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Successful Health Insurance Outreach, Education, & Enrollment Strategies for Rural Hospitals: Marcum & Wallace Memorial Hospital, Irvine KY

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Overview

This report provides information collected from a two-day site visit to Irvine, KY, where researchers met with staff at the Marcum & Wallace Memorial Hospital (M&W) and partners who engaged and enrolled rural residents during the first Open Enrollment period for state and federal health insurance marketplaces established by The Patient Protection and Affordable Care Act (ACA): October 1, 2013 to March 31, 2014. This case study describes the experiences of a number of local service providers serving the area as described during in-person interviews with key participants and a review of enrollment-related documents related to outreach, engagement, education, and enrollment activities.

A second, companion case study by the University of Minnesota RHRC focuses on a hospital and its partners in Marinette, WI. A related policy brief summarizes our findings.

Background

The ACA and Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, enabled the creation of a health insurance marketplace (or "exchange") in each state by January 1, 2014. Through these marketplaces, individuals and families receive information on theitr insurance options, compare and purchase Qualified Health Plans (QHPs), apply for financial subsidies, and (when applicable) obtain an eligibility determination for coverage under public programs such as Medicaid or the State Children's Health Insurance Program (CHIP).[1-3] States were given the option to create their own state-based health insurance marketplace, work with other states to establish a regional marketplace, run a marketplace in partnership with the federal government, or (following the Supreme Court decision) have a federally-facilitated marketplace.[4]

By the beginning of the first Open Enrollment, 16 states and the District of Columbia had elected to operate a State-Based Marketplace (SBM), with three of them electing to use the federal website (healthcare.gov) for enrollment.[5] Seven states entered into a State-Federal Partnership (SFP) and the remainder elected to have a federally-facilitated marketplace (FFM).[5] These

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same marketplace structures remained in place during through the second Open Enrollment (Nov 2014 – Feb 2015) and into the summer of 2015.[6]

Federal law does not prohibit states from modifying their marketplaces, as long as they have obtained the approval of the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services. Legislative proposals have been introduced in 14 states thus far to change a FFM or SFP to a SBM,[7] and a number of states have proposed strategies to shore-up vulnerable marketplaces.[7,8]

The Supreme Court's June 2015 ruling in favor of the ACA (*King v. Burwell*) upheld the legality of states offering Federal tax subsidies for eligible residents' insurance premiums.[9,10] Following the ruling, several SBM states initiated steps to explore and consider an expanded role for the federal government in their marketplace operations.[11,12]

The First Open Enrollment under the ACA
(October 2013 – March 2014)

During the first Open Enrollment period, 8 million people were enrolled by commercial QHP insurers selling through the new state insurance marketplaces; an additional 6 million were enrolled through Medicaid.[13] One study examining insurance coverage trends found that the proportion of people uninsured dropped from 17.1 percent in the fourth quarter 2013 to 15.6 percent in the first quarter of 2014.[14] Another study demonstrated that the net gain in insured Americans (after adjusting for those who lost their insurance coverage during the same time period) grew to more than 20 million: 9.6 million covered by Medicaid and another 11.2 million covered through QHPs.[15]

A critical element behind the success of the first Open Enrollment was the availability of trained and certified individuals to help consumers complete their applications for insurance coverage. Over 4,000 Marketplace Assister Programs were in place before October 2013; while some organizations did not receive approval to train assisters until after the opening date, more than 28,000 full-time staff and volunteers were assembled to make the Open Enrollment a success. In June 2014, a national roundtable on consumer assistance identified six critical areas in which assisters faced significant challenges to educate and enroll individuals (see Appendix A, "Challenges to Consumer Assistance").[13,14] For more information about Marketplace Assister Programs, see Appendix B, "The Role of

Assister Programs in Open Enrollment."
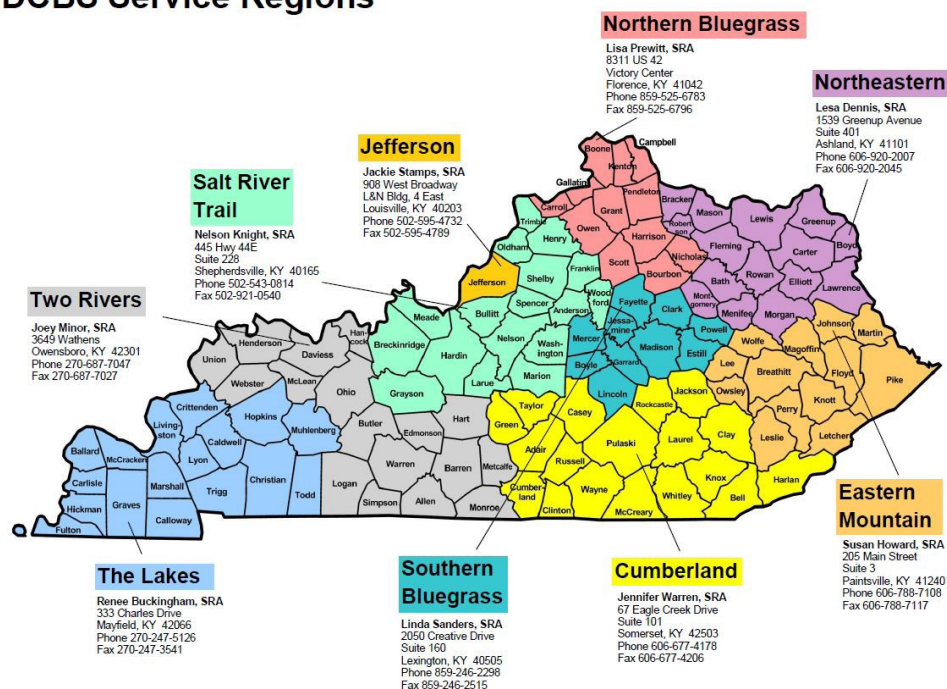
An Opportunity for Rural Uninsured

Of the more than 40 million individuals estimated to be uninsured at the beginning of the first Open Enrollment period in October 2013, 7.8 million resided in rural communities.[16] Decades of research have demonstrated that rural residents are more likely to be uninsured and to experience longer spells of uninsurance than their urban counterparts.[16-19] Rural families, on average, pay almost one-half of their total health care costs out-of-pocket; one-in-five farmers are in medical debt.[14] The implementation of the ACA provides a tremendous opportunity to expand health insurance coverage among rural populations, offset the bad debt and charity care burdens many rural providers have carried for years, and improve their capacity for serving the needs of their communities.[18,19] Rural hospitals and primary care practices are in an excellent position to serve as anchor organizations around which other interested stakeholders can add their support.

The June 2012 Supreme Court ruling allowing Medicaid expansion to take place on a state-by-state basis made the challenges facing the rural poor and uninsured more complicated. Prior to the first Open Enrollment, twenty-five states had expanded Medicaid coverage and four others tightened their eligibility criteria for the program.[20] As of June 22, 2015, all but one SBM state have continued with their expanded programs. Two states expanded after the close of the first Open Enrollment, three additional states are in the process of expanding, and another has passed legislation to expand but requires federal waiver approval before it can go into effect.[21]

A Case Study of Rural Enrollment

In the summer of 2014, the University of Minnesota Rural Health Research Center conducted studies on the role of rural hospitals and rural communities in the first Open Enrollment. Participants in that earlier telephone survey were recommended by State Offices of Rural Health, State Hospital Associations, and other rural experts as representing successful and exemplary models for enrolling rural residents. The Marcum & Wallace Memorial Hospital (M&W) participated in that survey, and was selected for this site visit for two main reasons. First, the telephone interview suggested that a more-detailed exploration of hospital and community-partner enrollment experiences could foster further successes in rural enroll-

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ment efforts. Second, the state of Kentucky had elected to operate a SBM and used a number of interesting strategies to educate residents and coordinate enrollment efforts at regional and local levels while allowing flexibility to address local situations. The second site visit, profiled in a companion case study report, was conducted with a hospital in Wisconsin, a state with a FFM as opposed to Kentucky's SBM.

The geographical area of interest is a five-county area in the southern portion of Kentucky's Bluegrass Region including Estill, Lee, Powell, Wolfe, and Breathitt Counties. The area, which opens to the southeastern coalfields and the western Appalachian Mountains, has a population density of 45.4 persons per square mile. Historically one of the poorest regions in the nation, the area has struggled for decades with some of the highest poverty, unemployment, and uninsurance rates in the state.

Planning for Open Enrollment

Statewide Planning and Preparation Efforts

Between 2010 and 2013 the state had received $253 million to plan, develop, and launch "KYnect," its state marketplace.[22,23] In May 2013, the Kentucky Health Benefit Exchange (KHBE) began a public education-and-awareness campaign.[24] The decision to brand the online marketplace "KYnect" helped the public to see the program as more of a state effort. A broader marketing campaign

began in August, with online ads and distributing KYnect-branded materials at local events and fairs. By October, the campaign expanded to other media: television, radio, newspapers, billboards, additional public events, and hospital kiosks.

At the same time, the state began issuing grant awards totaling almost $6.5 million to successful respondents of the state's earlier Request for Proposals for KYnector organizations to provide education and assistance for the state's eight Medicaid Regions. The five-county-area highlighted in this study benefitted from $600,000 in grants, awarded to the Primary Care Association.[25]

Phased marketing kept the messages up to date shifting from general information about KYnect early on and messages meant to spark people to action later in the implementation of the exchange. Navigators, In-Person Assisters, and Certified Application Counselors (CACs), dubbed "KYnectors," were used to engage educate and enroll individuals. Navigators conducted public education and outreach efforts while In-Person Assisters and CACs facilitated engagement and education efforts directly with clients and Navigators and CACs provided application assistance by phone or through face-to-face encounters arranged by appointment or handling walk-ins when possible. The first year budget for implementing KYnect was estimated at $39.5 million and operations beyond 2014 were expected to be covered by approximately $29 million in revenue collected through assessments of participating insurers and would not use the state's General Fund.

The Kentucky Primary Care Association provided resources for community health center members to train and place CACs in their facilities. Education materials were developed for its membership to identify and respond to outreach and enrollment issues, health and insurance illiteracy, provided tools for developing effective outreach and marketing strategies.[26] State grant funds for assisting Medicaid Region 8 were used to hire a KYnect coordinator to maintain an email listserv for recording and discussing issues and holding monthly meetings in the area for training and updates.

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Building on their prior experiences working together on health initiatives, service providers in the five-county-area organized the Project HOME (Helpful Opportunities for Medical Care Enhancement) Network in 2009 with a Rural Health Network Development Planning grant provided by the Federal Office of Rural Health Policy (FORHP). The Project HOME Network focused efforts primarily on the uninsured residents of Estill and Lee Counties coming to the M&W hospital emergency department. The Navigator[a] worked with those clients and others referred by network partners to obtain access to a primary care provider and a "medical home." The scope of network efforts expanded with the help of a 2012 Rural Health Services Outreach grant from FORHP.

Local Planning and Preparation Efforts

Planning for local enrollment efforts began in earnest with the network's Board of Directors, M&W hospital, and the network partners. The Program Manager (who had been managing networks for over a decade) and the Navigator trained for Project HOME were selected to take the lead in the network enrollment preparations. Both had been tracking the development of the state's enrollment strategies and discussions of potential issues, and had the trust of network members to proceed.

In early summer 2013, the Navigator began with educating the hospital's Board of Directors and staff. He also spoke with each of the network partners about the ACA, detailing the exchange and options for uninsured patients. He also asked private sector employers in the area to be aware of employees in need of health care coverage.

In September, the Board approved a plan of action for enrollment. It was decided that each network partner would target their own self-pay patients and that all would collaborate to reach the other members of their communities.

The network partners providing a CAC location included:

- Marcum & Wallace Memorial Hospital (M&W), a Critical Access Hospital (CAH) with a family-centered focus of care that served as a regional referral center for a wide geographic region. When the first Open Enrollment period began, M&W had purchased two private practices and enlarged their own medical practice to create Mercy Primary Care, with clinics in Estill, Lee and Powell Counties.

- Juniper Health, Inc., a Federally Qualified Health Center (FQHC) in Lee County, which had expanded to cover Wolfe and Breathitt Counties.
- Foothills Clinic, a FQHC in Powell County, which began as a mobile homeless clinic but had established itself in a permanent location, served both Powell and Estill counties.
- Whitehouse Clinics, which operated group practices in six locations – the one in Estill County offered Family Medicine, Pediatrics, Oral & Maxillofacial Surgery, and Internal Medicine with a geriatrics focus.
- Bluegrass Comprehensive Care, a behavioral health provider providing services in Estill and Powell Counties.

The CAH and FQHCs worked very well together to meet clinical needs of area residents. Several respondents commented on the solid working relationship and that both parties genuinely wanted to have a good working relationship from the beginning. One respondent not affiliated with either party commented that "it might be just part of our local culture, but we like to work together to solve our problems. You just need to call people to the table, sit down, and have a frank discussion about what issues are developing and how best to improve the delivery system. We come together to learn from each other and to solve issues." Another FQHC respondent noted "we're pretty isolated and needed to work with a closer hospital… for our three-county service area, we're all there is."

The remaining network partners offering support and referrals included Kentucky River Community Care, Marshall Emergency Services Associates (MESA), the Estill and Lee County Health Departments, WestCare, a substance abuse center, the Estill Development Alliance, and the Estill and Lee County Chambers of Commerce.

A Feeder System for Enrollment

Establishing a referral system among rural health and human service providers has been an effective strategy for many rural areas across the country, particularly when target populations are isolated and providers serving them have small budgets. The high rates of uninsurance among provider organizations made it a priority for all network partners to focus much of their enrollment activities on their own self-pay patients and to work collaboratively with other network partners to reach community mem-

[a]Navigator grants are generally large grants given to a consortium of agencies and, while administered by one key leader, often refer to a larger collective than individual CACs.

bers.

Network partners without CACs educated front desk staff to operate as In-Person Assisters to start the engagement and education process and refer the client to the nearest CAC. Sometimes the effort involved calling and setting up an appointment for the client; other times, it would just involve handing the client information on the location that included the phone number and name of the nearest CAC that could help. Some reported that their organization had a process in place to make follow-up phone calls with their clients to confirm that connected with appointment and enrolled.

Those network partners with CACs also used the referral plan to connect overflow clients with other CACs to avoid consumer frustration from long waits. They would also check with clients about setting an appointment for coming back another day, or ask them if they would prefer to come back in a while. CACs were willing to stay after hours if necessary.

Personalized engagement and education efforts made for happy enrollees, who would often spread the word. The hospital's three Rural Health Clinics (RHCs) had designated staff to educate people about the basic requirements for enrolling (photo ID, social security number, verification of income) and schedule an appointment with one of the hospital's CACs.

Self-pay patients were identified by using the Project HOME database, reviewing medical records, and catching patients as they appeared for services. Self-pay patients were alerted via calls and mailings about Open Enrollment and the availability of subsidies to offset premium costs. Callers would invite the patient to meet with a CAC to be enrolled. Network partners used a monitoring system to track the patients' assistance history and enrollment status.

Training all clinic staff from the front desk to practitioners was very important for enabling opportunities to market KYnect with others. All staff could speak to the key aspects of enrollment and the value of KYnect. Although one clinic mentioned that they did not have a formal strategy for enabling patients to spread the word, they did give patients assurances that the clinic would help all who called and provided the patient with contact information to give to those who were interested. All of this clinic's KYnectors had business cards to hand out.

Strategies for Engaging Multiple Populations
Discussions with network members made it clear that some partners would be using the KYnect-branded materials prepared by the state and others would also use materials developed locally to better target specific populations. There was general agreement over the need to keep basic information available on all marketing materials and to present a unified and consistent message for the public identifying CAC locations, the documentation needed and how long the process could take.

Similar to the state's strategy, marketing and engagement materials were disseminated via various media: radio advertisements, newspapers, billboards, posters, brochures, and flyers. Network partners used a number of venues for engaging local residents including local festivals, health fairs, back-to-school events, civic groups, county extension office events, and meetings at area social clubs. One network clinic partnered with a local library's bookmobile program and followed-up with enrollment events at the library. Many network partners also attended events held at food banks, soup kitchens, and substance abuse and homeless shelters for those most in need.

Several noted that conducting engagement efforts at local festivals and fairs was not very productive: "People were not at the events to enroll – they were there for recreational purposes. We handed out flyers and received some questions, but there were no enrollments." Others noted that outreach at such events were good in that they allowed community members to ask questions to get clarity but were under no pressure with several appointments arranged for later enrollment. However, in general those events did not justify the resources used to cover them.

Engagement efforts also included outreach to employees at small businesses. When called, some business owners would prefer that only they speak with a KYnector, while others would invite the KYnector to come to the business to talk with employees.

Events conducted at County Extension Offices and on

Example of Billboard

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Saturdays at the local library were encouraged by the state program but did not prove that successful largely because of low turnout and the lack of sufficient privacy to provide assistance.

Another network partner had success conducting outreach at a District Court House, which was thought to be in part because the non-federal venue provided a trustworthy environment. Some had considered conducting outreach and enrollment at Wal-Mart stores, at schools during PTA events, or at booths at the hospital. It was decided, however, that these locations were not practical because of the need for privacy and the time it would take to complete applications would not make it worth it for a commercial location.

Most partners agreed that keeping CACs in-house was the most efficient and effective use of resources. Referrals were made from schools, churches, businesses, and other health care providers with the most enrollments occurring in a clinic or the hospital.

The message of respondents was loud and clear: word-of-mouth was the best marketing they could get. They also agreed that although In-Person Assisters were valuable for channeling consumers to CACs, they could not capitalize on that education encounter to enroll the consumer. Time could be a critical factor for signup success. If you did not strike when the interest was fresh, other priorities or events could prevent the consumer from seeing a CAC for enrollment.

Because some of the state-provided materials were not appropriate for the literacy levels of some consumers in their area, the hospital created simplified versions of printed materials. Another noted that their clientele were also not very insurance-literate and had not been able to complete their application at the County Department for Community Based Services (DCBS) and that the CAC at the clinic needed to make changes to the client's application sometimes requiring them to be on the phone for long periods of time to straighten things out. They decided not to refer any overflow patients to DCBS because of a concern that they might be making more work for themselves if the patients were not able to complete their applications there.

Hospital materials also provided a phone number for its key CAC, who was primarily working in the emergency room as a Navigator for the Project HOME initiative. People would call the Navigator's number to arrange an appointment; other consumers just walked in the emergency room door. Because of efforts to educate the public about the streamlined application process, most consumers enrolled at the hospital had the documents needed to complete their applications in a single visit. The few that did need to retrieve additional documents were able to fax them to the CAC for verification and uploaded onto KYnect. In the hospital clinics, front-desk staff engaged consumers directly. If the conversation went well, In-Person Assisters would help enroll consumers there; if any issues arose, consumers were escorted to an area with more privacy and referred to the hospital for application assistance.

One of the FQHCs purchased cell phones for each of their KYnectors and published the numbers through radio and newspaper ads, flyers and brochures available for the community. Once most people knew where the KYnectors were located they just walked into the clinic without making an appointment. Another network partner mentioned that a number of people seen at their site had assumed they were not eligible for Medicaid. Once the application process was accomplished they were happy to be eligible. They told the happy enrollee to spread the word to other people in the community that doubted they were eligible to come in and see for themselves.

Enrollment 2013-2014

Capacity for CAC Support

CACs received their training through online modules with each requiring a test for competency and a final exam. One of the hospital CACs reported that it took a while for the test scores to get approved by the state certifying their competence to engage and enroll. The network had numerous In-Person Assisters to engage and direct clients to over a dozen CACs for enrollment assistance. One CAC described the process as simple and easy to use and that once they finished the application process consumers understood the premium tax credit that would be available, the options they had, and because the provider's knowledge of area primary care providers it was possible to also link the client with a source of primary care.

The exchange was set up so that a CAC could assign primary care physicians to patients in the community based on patient demand. Once selected, the CAC would try to set up a first visit for the enrollee for at least a check-up to get them into the provider's system and make it easier for the client to see them if they became sick.

CACs had different motivations for working hard to

enroll their uninsured neighbors. One reported that he was motivated because he had seen changes that could be made in people's lives by having insurance. He had witnessed situations where a person was dying with a chronic disease because they had not been able to access the needed preventive and treatment services to improve their health. Another reported that she was motivated by the joy she feels when she is able to help someone, noting that as a single mother of three who was grateful for the help she received, she wanted to pay it forward. A clinic manager stated that everything moved very fast for the enrollers and that she was very impressed with the way CACs applied their training and worked together sharing experiences to further develop their skills and knowledge to help others enroll.

Whitehouse Clinics received HRSA funding for outreach and enrollment to hire three half-time KYnectors and had four Financial Counselors available to rotate between the eight clinic locations. One clinic respondent commented that "without the grants I doubt that we would have been able to be as involved as we were. We just do not have the people (and) enrolling is labor intensive and took a lot of time to get people enrolled and to conduct follow-up."

Foothills Clinic used funding from the state Primary Care Association as well as HRSA to field four CACs for their service area. The KYnector funded through federal dollars served Estill and Powell Counties while the other three served Estill as well as the other service area counties.

Juniper Health was awarded a HRSA grant to hire KYnectors for Breathitt and Lee Counties and funding from the state Primary Care Association to hire a KYnector for Wolfe County. Conducting over-the-phone applications and the use of extended hours of operation on Saturdays and through the week to accommodate the schedules of working families enhanced the clinics capacity to serve their clients.

Bluegrass Comprehensive Care, a behavioral health provider providing services in Estill and Powell Counties used a CAC on loan from the Foothills Clinic to assist clients a couple of days a week on an as-needed basis. The system broke down, though, due to miscommunications between the facilities.

CAC Challenges

Enrollment efforts for the area were late in getting un-derway because of delays in the availability of KYnector training. When M&W contacted representatives about the delay they were told that KYnector training was being conducted region-by-region with the first training slots for each region reserved for insurance brokers. The CACs for the hospital were not trained until December 2013.

A number of respondents at M&W noted that training fell short of preparing them for the issues of enrollment. Based on our earlier telephone surveys of hospitals around the country, this was not an uncommon experience in other states. One respondent reported that there seemed to be far more questions than answers at of one of the preliminary sessions she attended. The ramp-up time was so short and the learning curve so steep that even trainers were having a rough time addressing scenarios not included in their PowerPoint slides.

One KYnector felt that she would have been better prepared had the training been offered on-site. Others reported that understanding the commercial insurance co-pays and relevant policies were cumbersome and feedback in that regard was communicated back to the state.

Although the state marketplace worked smoothly throughout the enrollment process, there were initial problems with the firewall in place for KHBE-related databases housed in Frankfort. The firewall problem would not allow people who were working with the Health Department to get connected with client information. This presented a challenge for those who had started their application online or at the County DCBS office and came to their nearest CAC to edit and/or complete their application. The clinic and hospital CACs needed to start the application process anew to enroll their clients.

Long lines for application assistance could develop on any given day. Although one of the FQHCs reported that three-quarters of the clients were enrolled on the spot, people would sometimes have to wait in line, and seemed unsure if or when they would be able to come back. Clinic staff would ask the person if they had any business to take care of in town for an hour or so and that when they were finished they could come back to the clinic that day to enroll. Staff were trained to be sure to tell the person that the clinic would stay open after hours just for them to complete their enrollment.

Toward the end of enrollment, many CACs were working beyond a 40-hour week. One respondent noted that "if we had someone who missed their appointment, there was someone else waiting in the clinic to get enrolled."

Thousands of Kentucky residents completed their applications during the last few days of enrollment; 12,000 on the last day of March.

Results

At M&W, comparisons of 2013 with the first six months of 2014 revealed:

- A 14 percentage-point reduction in emergency department self-pay patients from 22 to 8 percent, with network partners experiencing similar trends.
- A 22 percentage-point reduction in the percentage of outpatient self-pay, from 28 to 6 percent.
- An 11 percentage-point increase in the percentage of Medicaid patients, from 36 to 47 percent.

These trends contributed to a huge reduction in charity care, but bad debt has yet to be influenced by enrollment outcomes. There was also a 5 percent bump in commercially insured patients; however, the hospital is still seeing denials of services from MCOs for seriously-ill patients.

Network providers engaged thousands of individuals with marketing and outreach efforts. At least 2,000 people were assisted and almost 3,000 were enrolled.[b] While it was not possible to determine the ultimate enrollment status of those who were assisted but not enrolled at that particular site, they were made aware of their eligibility for a tax subsidy as well as the healthcare insurance plans that most closely matched consumer needs and priorities. It is assumed that many of these people went on to either enroll themselves online or to receive assistance and enrollment at another location.

The hospital enrolled 246 people. Of these, 205 were from Estill County; the remainder were from Powell (17), Lee (10), Madison (8) and various surrounding counties (6). One FQHC enrolled 954 people from Estill and Powell Counties, another enrolled 980 from Estill County, and the third enrolled 632 people from Lee (250), Breathitt (213) and Wolfe (169) Counties. Approximately 15 people enrolled at one of the behavioral health providers during the month of January. The total number enrolled for the target area was 2,827 individuals – an incredible number.

In addition to the added benefit for enrollees of having access to a broader range of preventive and acute care services and a safe harbor for handling medical crises, several of the network partners observed a range of beneficial outcomes.

Network partners reported the following:

- One of the behavioral health network partners noted that clients were more likely to have insurance coverage after Open Enrollment and were now using insurance to pay for substance abuse services.
- One FQHC reported a drop in self-pay from 45 percent before enrollment to 5 percent for the first six months of 2014 and did not experience any drop in utilization.
- Another clinic experienced a drop in self-pay from 80 percent to 5 percent.
- Estill, Lee, Wolfe, and Breathitt Counties saw their uninsured rates drop from up to 20 percent to between 5 to 8 percent after Open Enrollment; Powell County's rate dropped from 14-17 percent to 5-8 percent.[27]

Relevant statewide results and observations:

- Although the federal website (HealthCare.gov) was plagued by technical problems during the first Open Enrollment period, KYnect operated with only a few glitches that were corrected early in the exchange's launch. KYnect has been hailed as a national model since its launch in October 2013 for its smooth operation and easy interface for users. The exchange continued to evolve to best meet consumer needs adding customer representatives to call center duties, extending hours of call-in support to Sunday, and gathering feedback from consumers and KYnectors to improve operations.
- The governor's office indicated that 886,502 Kentuckians conducted preliminary screenings to determine qualifications for subsidies, discounts or programs like Medicaid and 839,398 had used the KYnect call center.
- By the end of the first Open Enrollment period, 413,410 Kentuckians (nearly ten percent of the state's total population) had enrolled for health insurance through KYnect. About 80 percent of those enrollees qualified for coverage under the Medicaid expansion. Of the remaining 20 percent who purchased QHPs, 72 percent qualified for a subsidy to assist with their premiums.[28]
- Seventy-five percent of enrollees reported that this was the first time they have had health care coverage.
- After the first Open Enrollment period, the state reported a drop in its uninsured population from 20.4 percent to 11.9 percent for a 42 percent decline making the state

[b]These numbers are from the M&W service area and part of the 12,000 statewide final-day enrollees mentioned just above. Approximately 80 percent of these new enrollments were with the Kentucky Medicaid program.

the second in the nation in reducing uninsured rates. Only Arkansas saw a greater drop in the uninsured.

Reasons for not Enrolling

CACs reported the following as reasons why some did not enroll despite receiving notice of their eligibility:

- Financial issues (unaffordable premiums and ineligible for Medicaid, difficulty understanding or having faith in tax credits).
- Consumers feeling that they did not need health insurance and/or could weather any financial storms stemming from a lack of insurance.
- The presence of negative perceptions of the ACA in general.
- Feeling overwhelmed with the process and/or unclear about how it would work.
- Consumers lacking the necessary documents needed to complete their applications.

Financial issues can certainly become a problem for those earning too much for patient assistance programs but not enough to afford monthly premiums. Difficulty understanding the complexities of insurance and its related jargon can only be addressed with better outreach and education efforts.

There is no doubt that many people experienced their enrollment process as an emotionally-charged event that could easily overwhelm the uninformed or could create an intimidating environment. Some of the reasons given may have simply been a polite way to exit the enrollment process without lengthy discussions. While records do not detail the reasons for not enrolling, future efforts may benefit from this knowledge to refine engagement and marketing strategies.

Strategies that Worked

Respondents identified strategies that worked to engage, educate, and enroll patients:

- Taking a broad approach to marketing and outreach, specifically targeting local businesses.
- Utilizing PowerPoint presentations that pull from a variety of sources, to help network members visualize their role and place in the larger Open Enrollment effort.
- Displaying the screen with insurance options for consumers and/or printing a screenshot so that they could take the information home to discuss options with family members.
- Highlighting the elements of various plans that CACs observed people were most interested in com-

paring to help them decide.
- Providing time for KYnectors to get together with colleagues and talk about issues that they ran into, share questions and answers, and discuss how to help enrollments be a more positive experience for the client.
- Having flexible schedules for CACs to accommodate consumer availability.
- Using portable devices to connect with the marketplace (e.g., tablets) to give CACs maximum flexibility to reach potential enrollees in any location in the facility.
- Spacing out enrollment appointments to accommodate potential issues with the website or consumer documentation, to minimize consumer frustration.
- Persistently advocating for the client (e.g., staying on hold for more than an hour for urgent issues that require correction): perceptions of advocacy help strengthen levels of trust.
- Having a Navigator meet with participating providers to prepare them for insurance-related issues (e.g., insurance illiteracy, health illiteracy) to prevent miscommunications, misunderstandings, and general education barriers on the key elements of coverage and how to use that coverage.
- Having a strategy for handling enrollment leads that surface during off-hours.

Lessons Learned

Interviewees cited a number of important lessons learned:

- <u>Start Early</u>: Start as early as possible with marketing and engagement, and prepare staff to answer questions that will come when they meet community members at the store, bank, or social events.
- <u>Find the Right People</u>: Select In-Person Assisters carefully and focus not only on their level of knowledge of the ACA and the state's marketplace but also on their past experiences working under similar stressful situations dealing with people and on their general personality (e.g., compassion for helping people, belief in the program, willingness to give a full effort to help people get enrolled). Make sure that your CACs understand the key elements of commercial insurers – understanding the state's Medicaid is much easier and less problematic.
- <u>Employ at least one full-time CAC</u>: Find the external or internal resources to get at least one CAC to devote their full effort to enrollment. Avoid requiring current

employees to balance their regular work with enrollment efforts.

- Conduct training close to enrollment: Ensure that concepts are fresh in the minds of staff, CACs, and In-Person Assisters.
- Be Flexible: Be available after hours and on weekends to accommodate the schedules of clients who work all day. Have a CAC on site to meet with clients who walk in to a clinic for services.
- Be Empathetic: There will always be clients who have not understood or had the opportunity to think about written materials or media notices that market local enrollment efforts. Do not judge them for not reading or understanding the message. They are with you to enroll.
- Be Respectful: Communicate with clients with respect and a clear acceptance of who they are when reintroducing the messages within the context of local language and culture. The goal is to provide a safe and comfortable setting for them to make decisions. Discuss issues calmly without getting involved in political arguments.
- Make it Personal: Perseverance, advocacy, and respect are the best way to build the trust needed for effective education in one-on-one conversations. Whenever possible, focus on what health insurance coverage can mean for them and the people they love. Rise above political discussions and find connections that have a deeper meaning for the client.
- Stay Up-to-Date: State Offices of Rural Health need to stay up-to-date with policy changes and communicate those changes to relevant parties.
- Track Your Efforts: Develop databases to track enrollment efforts and identify areas in need of improvement. Capture and use that information to better serve target populations.
- Provide Ongoing Assistance: Many people who have never had insurance before have no clue how to use it or understand what coverage does for them. Clients need support; there is more to it than just signing people up for coverage. Be prepared to have further discussions with clients after they have been enrolled. They are more likely to give the CAC a call than they are to use any 1-800 numbers for help.

Advice to Others
- When asked what advice they might have for other rural communities or small rural hospitals and providers

to best address the challenges presented during Open Enrollment, respondents emphasized the following:
- Find a dedicated person who can get out into the community. If you cannot have a dedicated person then you need several people that can divert several hours a week off their regular schedule. The investment of resources is small compared to the relative gain.
- Utilize staff who have experience serving as financial counselors or patient service representatives as CACs.
- Create a list of all self-pay patients and have staff call them to let them know that they can get assistance and tax credits by coming in to an appointment.
- Face-to-face interactions aid communication; you need to be able to speak their language and be an insider. It is important that your CACs live in the community and understand the values and culture of the community.
- Word-of-mouth is key. Understand that if you are successful with one person and treat that person well, their word-of-mouth helps get their extended family in as well as friends who need to sign up.
- Do not be judgmental of or shocked by what consumers reveal (e.g., prison time, child support issues). Once they sense you are judgmental, you lose them.
- Train all staff having contact with clients to pass correct, consistent information to prospective enrollees.
- Share information with other assisters and CACs in your local group frequently to enhance the learning curve for people with contact with the public.
- Focus on emergency departments. This is critical, since many come to the ED regardless of insurance coverage, while that is not so often the case for practitioner locations.
- Go above and beyond to make contact with consumers who have not returned with their documents or otherwise have not completed their application.
- Complete and accurate knowledge is the key to enrollment successes. There are many misconceptions and rumors about the ACA and it is important for staff to present an accurate portrayal of the program and its potential benefits.
- Avoid getting involved in political conversations surrounding the ACA.
- Educate State Offices of Rural Health so they understand how the process is unfolding in their state, what is going on, what issues seem to present the greatest challenges and opportunities for enrollment success, and where to obtain available resources for

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Successful Health Insurance OEE Strategies for Rural Hospitals
Case Study: Marcum and Wallace Memorial Hospital, Irvine KY

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Appendix A: Challenges to Consumer Assistance

1. Insurance Literacy and Community Engagement
- In-person approaches and developing trust to get attention and educate
- Health insurance education to meet information, linguistic, and cultural needs
- Partnership with community-based nonprofits to support education and engagement
- Use front-line assisters to educate and engage target populations on fulltime basis
- Use generic marketing materials that can be branded with local contact information

2. Managing Early Implementation Glitches and Shortfalls
- Prepare for fast pace of emerging state/federal information about implementation
- Use regular meetings and conference calls with state or regional staff to stay up-to-date
- Develop process for follow-up and on appeals on in eligibility determinations
- Use call centers as a built-in resource for timely resolution of emerging consumer issues
- Use "no wrong door" approach - single application to avoid eligibility transfer issues

3. Complicated Eligibility Requirements
- Prepare for complex issues on tax rules, immigration and family law, and evolving policy
- Single referral point for consumers with complex issues needing specialized knowledge
- Use spoke and hub models to link assisters together for rapid turnaround consultation
- Use a team model with specific, coordinated areas of expertise to speed referrals
- Use assister feedback to analyze lessons, strengthen systems and avoid similar issues

4. Matching Consumer Needs with Coverage
- Use plan comparison tools with consistent metrics on cost sharing, provider networks
- Comparison tools for in-plan providers and coverage costs based on health status
- Plan information on coverage/service needs for disabled and seriously ill consumers
- Use data collection tools to log complaints and/or consumer satisfaction information
- Special attention to enrollees with special or chronic health needs that test coverage

5. Post – Enrollment
- Be ready for a "boomerang" effect with post-enrollment questions and issues
- Referrals for help with post-enrollment issues to Consumer Assistance Programs
- Prepare for questions/issues about using new coverage, pay premiums, appeal denied claims and resolve complaints
- Be aware of referral requirements and oversight to ensure clients have timely referral

6. Consumer Assistance Infrastructure
- Need for assister programs that adapt to the transitional aspect of health reform
- Collect data for quality improvement, professional development in a learning setting
- Centralize scheduling for shorter wait times and even workload distribution for assisters
- Train assisters on specific issues – training modules on consumer needs and questions
- Use performance monitoring, assess impact on target groups and follow-up issue cases
- Document assister time/effort to build data base for evidence-based practice guidelines
- Use long-range plans for improving coordination adopting advances and building a knowledge base on year to year experiences

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Successful Health Insurance OEE Strategies for Rural Hospitals
Case Study: Marcum and Wallace Memorial Hospital, Irvine KY

Appendix B: The Role of Assister Programs in Open Enrollment

Assister Programs played a critical role in obtaining high enrollment outcomes during the first and second Open Enrollments and will be hard-at-work during the third Open Enrollment between November 1, 2015 and January 31, 2016. Consumer assistance is critical for engaging, educating, and enrolling consumers. The ACA provides resources to support an infrastructure for training, certification, technical assistance, and planning support to successfully engage and enroll consumers in health insurance plans the meet their circumstances, needs, and preferences.

Many types of organizations sponsored Assister Programs during the first Open Enrollment including non-profit Community Service Organizations (38%), Federally Qualified Health Centers or FQHCs (28%), Hospitals and other health care providers (15%), State, County, or Local Government Agency (8%) with the remainder from for-profit organizations (3%), Faith-based Organizations (1%) and others. The distribution of resources across states to support such activities was uneven. States operating their own marketplace received almost twice as much as those with federally facilitated or state-federal partnership marketplaces.

Assisters for consumers come from largely from five types of Assister Programs including: (1) Navigator Programs; (2) In-Person Assister (IPA) Programs; (3) Certified Application Counselor (CAC) Programs; (4) FQHC-based Assister Programs, and; (5) Federal Enrollment Assistance Programs. CAC programs which provided assistance without marketplace funding, and Programs sponsored by FQHCs funded by grants from the Health Resources and Services Administration (HRSA) together accounted for 71 percent of all Assister Programs and for more than 6 million people who received help.[14]

1. Navigator Programs, representing only 2 percent of all programs, contracted directly with the Centers for Medicare and Medicaid Services (CMS) provided free outreach and enrollment services, public education and outreach, help applying for subsidies, facilitated enrollment in QHPs, and provided fair and impartial information about QHP options. To be certified they needed to complete 20-30 hours of federal training, and those working in federally facilitated or partnership marketplaces were required to periodically report data on their efforts and performance. During the first Open Enrollment Navigators were supported with funds drawn from CMS's implementation pool and included $67 million in federal grants to serve 34 federally facilitated and state-federal partnership marketplaces.[29]

2. In-Person Assister (IPA) Programs (26% of all programs) were contracted directly by state-run marketplaces or a state-federal partnership marketplace. The duties of an IPA mirror those of a Navigator. The IPA program was established by federal legislation to make federal exchange establishment grants available for state-based and state-federal partnership exchanges. Unlike Navigators operating under a standard set of rules across states, IPA programs have more variation in size, structure, and function. In some states they are paid on a per-enrollment basis while in others they are funded through grants.

3. Certified Application Counselor (CAC) Programs (45% of all programs) provided trained CACs but received no direct funding from the state marketplace. They provided services free of charge and operated under federal rules that were somewhat less extensive than for Navigators or IPAs. They typically did not provide outreach and education services. However, states were give flexibility to require additional standards if deemed necessary.

4. Federally Qualified Health Center (FQHC) Programs (26%) received federal funding to provide comprehensive primary care services regardless of the ability of the client to pay and generally serve patients that are low-income and uninsured. HRSA awarded $150 million in July 2013 to over one thousand health centers in every state and DC to facilitate enrollment of uninsured people and another $58 million in December of that year to support the anticipated surge in enrollment assistance needs. HRSA awarded an additional $6.4 million to state and regional Primary Care Associations to provide technical assistance and other support to FQHC Assister Programs. Some of those programs also applied to be Navigators or IPAs and received additional direct funding from marketplaces.

5. Finally, Federal Enrollment Assistance Programs (FEAP) (1%) contracted with CMS to provide supplemental enrollment assistance services within federally facilitated and state-federal partnership marketplaces serving select communities with large numbers of uninsured consumers. The duties of these individuals was similar to those for the Navigator except they were reserved for "surge" assistance.

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