients, with just under half (45 percent) of those served outside of the patient caseload in the first two years.[21] Some of its major functions in this work include: assisting with enrollment, renewal, and reporting changes in individuals' income or eligibility status, participating in a locally-organized Board of Health committee that includes kynect, Medicaid, and other stakeholders, providing a feedback loop to state officials about implementation challenges, and allowing the state agency to use the health center space for kynector training events. HRSA funding has provided significant support for its work, providing $300,000 during the first year of open enrollment, and comparable funds in the second year built into its base grant. The health center has also supplemented this funding with its own funds to primarily cover staffing, translator services, and materials. To support this work, the health center has employed between six and nine full-time equivalent staff, mostly relying on staff with a social work background.

The PCA and health center representatives interviewed cited a number of structures that support their outreach and enrollment assistance work. The PCA shares the latest policy and operational developments with health centers, using periodic calls and updates, webinar series, virtual meetings, and trainings to transmit new information and hosting an annual peer-learning meeting. The exchange also supports PCA enrollment work by providing incentives and targets for PCA and health centers to meet, that includes: targeting certain sub-populations for outreach, setting a quota for the number of applications or assistance contacts, and sharing new strategies. The exchange offers a dedicated kynector call-in line and also offers a back-end portal to the eligibility system that make it easier for health center kynectors to resolve issues. The state-sponsored media campaign for kynect also supported outreach efforts by creating a buzz about coverage that brought newly eligible individuals into health centers for enrollment.

Key Outreach and Enrollment Assistance Strategies

Both the PCA and the health center interviewed engaged in a series of diverse strategies to find, educate and enroll eligible individuals. Examples include:

- **"Inreach" to Existing Patients:** The health center staff described a series of strategies to engage current patients directly to apply for coverage. Examples included calling patients directly, announcing staff availability for assistance in the waiting room, and asking patients at every point of contact (including at pharmacy pickup) whether they wanted to apply for coverage. The health center also created and placed colored interest forms that patients could fill out in the waiting room for a follow-up call and typed messages on bills to reach patients who might not know about coverage options. The health center reported these inreach efforts were an important factor in shifting their eligible population into coverage.

- **Pioneering New Strategies for Hard-to-Reach Populations:** During the second open enrollment period, the health center and PCA developed innovative strategies to increase enrollment among QHP-eligible and other hard to reach low-income individuals. Some of these included having workers engage individuals at gas stations, apartment complexes, parks, little league tournaments, and fairs. The PCA also provided outreach and education to farmers in rural communities to educate them about changes in Medicaid eligibility due to the elimination of tests that would have previously made them ineligible for Medicaid because of their assets (land, buildings, equipment, etc.). The health center also forged new partnerships with Family Resource Youth Service Centers and high school athletics programs to coordinate outreach to children, and with libraries to educate the general public. The exchange is also providing 120 additional enrollment kiosks to be placed in health centers throughout the state to increase access to electronic applications.

- **Justice-Involved Outreach and Enrollment Work:** Working with Medicaid, kynect and other kynector organizations, the PCA helped to create and lead the Healthy Re-Entry Coalition, a coalition promoting enrollment and retention among incarcerated and recently released prisoners. Through this coalition, the state and partners are working closely with all corrections facilities in Kentucky, including state and federal prisons, county jails and metropolitan correctional facilities. As a result of this work, the coalition has been able to place an assister in Louisville's Metro Corrections facility about five days per week and was able to generate approximately 400 applications from inmates per month in April and May of 2015. Going forward, the coalition will be pursuing four strategies to promote awareness and enrollment among eligible prisoners: (1) showing a newly produced video featuring personal testimonials from prisoners who enrolled in coverage; (2) creating a printed brochure targeted to justice-involved populations that is written at the fourth grade level to be more accessible; (3) implementing a policy change in August, 2015

to suspend Medicaid eligibility for prisoners upon incarceration instead of terminating benefits, thereby making it easier for the state to renew eligibility upon release; and (4) instituting a new electronic file-sharing site to support faster and more reliable electronic submission of applications from jails.

- **Outreach to Target Populations:** The PCA and health centers partnered with the state on targeted approaches to identify, educate and engage disproportionately uninsured and hard-to reach populations. In 2015, targeted subgroups included limited-English proficient immigrants and refugees, Veterans, and lesbian, gay, bisexual and transgender (LGBT) individuals. To support outreach to immigrants and refugees, the state is translating topical fact sheets outlining new coverage options in 16 languages that will be shared with health centers and other kynectors.[22] The health center also noted special strategies one of their sites is using to promote enrollment and retention among homeless patients, including putting flyers in places where these patients gather and having kynectors come to those locations at set times and through street outreach. Due to these efforts and others, this site was able to achieve a higher enrollment rate than other sites – approximately 88 percent compared to 80 percent.

- **Health Literacy and Education:** The PCA noted that in the second year of open enrollment there was a stronger emphasis on educating applicants and patients to improve their health insurance literacy. The PCA incorporated education into outreach events and applicant contact as much as possible to improve enrollees' ability to understand and use coverage once enrolled.

Challenges and Successes

State and health center officials reported a number of challenges experienced during the first two years of enrollment. The health center reported that health insurance literacy was low among many of their patients despite efforts to improve patient understanding. For instance, QHP-enrolled patients were unprepared for high deductibles, and as a consequence many went to the emergency room instead of seeking non-emergent treatment. Persistent confusion about Medicaid eligibility rules and pockets of resistance to "Obamacare," especially among rural farmers who were now Medicaid-eligible, was also a challenge cited by both the PCA and the health center. As noted above, health centers and the PCA spent more time educating consumers to understand health coverage requirements and the enrollment process during the second year. The sheer volume of applications, especially in the first year, presented staffing and resource challenges for all informant entities engaged in outreach and enrollment. The health center also mentioned challenges with the application process for immigrant populations, saying they frequently saw errors in these applications and encountered difficulties with enrollment. The health center experienced challenges in identifying individuals eligible for renewals in the second year and in responding to their patients' needs during the renewal process because they were often unaware of the individuals' status in the eligibility process. This challenge underscores the importance of improving assisters' information about enrollment status during the renewal process to improve their ability to help patients.

PCA, health center, and state officials also attributed a number of positive impacts to their proactive, targeted and collaborative approach to outreach and enrollment. The PCA noted that most health centers have seen a decrease in uninsurance rates among their patients. The health center reported a greater than average decrease in their uninsured rate at the end of year two, which they said was due to intensive inreach efforts, although health centers serving homeless populations reported greater challenges in enrollment and retention. Increased targeted outreach to QHP-eligible populations in the second open enrollment period had increased QHP enrollment rates for health centers by seven percent, according to the PCA. The state Medicaid agency also reported a spike in the number of preventive services delivered to Medicaid enrollees, including substantial increases in annu-

al physicals, dental visits, breast cancer screenings, colon and cervical cancer screenings, saying it was one of the most tangible positive effects of enrollment.[23] In addition, state agency and health center officials reported that their mutual collaboration and engagement to support enrollment efforts increased significantly compared to pre-Affordable Care Act engagement. The PCA and health center both cited the state's kynect marketing campaign as providing an important boost for their efforts because it created "word of mouth" that brought applicants to them. The state's campaign was recognized in 2015 with a gold Effie award, a national advertising industry award for an effective media campaign.[24] The health center said being a "bricks and mortar" site, where individuals living in rural areas or those with low computer literacy or access could enroll in person, was one of their greatest values to the community.

Montana

Background

Montana relies on the FFM to administer health insurance exchange coverage, but the Montana Commissioner of Securities and Insurance (the state's Department of Insurance and State Auditor) retains direct plan management authority, giving the state authority comparable to a state partnership marketplace state.[25] Montana also opted to delegate the authority to determine Medicaid and CHIP eligibility to the FFM.[26] Although Montana initially opted not to expand Medicaid eligibility under the Affordable Care Act, the state recently enacted a law that will expand Medicaid eligibility to 133 percent of the FPL for the 2016 plan year. The expansion is expected to cover 45,000 additional uninsured Montanans under Medicaid.[27] During the first two years of open enrollment, uninsured low-income individuals with family incomes between 100 and 400 percent of federal poverty guidelines that were ineligible for Medicaid could apply for subsidized QHPs offered through the FFM, but many low-income adults under the federal poverty guidelines were ineligible for Medicaid and remained uninsured.

Montana's Commissioner of Securities and Insurance has led the state's implementation of the Affordable Care Act's new requirements for health insurance issuers and has been the primary point of contact for consumer assistance issues related to enrollment in QHPs, including managing training for navigators, CACs, agents, and brokers. The Department of Public Health and Human Services, which is home to the state's Medicaid agency, has led the work relating to Medicaid enrollment, including collaboration with the FFM and assistance entities relating to Medicaid eligibility. These agencies coordinated messaging and outreach initiatives and included other parts of state government, including the governor's tribal liaison for an outreach and education initiative for Native American tribes.

Montana's percentage of uninsured individuals has declined dramatically since the implementation of the Affordable Care Act, from 20.7 percent in 2013 to 15.8 percent in 2014, representing a nearly 24 percent decrease in the uninsured rate.[28] In 2015, 54,266 people enrolled in QHPs through the FFM. Also, although the state initially opted not to expand Medicaid, it still experienced significant Medicaid and CHIP enrollment growth, likely due to the "welcome mat" effect of increased outreach encouraging more Medicaid-eligible individuals to apply for coverage. Between the third quarter of 2013 and April of 2015, Medicaid and CHIP enrollment grew by 16.7 percent.

Montana Health Center's Role in Outreach and Enrollment Assistance

Safety net providers such as health centers and the PCA coordinated with state agencies, including Medicaid and the Commissioner of Securities and Insurance, in their enrollment work. Health coverage enrollment assistance in Montana is coordinated by various assister entities within the state, including: (1) federally-funded navigators; (2) CACs and (3) insurance agents and brokers.

CMS awarded federal Navigator grants to three Montana grantees in the first and second year of open enrollment. Each of these grantees worked with health centers to train staff as navigators to provide enrollment assistance at the local level. The Montana PCA was a Navigator grantee in the

first year, receiving $299,382, some of which was re-granted to 17 partner FQHCs operating in 21 counties statewide.[29] The PCA was unsuccessful in its bid for Navigator grant funds in the second year and instead opted to take on a central organizing role for Montana stakeholder and assistance organizations to support information dissemination and branding for outreach, enrollment, and coverage expansion efforts under Cover Montana—a network of enrollment stakeholders led by the Montana PCA. Some health centers opted to work with the PCA during the first year to train their staff as navigators and coordinate with the PCA on enrollment. Health centers have also been trained and certified as CACs in both years. The PCA and health centers collaborated with other assistance entities, including tribal assistance entities, during both years of implementation.

The Montana PCA is made up of 17 health centers, together serving 100,439 individuals at about 69 sites across the state.[30] Among all of the patients served at the health centers, 57.5 percent are at or below 100 percent of the federal poverty level; 87.3 percent of patients are at or below 200 percent of the federal poverty level; and 43.3 percent are uninsured. According to 2014 Uniform Data System (UDS) data, Montana's health center patients are 86.8 percent white, seven percent Native American/Alaska Native, and 5.1 percent Hispanic/Latino.[31] Health centers disproportionately serve rural areas, with 88 percent of the population served residing in rural areas.[32] The health center served about 16,742 patients at 4 sites in southwestern Montana and provides outreach and enrollment assistance as a state-certified CAC. The health center reported that 62.6 percent of its population is at or below 100 percent of federal poverty guidelines and that patients are disproportionately uninsured, with just under half (48.2 percent) of patients uninsured, 18.7 percent enrolled in Medicaid, and 10.2 percent enrolled in Medicare.

The Montana PCA's role in state enrollment efforts has evolved over time. In the first year, the PCA served as one of three statewide federal Navigator grantees, with responsibility for granting funds to health centers statewide, coordinating outreach efforts, interfacing with federal and state agencies to manage application and enrollment challenges, and organizing health center outreach and enrollment staff for peer-learning. Like other PCAs, the Montana PCA also received federal funding from HRSA, including $148,730 for the first year of open enrollment and comparable funds built into their base grant in the second year, to support ongoing technical assistance and support to health centers in Affordable Care Act-related outreach and enrollment related work.[33]

After serving as a Navigator grantee the first year, the PCA decided to instead take on a statewide organizing role for assistance entities during the second year. This entailed building a central Cover Montana website (www.covermontana.org), providing outreach and enrollment training, webinars, convening assistance organizations into the new statewide coalition, and engaging with state agencies and federal partners to collaborate and resolve issues. As part of its organizing, the PCA was able to connect with and include tribal leaders and representatives from the Indian Health Service (IHS), independent hospital enrollment staff, and some CACs, agents, and brokers in rural areas. The PCA has one to two staff members in addition to 55 health center CACs they work with as part of the coalition.

The health center interviewed mostly provided direct outreach and enrollment assistance support for patients or interested applicants within the county area, providing application and enrollment assistance through healthcare.gov or assisting consumers with paper applications. The PCA received Navigator grant funding during the first year of open enrollment, and received HRSA funding as well as federal and state CAC certification both years. The health center hired an outreach coordinator and three other full-time equivalent staff who have outreach and enrollment as primary job responsibilities but will take on additional responsibilities with the expansion of Medicaid.

A number of structures support the outreach and enrollment work of the PCA and health centers in collaboration with state agencies in Montana.

The PCA organizes calls, webinars, and statewide peer-learning summits including up to 90 enrollment and outreach representatives, and 20 leaders from Indian Country. The Cover Montana website hosted by the PCA is also an important structural support for this work, providing consumer-centered information to support enrollment, organizing, and branding for outreach and enrollment which will soon include Medicaid expansion. The state agencies, Medicaid, and the Commissioner of Securities and Insurance, also play key roles and support collaboration through a number of engagements. The Commissioner of Securities and Insurance holds periodic meetings with safety net providers, Medicaid puts out a twice-monthly newsletter with updates, and both organize briefings to share information, answer questions and sponsor Medicaid-specific trainings. Medicaid also provides a central contact person to elevate cases and engage officials, as needed.

Key Outreach and Assistance Strategies

Given limited financial and human resources in Montana, those involved with outreach and enrollment assistance have had to employ strategies to maximize efficiencies to support their goals. Some of the strategies mentioned that have been most impactful in the first two years of enrollment include:

- **Convening Coalitions of Assister and Stakeholder Organizations:** The PCA said their highest impact strategy was convening assistance organizations to emphasize a culture of "working smarter not harder." While having a centralized, statewide communication venue through the coalition was valuable; the PCA said that the local coalitions that emerged were just as important. Comprised of CACs, Urban Indian Organization health clinics, hospitals, or other stakeholders, they worked effectively together to maximize enrollment by picking the best messenger for target audiences.

- **Tribal Outreach Effort:** In preparing for the first open enrollment period, state agency leaders, including the Commissioner of Securities and Insurance, Medicaid, and the governor's tribal liaison, joined with the PCA and other navigators along with a regional IHS official to educate those living in tribal areas about Affordable Care Act coverage options and support enrollment into coverage including: on-site briefings of every tribal reservation in Montana; calls between Native American leaders and other stakeholders; and providing scholarships to the learning summit.

- **Inreach to Patients and Enrolled Members:** Both the health center and the state reported successful inreach campaigns to educate patients about Affordable Care Act coverage options. The health center used a postcard mailing to existing patients and also put messages and flyers into billing statements that resulted in an uptick in calls after the flyers were sent. With all the news about new Affordable Care Act coverage options, the Medicaid agency was concerned in the first year that current enrollees might think they needed to enroll in new coverage, so they created a "do nothing" campaign, sending informational letters to 70,000 households to let them know that if they were enrolled in Medicaid they could keep their coverage. The Medicaid agency believed this campaign lessened confusion and minimized new applications from existing members.

- **Collaborative Promotions with Medicaid:** The PCA and the state mentioned two collaborative promotions. First, health centers helped to disseminate new business cards created by the state to promote the FFM website, healthcare.gov, to uninsured members and applicants. Second, the PCA paid for an informational mailer that Medicaid sent to existing program enrollees to let them know about their potential eligibility for QHP enrollment. The mailer was sent to 10-12,000 individuals and was considered an effective collaboration with Medicaid.

Challenges and Successes

While these enrollment strategies by safety net providers proved to be effective, challenges also surfaced. The health centers reported providing over 32,000 assists with actual or potential enroll-

ment or reenrollment in health insurance available through Marketplace qualified health plans and/or through Medicaid or CHIP in the first year, and over 14,000 assists during the second open enrollment period. They believed that the decreased enrollment was due to QHP-enrolled individuals losing coverage for non-payment of premiums and that the loss in coverage may have been due to a lack of knowledge about health coverage rules, indicating gaps in health literacy among consumers. For example the health center reported that some consumers delayed paying the first month's premium for QHP coverage, then were surprised when they weren't allowed to pay it later, as they would with a cell phone or cable bill. Health center and PCA staff reported working to improve understanding of coverage program rules among staff and at outreach events, including income tax events at libraries, but the health center reported the tax events needed to be better timed with tax season to be effective. Health center assisters also reported it was difficult for them to manage the volume of information and individuals needing assistance given limited staff. For example, they said describing differences in plans, what insurance will cover and difference in terms within an hour-long assistance appointment presented a challenge.

Montana's decision not to expand Medicaid in the first two years also posed a major challenge to enrollment efforts, because many who apply for coverage fell into the coverage gap between Medicaid and QHP eligibility. Health centers reported that they felt they were the best messengers to communicate with ineligible applicants because they could offer a low or no cost treatment alternative.

Despite these challenges, Montana has experienced great success with enrollment. The PCA, health center, and state agencies reported the important role collaboration across agencies played in improving enrollment in the state. Cover Montana, joint trainings, and statewide convenings allowed outreach and enrollment stakeholders to share best practices, trouble shoot questions and concerns, and brainstorm strategies to reach their target population. Safety net provider and state agencies noted that the joint informational mailers to DPPHS clients resulted in an uptick in enrollment. Additionally, interviewees noted success in engaging consumers by conducting outreach at locations with a wide reach such as libraries, mental health centers, and parole agencies.

Collaboration Experience with State and Federal Agencies

The success of outreach and enrollment efforts in both case study states was heavily dependent on the strength of collaboration and support between the health centers, their leaders, and state and federal agencies. In both states, informants credited their enrollment success to a tightly coordinated effort and consistent communication with state agencies. Strong and trusted relationships with agency leaders were also important, with both health centers and PCAs reporting that trust and openness had fostered a relationship of mutual reliance and respect. In Montana, the PCA flagged early challenges in working with local offices of public assistance which had varied knowledge and available resources. This may signal an opportunity for other states with local eligibility offices to work more closely in partnership with local officials to ensure consistent messaging and oversight.

Collaboration with federal agencies received mixed reviews from health center and state agency staff. While health centers and PCAs universally expressed appreciation for HRSA funding and coordination efforts, including forums and monthly best-practices calls, they also voiced some concerns about how well federal efforts were coordinated. Enrollment stakeholders noted the disconnect between enrollment reporting and metrics for health centers used by HRSA and the navigator metrics used by CCIIO, which they said made reporting more difficult and time-consuming. Some consumer assistance entities in Montana said they were unclear on CCIIO's planned role and responsibility given the state's FFM status and said that a more consultative approach to outreach and marketing would work well going forward. Some officials mentioned they were unaware of HRSA's funding and outreach strategy and suggested more direct communication with state officials

could maximize impact and improve collaboration. Both states reported that the combination of CCI-IO-sponsored trainings with state-specific trainings and materials had worked well to complement education for assistance organizations.

Lessons Learned

Informants from these case study states shared some lessons from their first two years of successful enrollment and collaboration.

- **State and PCA Leadership:** Informants said success was supported by state agencies and the PCA, setting a proactive and enthusiastic approach to enrollment and sharing the goal of enrolling as many people as possible.

- **Consistent, Constant, Communications:** Informants noted the importance of communication both with the state and stakeholders through networking and through what one health center called "cooper-tition," a method of having competing organizations come together to share their needs, goals and limitations so they can amicably discuss how to coordinate enrollment efforts.

- **Trust:** State agencies and health centers shared that having stakeholders know and trust you will improve the states' or the health centers' ability to be successful in promoting collaboration or enrollment.

- **Branding and Identity:** State officials said they had learned the importance of branding an enrollment program or campaign from previous experience with CHIP enrollment. The PCA mentioned the importance of helping enrollment workers foster a community tie to help them understand the bigger mission they are a part of, which might sustain their work when things are inevitably hard along the way.

- **Flexibility in Approach:** State and health center officials stressed the importance of being creative and adaptive in pursuing strategies that will work to find and enroll new populations, since most are invariably paving new pathways to coverage. One health center said that technology is important, but sometimes a simple piece of paper, like a business card or "need assistance" form can do the trick just as well.

Looking Ahead

In considering future enrollment efforts, informants raised a number of common themes relating to challenges and opportunities, including:

- **Increased Communication Among Federal, State, and Safety Net Agencies:** In both states, key informants noted that more could be done to improve communication on enrollment efforts and assister funding among CMS, HRSA, state agencies, and health centers. The multiple funding sources and reporting requirements could be better aligned to improve access to health coverage for the populations all these entities serve.

- **Sustainability:** While HRSA funding to support outreach and enrollment efforts has been rolled into base funding allocations and was considered "solid," both state and health center entities mentioned questions about future funding from other sources. kynect is relying on Medicaid support for the first time in 2016 with its federal exchange grant ending, but will continue to fund Medicaid outreach work with operational funds. The PCA's current contract with the exchange agency ends after 2016, so there is some uncertainty as to whether state funding will continue. Montana Medicaid also expressed concerns about how they will fund outreach efforts needed to find and enroll individuals newly eligible for Medicaid in 2016. The Montana PCA has suggested partnering with the state on outreach, so that may offer an option.

- **Health Insurance Literacy:** Both state's health center informants mentioned similar concerns about health and health insurance literacy for eligible and enrolled populations. This may indicate an opportunity for greater educational out-

reach and engagement, both by health centers at the local level and by national organizations, to support continued learning about how health insurance works and how to use it to access care in a coverage program. National resources, like the CMS Coverage to Care Campaign, which provides information, videos, and training materials designed to "help people with new health care coverage understand their benefits and connect to primary care and the preventive services that are right for them," may offer important technical assistance to PCAs, health centers and other stakeholders in this effort.

- **Hard-to-Reach Populations:** Both states identified the importance of working to make progress in educating and enrolling remaining uninsured populations that are hard-to-reach, with informants in both states voicing concerns about how bias against "Obamacare" and misconceptions about eligibility may make this effort more challenging. Informants suggested they may need to become more creative in engaging the remaining uninsured, including through advertising campaigns.

- **Improving Connectedness of Assisters**: Health center leaders in both states mentioned that navigators, in-person assisters and CACs are being viewed as caseworkers by new enrollees and will need direct access to more information, about system changes and case status updates, so they can more effectively assist both enrollees and state agencies.

- **Major Policy Changes on the Horizon:** Both states are implementing significant policy changes in the coming year. Montana expects to expand Medicaid for FY 2016, which poses opportunities for a more seamless eligibility interface between the FFM and Medicaid. Health centers will likely play a central role in supporting implementation – they are already invited to serve on an expansion oversight committee, hosting the covermontana.org website to promote coverage, and offering other supports to the state. Kentucky is implementing passive, automated renewals for all enrollees and suspension of benefits instead of termination of benefits for incarcerated individuals in August 2015, both of which are expected to improve the seamlessness of coverage for enrollees.

Conclusion

Health center experience in Kentucky and Montana highlights how PCAs and health centers can be critical partners for high-performing states' efforts to promote outreach and enrollment into new coverage opportunities. Even with limited experience in the first two years of enrollment, these PCAs and health centers are modeling opportunities for leadership, community engagement, and developing innovative inreach and outreach strategies to find and enroll uninsured individuals, including hard-to reach subgroups. Even with early successes, these entities have faced numerous challenges that may threaten future enrollment and retention of coverage, including low health literacy, resistance and misunderstanding of Affordable Care Act coverage options, and logistical challenges impeding renewals. As PCAs and health centers look ahead to future collaboration with state leaders, they can draw on key lessons shared from these states' experiences regarding the value of leadership by state and health center leaders, the importance of communication and trust, the impact of branding and forging community ties for assisters, and, most importantly, the powerful impact of strong collaboration between state and federal agencies with health centers to support the mutual goal of promoting enrollment.

Endnotes

1. In Kentucky, representatives from the Health Benefit Exchange agency were also interviewed.
2. Ten Napel, Shelly and Daniel Eckel, Navigators and In-Person Assistors: Key Policy and Design Choices for States, State Health Reform Assistance Network, March 12, 2013. http://statenetwork.org/resource/navigators-and-in-person-assistors-state-policy-and-program-design-considerations/
3. Ways to help consumers Apply & Enroll in Health Coverage Through the Marketplace, June 2014 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/AssistanceRoles_06-10-14-508.pdf
4. http://bphc.hrsa.gov/about/healthcentersaca/outreachenrollment/
5. Specific activities identified by HRSA included: "inreach" to existing health center patients; outreach to new individuals within the health center's traditional service area; individual education sessions about coverage options; securing access to Medicaid, CHIP, and other social service, pharmacy or assistance programs; assistance with filing appeals and exemptions; assistance with requesting a special enrollment period; assistance with renewals; assistance with improving health insurance literacy; assistance with certification of the health center as an assistance entity; supporting an assistance workforce; planning and maintaining partnerships to support enrollment efforts and identifying and sharing lessons learned to improve future enrollment efforts.http://bphc.hrsa.gov/archive/outreachandenrollment/oefaqs.pdf
6. http://content.healthaffairs.org/content/early/2015/05/04/hlthaff.2015.0266
7. http://hrms.urban.org/briefs/gains-in-health-insurance-coverage-under-the-aca-as-of-march-2015.html
8. While this paper focuses on new coverage programs created for non-elderly individuals, the Affordable Care Act also changed reimbursement methods for services provided to Medicare-eligible populations and, as such, may also impact the percentage of patients served by Medicare within health centers' patient population.
9. According to 2014 UDS data, health centers experienced a 5.3 percent increase in the number of patients served in 2014 compared to pre-implementation figures in 2013, from 21,726,965 in 2013 to 22, 873,243 patients in 2014. HRSA Health Center Program, "2014 Health Center Data: National Program Grantee Data,", retrieved August 25, 2015, http://bphc.hrsa.gov/uds/datacenter.aspx.
10. In the first year of Affordable Care Act implementation, health centers experienced a 20 percent drop in the percentage of uninsured patients they were serving, from 34.9 percent in 2013 to 27.9 percent in 2014. Coverage rates among health center patients for all types of coverage programs increased during this period, with Medicaid and CHIP coverage showing the greatest gains: Medicaid and CHIP coverage increased by 14 percent; third party coverage increased by 6.5 percent and Medicare coverage increased by 2.4 percent. Ibid., 2014 Health Center Data: National Program Grantee Data.
11. While beyond the scope of this paper, it is worth noting that some state Medicaid officials may have mixed views about health centers' increased role in enrollment. Although they may appreciate the connections that centers bring to hard-to-reach communities, some may also be concerned that giving centers a prominent enrollment role will lead to health centers being designated as PCPs and, ultimately, cause the state to pay higher payment rates under the prospective payment system. This paper does not explore or address this experience with the case study states interviewed, as these concerns were not expressed by Medicaid officials interviewed in these states.
12. Montana enacted legislation to implement Medicaid expansion for the open enrollment period for FY 2016. At the time of publication, Montana's expansion proposal was pending CMS review.
13. Most health centers function as CACs in the states in which they operate.
14. Outreach and Enrollment Assistance to Health Centers (FY 14 figures provided): http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/index.html
15. HRSA Primary Care Association Outreach and Enrollment Awards (FY 13 One-time supplemental OE funding) http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/pcas.html
16. Dan Witters. "Arkansas, Kentucky See Most Improvement in Uninsured Rates." (Gallup, February 24, 2015). Accessed here: http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx
17. Medicaid and CHIP: April 2015 Monthly Applications, Eligibility Determinations and Enrollment Report, CMS, May 1, 2015 http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf
18. Health Insurance Marketplaces Open Enrollment Period: March Enrollment Report, ASPE, March 15, 2015, http://aspe.hhs.gov/health/ reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf
19. BPHC UDS Data 2013 State Profile for KY: http://bphc.hrsa.gov/uds/datacenter.aspx?year=2013&state=KY

20. These include assistance activities such as: "understanding health insurance options through one-on-one or other customizable education; creating a user account in the marketplace; updating an account profile and/or income information; filing an exemption or appeal; understanding marketplace auto-enrollment notices; submitting an application to/through the marketplace or directly to the state Medicaid agency (also include as an application submitted); understanding an eligibility determination; or selecting a new or different marketplace plan" Email from Lynette Araki, HRSA, July 13, 2015.
21. Email from Family Health Centers, August, 2015.
22. The languages KHBE is planning to translate into, in addition to the current English and Spanish, include: French, Kinyarwanda Chinese (Simplified and Traditional), Burmese, Karen, Kirundi, Somali, Chin, Karenni, Nepali, Swahili, Arabic, Russian, Vietnamese, Tigrinya
23. Medicaid data showed a significant increase in utilization of preventive services from 2013 to 2014, including a 187 percent increase in physical exams, a 116 percent increase in adult dental visits, a 111 percent increase in breast cancer screenings, a 108 percent increase in colon cancer visits, and a 98 percent increase in cervical cancer screenings. More Kentucky Medicaid Patients Get Preventive Care, Kentucky Courier-Journal, August 5, 2015 http://www.courier-journal.com/story/life/wellness/2015/08/05/preventive-%20care-rises-among-kentucky-medicaid-patients/31190973/
24. Doe-Anderson Scores Gold for its Work on Kynect, Insider Louisville, June 5, 2015 http://insiderlouisville.com/business/advertising-2/lou-advertising-firm-doe-anderson-scores-gold-effie-ky-firm-win-year/
25. Letter from State Auditor and Commissioner of Securities and Insurance Monica Lindeen to Gary Cohen, CCIIO Director, February 26, 2013 (accessed July 21, 2015) https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/mt-exchange-letter-2-26-2013.pdf
26. http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/medicaid-chip-marketplace-interactions.html
27. At time of publication, the state was planning to develop and submit a Section 1115 waiver to support the state's expansion for review by the Department of Health and Human Services in September, 2015. Montana Governor Signs Medicaid Expansion into Law, Kaiser Health News, April 30, 2015, http://khn.org/news/montana-governor-signs-medicaid-expansion-into-law/
28. http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx
29. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013.pdf
30. Map of Sites Served by the Health Center Program, NACHC, Accessed July 17, 2015 http://www.nachc.com/client/documents/research/maps/MT2015.pdf
31. Note that these percentages may be greater than 100 percent due to independent calculation of race and ethnicity. Hispanic ethnicity may be of any race (ie. Black or white). Montana Health Center Fact Sheet, NACHC, Accessed July 2014, http://www.nachc.com/client/documents/research/maps/MT13.pdf
32. Montana Health Center Fact Sheet, NACHC, Accessed July 2014, http://www.nachc.com/client/documents/research/maps/MT13.pdf
33. http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/pcas.html
34. https://marketplace.cms.gov/technical-assistance-resources/c2c.html

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Appendix

Affordable Care Act Enrollment Glossary:

- **Health Insurance Marketplace (or exchange)**— A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. In some states, the Marketplace is run by the state. In others it is run by the federal government.
  - **State-based Marketplace (SBM)**—States that operate their own marketplace
  - **Federally facilitated Marketplace (FFM)**— States that opt to use the federal healthcare.gov platform maintained by the Centers for Medicare and Medicaid Services (CMS)
  - **Federal Partnership Marketplace (FPM)**— States that opt to administer some marketplace functions, but partner with healthcare.gov for certain eligibility functions

- **Qualified Health Plan (QHP)**—A health insurance plan that is certified by the Health Insurance Marketplace to meet the standards outlined by the Affordable Care Act such as providing essential health benefits and following limits on cost-sharing

- **Enrollment assistance entities**—trained and certified organizations that help consumers understand, apply for, and obtain health coverage. These can include:
  - **Navigators**- Individuals or organizations that are funded by CMS to provide free outreach and enrollment assistance services in a culturally and linguistically appropriate manner to consumers in FFM and in FPM states; provide education about the Marketplace; facilitate enrollment into QHPs; and provide consumers with referrals to agencies for grievances, questions, or complaints. Navigators are required to participate in federal training to become certified and report on their activities and performance
  - **In-person assisters (IPAs) or non-navigator assistance personnel**— Individuals or organizations that contract directly with SBMs or FPMs to provide free outreach and enrollment assistance; these entities can receive grant funding to perform their enrollment and outreach activities but must be distinct from Navigator programs
  - **Certified application counselor (CAC)-** assister entities or individuals that are trained to provide free enrollment assistance; these organizations educate consumers and help them complete an application for health coverage. CACs must meet training requirements, security standards, and conflict of interest rules as do Navigators and IPAs although their training differs.

- **Health centers—**public and private non-profit organizations that provide high quality preventive and primary health care to medically underserved communities and populations. In this brief, "health centers" refers to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act.