School of Public Health & Health Services
THE GEORGE WASHINGTON UNIVERSITY

Geiger Gibson Program in Community Health Policy

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RCHN Community Health Foundation Research Collaborative

Policy Research Brief # 35

Assessing the Potential Impact of State Policies on Community Health Centers' Outreach and Enrollment Activities

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at http://sphhs.gwu.edu/projects/geiger-gibson-program or at rchnfoundation.org.

Executive Summary

This nationwide analysis of community health centers' early outreach and enrollment experiences under the Affordable Care Act (ACA) finds that all health centers are engaged in a significant and sustained effort to identify and assist eligible patients and community residents in obtaining health insurance coverage. Virtually all health centers have received expanded outreach and enrollment grants; in this survey, conducted on the eve of open enrollment, nearly three-quarters reported offering a range of outreach and enrollment assistance, such as locating eligible patients and community residents, assisting with both online and paper applications, and making the application process accessible to a multi-cultural, multi-language population.

But in states with restrictive policies toward ACA implementation (defined as both opting out of the Medicaid adult expansion and adopting Navigator laws), health centers are confronting significantly greater outreach and enrollment challenges compared to health centers in states that have fully implemented the law through Medicaid expansion and without outreach and enrollment restrictions.

Health centers located in restrictive states are significantly more likely to report constrained outreach and enrollment activities. Health centers in restrictive states were significantly less likely to: receive financial support for outreach; notify patients of potential eligibility; complete paper applications; and monitor the status of applications. In restrictive states, health centers were significantly more dependent on the federal government and their own primary care associations for information about the ACA. Health centers in restrictive states were also significantly less likely to have access to information from state officials, including information about Medicaid, which even in restrictive states is controlled by the state. Health centers in restrictive states were also less likely to provide access to legal services in the event of application denials.

Of particular significance in measuring the impact of Navigator restrictions is the fact that health centers in restrictive states were significantly less likely to assist with plan enrollment. Many health center patients can be expected to have limited familiarity with health insurance and will need extensive help not only to obtain subsidies but also to enroll in health plans. Even though only slightly more than 2% of health centers receive Navigator grants, the significantly lower rate of plan enrollment assistance suggests that the regulatory burdens created by Navigator laws are affecting not only the work of certified Navigators but community outreach and enrollment efforts more generally.

The greater outreach and enrollment challenges faced by health centers in restrictive states were mirrored in health center leaders' views regarding the ACA's ultimate impact on their patients. Among respondents in full implementation states, over one-third (37.5%) believed that the ACA would reduce their uninsured proportion to less than 10% of all patients. By contrast, only 11.3% of health center leaders in restrictive states believed that the ACA would have such a beneficial impact. In restrictive states, more than 10% of health center leaders believed that 75% or more of their patients would remain uninsured.

These findings suggest that the policy and political environment in which community-based outreach activities are undertaken has a significant impact on the scope of outreach efforts as well as on perceptions regarding the ACA's ultimate impact on medically underserved communities. These findings also underscore the critically important role played by national organizations, state primary care associations, and the federal government in assisting community outreach efforts through information, technical assistance, and resources.

Introduction

The nation's 1,198 federally-qualified and 93 look-alike community health centers are poised to play a central role in enrolling medically underserved populations in coverage under the Affordable Care Act (ACA).[1] In July 2013, the Health Resources and Services Administration (HRSA) awarded over $150 million in supplemental outreach and enrollment grants to 52 primary care associations (PCAs) and 1,159 federally funded health centers (97% of all grantees) to assist patients and community residents.[2] Total amounts awarded by state ranged from slightly more than $464,000 in Wyoming to more than $25 million to California's health centers.[3] Although the aggregate amount varies, per-health center awards are roughly comparable, at about $130,000 per health center grantee.[4]

Health center outreach and enrollment efforts are underway in states that have expanded Medicaid to cover all nonelderly low-income adults as well as in those that have opted out of the Medicaid expansion and continue to limit adult coverage to traditional adult groups (pregnant women, adults with disabilities, and very low-income parents with minor dependent children). **Figure 1** displays Medicaid expansion policies as of mid-December 2013, as well as state Navigator policies.

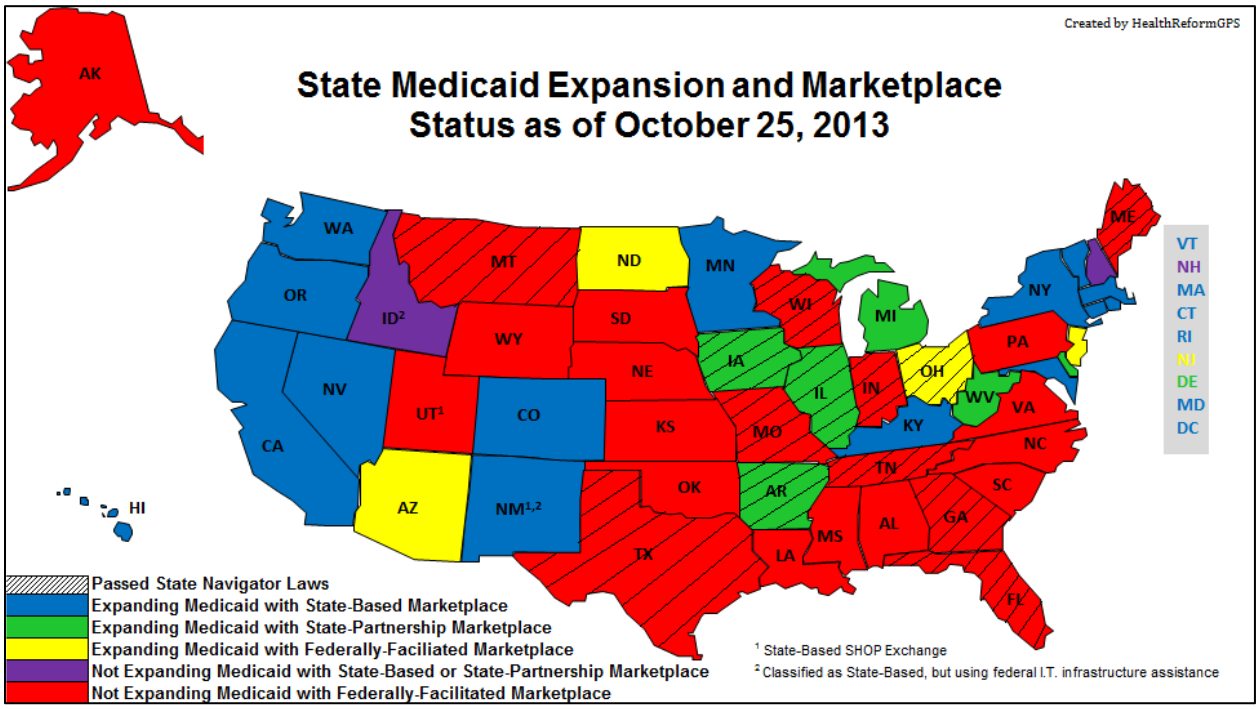
[1] HRSA. 2012 Health Center Data National Program Grantee Data http://bphc.hrsa.gov/uds/datacenter.aspx?year=2012; HRSA. 2012 Health Center Data National Look-Alikes Data http://bphc.hrsa.gov/uds/datacenter.aspx?q=a&year=2012

[2] http://bphc.hrsa.gov/outreachandenrollment/ (Accessed online December 1, 2013)

[3] http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/ (Accessed online December 1, 2013)

[4] Average funding based on $150 million distributed to 1,159 health centers across the 50 States, District of Columbia, and U.S. territories per http://www.hrsa.gov/about/news/2013tables/outreachandenrollment (Accessed online December 1, 2013)

Figure 1: Medicaid expansion and navigator laws by state[5]



HRSA's supplemental outreach and enrollment awards can be used to strengthen outreach services and to hire and train paid and volunteer staff to assist with eligibility determinations for the three major insurance affordability programs under the ACA (Medicaid, the Children's Health Insurance Program (CHIP) and premium subsidies and cost-sharing assistance), as well as health plan selection and enrollment. The HRSA outreach funds thus mirror the activities identified by the Centers for Medicare and Medicaid Services (CMS) in its certified application counselor (CAC) rules.[6] Status as a certified and trained CAC is a HRSA requirement of health centers engaged in ACA outreach and enrollment. [7] Health centers do not have to be certified as Navigators, a special class of outreach and enrollment assistance worker under the ACA. Navigators, like CACs, assist with enrolling in Medicaid, CHIP, and premium assistance and also help with plan enrollment. They are also trained to handle post-plan-membership questions.

In the case of historically uninsured populations, the health plan selection and enrollment phase takes on special importance, because uninsured health center patients and community residents are likely to have limited experience with the concept of provider networks and the implications of networks for access to care. Furthermore, recent news accounts have focused on the potential for new health plan networks to be more limited.[8]

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[5] http://www.healthreformgps.org/wp-content/uploads/333.pdf
[6] 45 C.F.R. §155.225
[7] Id.
[8] See e.g., By Sandhya Somashekhar and Ariana Eunjung Cha, Insurers restricting choice of doctors and hospitals to keep costs down, *Washington Post* (Nov. 20, 2013) http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html

Restrictive provider networks may be especially common in medically underserved communities that lack a sufficient supply of health professionals to begin with, for residents of those communities, help in selecting plans that offer adequate capacity is thus especially important. A previous study of health center outreach and enrollment activities in Massachusetts[9] found that some health plans offered to consumers in some communities lacked any local network presence, underscoring the need for help in plan selection.

The HRSA outreach and enrollment award guidelines require health centers to comply with all federal and state laws, including state laws that add additional regulatory requirements for Navigators.[10] As of July 2013, at least 19 states using the federally-facilitated Marketplace had adopted laws regulating activities of Navigators[11] (**Figure 1).** In some instances, state laws are ambiguous and could be understood as applying not only to federally-certified Navigators but also, more generally, to entities engaged in outreach and enrollment efforts.[12]

Study Purpose and Methods

The purpose of this study was to understand the early outreach and enrollment experiences of health centers both generally and within the highly variable policy and political context in which ACA implementation is unfolding. The project sought information on how health centers were approaching expanded outreach and enrollment, the resources they would have to support their efforts, how health center staff perceived the potential impact of the ACA to change the opportunity for health insurance coverage among their patients and communities, and the barriers encountered in establishing expanded outreach and enrollment programs.

The Survey of Health Centers' Outreach and Enrollment Activities was conducted by the George Washington University (GW) Geiger Gibson Program in Community Health Policy and the National Association of Community Health Centers (NACHC) and was supported by the RCHN Community Health Foundation. The survey was conducted from early September to mid-October 2013 through the use of an online survey instrument, Survey Monkey. The survey was intended to be completed by health center CEOs or their designees. All federally qualified health centers were targeted using CEOs' email addresses from the 2011 Uniform Data System (UDS) and the 2012 UDS data when it became available later in the recruitment period. Multiple follow-up emails and phone calls to CEOs were used to

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[9] Rosenbaum, S., Shin, P., Sharac, J., Alvarez, C., Zur, J., Ku, L., & Paradise, J. (2013). *Providing outreach and enrollment assistance: lessons learned from community health centers in Massachusetts*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation and the RCHN Community Health Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8479-providing-outreach-and-enrollment-assistance1.pdf

[10] HRSA, Health Center Outreach and Enrollment Technical Assistance Call (September 27, 2013), available at http://bphc.hrsa.gov/outreachandenrollment/ (Accessed online, December 1, 2013).

[11] Katie Keith, Kevin Lucia, Kristine Monahan, *Will New Laws in States with Federally Run Marketplaces Hinder Outreach?* http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx

[12] See e.g., St. Louis Effort for AIDS v Huff (Case No: 2:13-cv-4246) W.D. MO (challenging Missouri Navigator statute as preventing community based outreach and enrollment activities).

increase the response rate. Primary Care Associations (PCAs) also encouraged their community health centers to participate.

Because this survey was opened prior to October 1 and lasted through mid-October as the HRSA awards were being implemented and health centers were preparing their expanded activities, the information captured in this early data collection round would not reflect how health centers may have altered their outreach and enrollment activities as experience was built.

The survey questions focused on all phases of outreach and enrollment, from the earliest point at which information is provided to patients and community residents through the final selection of and enrollment into a health plan. Respondents were asked questions that referred to their current activities as well as to activities they planned to implement in the future.

The study was designed to collect descriptive findings for all respondents. In addition, the study sought to measure differences in responses among health centers falling into two key groups of states, which were categorized by their decisions to expand Medicaid and the presence or absence of state Navigator laws. Only about 2% of health centers have Navigator grants. However, many state Navigator laws are written with sufficient breadth to potentially reach not only entities that are certified as Navigators but also entities that perform generic navigator functions (e.g., assistance in securing Medicaid, CHIP, or premium subsidies; assistance with plan enrollment).

The first group of 21 states and the District of Columbia, classified as "full implementation" states, consists of states that have fully embraced the law, as measured by adoption of the ACA Medicaid adult expansion and the absence of state Navigator laws regulating community outreach and enrollment assistance. The second group, classified as "restrictive" states, consists of nine states that have opted out of the Medicaid expansion and that have also implemented laws regulating Navigator activities. Statistical analyses (X^2 and t-tests) were performed to assess whether there were significant differences in their survey answers. For this study we excluded respondents in "mixed" states (either those that couple the Medicaid expansion with Navigator laws or those that neither expand Medicaid nor maintain Navigator laws).[13]

States Classified as Either Full Implementation or Restrictive States

Full Implementation states: AZ, CA, CO, CT, DC, DE, HI, KY, MD, MA, MI, MN, ND, NJ, NM, NV, NY, OR, RI, VT, WA, WV
Restrictive states: FL, GA, IN, ME, MO, MT, TN, TX, and WI

[13] Excluded "mixed" states: AK, AL, AR, IA, ID, IL, KS, LA, MS, NC, NE, NH, OH, OK, PA, SC, SD, UT, VA, WY.

Findings

1. In General

After removing duplicates, there were 606 survey responses for a response rate of 50% of all health centers listed in the 2012 UDS (four responses were from look-alike centers). Responses came from health centers in all fifty states, the District of Columbia, Puerto Rico, and three other U.S. territories, with a response rate of 50% or more CHCs in 31 states or territories and a response rate above 30% in 51 of the 55 states or territories participating. About two-thirds of responses (400) were completed prior to October 1, while the remaining 206 responses were completed on or after October 1. The survey respondents are also nationally representative. Based on urban and rural location, practice size, and patient mix, the survey sample was not found to be significantly different from survey non-respondents.

Table 1 summarizes the study's overall findings for all respondents and reports on health centers' current activities as they were ramping up on the eve and in the first stage of full ACA implementation. Percentages refer to all responses from the 606 respondents. Because respondents could give more than one answer to some questions, percentages reflect the number of CHCs selecting each response, rather than a proportion of the total. For example, responses to the question about whether the health center staff find out directly if coverage applications have been approved demonstrated that 54% do; in a follow-up question, 36% of all respondents reported finding out from the state, 16% from the health plan, and 20% from another source. These percentages reflect the fact that among the 54% of all centers that receive coverage notifications, the information about the approval may come from more than one source.

Table 1: Descriptive findings for all survey respondents (n=606)

	Percentage
Current types of enrollment assistance	
Notifying existing patients of potential eligibility status for new programs	72.8%
Assistance in filling out paper enrollment applications for insurance (e.g. Medicaid/CHIP or subsidized coverage)	77.6%
Assistance in getting the necessary documents for insurance applications	64.9%
Online assistance and electronic application filing for insurance (e.g. Medicaid/CHIP or subsidized coverage)	57.3%
Non-English language enrollment forms and assistance	62.2%
Culturally appropriate enrollment materials or resources for the Non- English speaking population	65.2%
Eligibility determination	63.2%
Assistance in selecting a health plan	37.8%
Assistance in selecting a primary care provider	62.9%
Monitoring status of applications for coverage	50.5%
Other	9.9%

Multilingual enrollment staff	
The health center has multilingual enrollment staff	70.8%
Application approvals and denials	
The health center finds out whether applications have been approved	53.5%
Find out from state	36.3%
Find out from health plan	15.8%
Find out from other	19.8%
The health center provide assistance with appeals for people whose applications are not approved	37.8%
Provide access to on-site legal aid	3.5%
Referral to legal aid	22.8%
Other assistance	18.8%
New technologies	
The health center currently uses new technologies to increase outreach and enrollment	65.8%
Types of new technologies used:	
Instant messaging service	3.0%
Emails to patients	21.0%
Facebook	32.2%
Twitter	11.1%
Website	49.5%
Laptops	40.4%
Texting	8.6%
Self-serve kiosks	8.6%
Other	7.3%
Funding for new technologies:	
CHIPRA Outreach and Enrollment grant	9.9%
State/local grants	16.7%
Private grants	8.4%
Medicaid	8.4%
Other	22.1%
Expected barriers to outreach and enrollment activities	
Lack of staff time	41.6%
Lack of funding	40.6%
Lack of training for enrollment system	36.6%
Greater patient demand for assistance than what we can provide	44.6%
Continued reliance on paper-based and/or faxed applications	21.8%
Incomplete documentation from patients	66.8%
Notification letters from the state regarding eligibility	29.4%
Patient confusion regarding their eligibility for insurance programs	76.2%
Lack of culturally and/or linguistically appropriate documents and materials	27.4%
Other	11.1%

Partnerships	
Health centers currently partner with:	
Hospitals or other safety-net providers	54.5%
Health plans	27.2%
Churches or faith-based organizations	50.2%
Community or social organizations	75.2%
Local or national legal aid organizations	16.3%
Local or national health advocacy organizations	35.3%
Local businesses	34.8%
Schools and universities	43.7%
Teen or young adult programs	21.3%
Recreation centers	19.5%
Radio or television	31.7%
Other	18.3%
None	5.4%
Health centers planning to create new partnerships	84.2%
Planning to partner with:	
Hospitals or other safety-net providers	57.4%
Health plans	34.3%
Churches or faith-based organizations	54.8%
Community or social organizations	69.8%
Local or national legal aid organizations	23.6%
Local or national health advocacy organizations	38.8%
Local businesses	44.7%
Schools and universities	51.7%
Teen or young adult programs	31.2%
Recreation centers	29.2%
Radio or television	31.5%
Other	9.7%
Understanding the new enrollment system	
Ready for the new system:	
No, the enrollment system is still a work in progress	51.3%
Yes, we know what the new system will require	43.2%
Enrollment staff have received any formal training in regard to changes to the program	63.4%
If there are questions about the (pending) new enrollment system, which agency or organization can you go to:	
State Medicaid agency	45.4%
Local government or community agency	24.3%
PCA	56.3%
HRSA	49.3%
Other	23.3%
Don't know	5.3%
If enrollment staff have questions as they are completing enrollment, they know where to turn to get answers	81.2%

Community outreach		
The health center is actively providing education or resources about the pending coverage expansions under the ACA to community members	88.4%	
Where did the health center obtain the outreach/educational resources or materials about coverage expansions being used:		
Developed by our organization	38.4%	
Developed by another organization	27.4%	
Developed by the state	35.6%	
Developed by the Department of Health and Human Services	50.5%	
Other	16.3%	
Anticipated impact of the ACA		
The health center has already identified eligible patients within their existing patient base that may be covered under expansions	71.1%	
Approximately what percentage of total patients may be newly eligible for Medicaid/CHIP or subsidized coverage:	*Out of all*	*Out of 403 respondents*
Less than 10%	11.2%	16.9%
11-25%	28.2%	42.4%
26-50%	17.5%	26.3%
51-75%	6.9%	10.4%
Greater than 75%	2.6%	4.0%
Approximately what percentage of total patients is likely to remain uninsured:	*Out of all*	*Out of 388 respondents*
Less than 10%	18.2%	28.4%
11-25%	30.9%	48.2%
26-50%	10.1%	15.7%
51-75%	3.1%	4.9%
Greater than 75%	1.8%	2.8%

Methods of assistance. Nearly three-quarters of all health centers (72.8%) were notifying existing patients of their potential eligibility status. Over three-quarters (77.6%) were providing assistance in completing paper applications for insurance affordability programs (i.e., Medicaid, CHIP, premium subsidies and cost-sharing reduction assistance), a signal that the vast majority of health centers were ready to provide paper application assistance in the event that the online system did not work. Two-thirds of health centers (64.9%) were providing assistance in obtaining needed documentation, while nearly 60% were offering online application-filing assistance. Enrollment forms and application assistance for affordability programs in languages other than English were available at two-thirds of all health centers. Approximately 71% of health centers indicated that they had multi-lingual enrollment staff. Strikingly, a much smaller proportion of health centers, only slightly more than one-third (37.8%), were prepared to offer assistance in selecting a health plan, although a far greater proportion (62.9%) were prepared to help community residents select a primary care physician.

Application monitoring. Over half of all health centers (53.5%) reported having systems in place for monitoring the status of applications for insurance affordability programs and more than one third (37.8%) provided assistance with appeals in the event of eligibility

denials. Of those health centers offering assistance with appeals, 21 (3% of all respondents) did so through on-site legal assistance, while 252 - the vast majority - provided assistance through referrals to legal aid or another source of legal assistance.

Using new technologies. A high proportion of respondents (65.8%) reported that they were employing one or more new technologies, including instant messaging, email, Facebook or Twitter, out-stationed assistance in community locations and the use of laptops, their health center's website, and self-serve kiosks. The most commonly used technologies were the health center's own website and laptops that could be taken into waiting rooms and mobile locations. Seventeen percent of respondents reported receiving additional state and local funding, with smaller proportions receiving CHIPRA funding, Medicaid funding, and private grants to support the technology efforts.

Expected enrollment barriers. In terms of perceived barriers to outreach and enrollment that centers expected to face in the future, the most significant barriers respondents expected to arise were problems associated with documentation (66.8%) and general patient confusion regarding the programs for which they would be eligible (76.2%). Concerns over documentation persisted among respondents, even though the ACA reduces the range of documents required of applicants. Other significant barriers noted by respondents were staffing and resources, insufficient training regarding how the new enrollment system would work, and the need to rely on paper and faxed applications. (This final concern, of course, was likely to grow in importance during the early enrollment period when the federal website and some state websites were working only fitfully).

Partnerships. Partnerships were common among health centers. More than half reported currently partnering with hospitals and other safety-net providers or churches and faith-based organizations and three-quarters with community and social organizations. Given the emphasis on enrolling younger adults, a notable 43.7% reported partnerships with universities and schools. More than 84% of respondents reported that they were planning to create new partnerships beyond those already established; among the most common expected partners were hospitals and safety net providers, health plans, churches and faith-based organizations, community or social organizations, and schools and universities.

Readiness for the new system. In terms of feeling ready for the new enrollment system, health center respondents were mixed. Slightly more than half perceived the new system as a "work in progress" while 43% felt that they understood what the new system would require. At the time of the survey, two-thirds reported that enrollment staff had received training. Nearly half (45%) perceived that they could secure information from their state Medicaid agencies, suggesting that a strong working relationship was relatively common. An even greater proportion (56%) reported depending on their state or regional primary care association, while nearly half reported depending on HRSA for information about the new enrollment system. Most importantly perhaps, 81% reported that their enrollment staff knew where to go if they had questions as they were completing enrollment.

Community outreach. Health centers obviously have large numbers of established patients in need of enrollment assistance. We separately sought information about whether centers were also reaching out to the broader communities beyond the patients they served

directly; nearly 90% of all respondents reported that they were actively providing education to the community at large in addition to their patients. Most commonly, health centers were using materials prepared by the United States Department of Health and Human Services (50.5%), but over one-third (35.6%) were using materials prepared by their state and nearly two in five (38.4%) were using materials developed by their own organization.

Anticipated impact of the ACA. In general, health centers reported significant coverage opportunities for health center patients. Among all respondents, over 49 percent believed that implementation would mean that only 25% or fewer patients would remain uninsured, while less than 2 percent believed that 75% or more of their patients would remain uninsured following implementation.

2. Health centers in states that have fully implemented the law versus those in restrictive states

There were 247 health center responses from full implementation states and 136 from restrictive states. In general, health centers in restrictive states reported facing significantly greater challenges in staffing up their enrollment capacity, had more limited resources to provide enrollment assistance, and expected to maintain a higher burden of uninsured patients. Results for the two groups are presented in Table 2. The following findings were significant:

- Health centers in restrictive states were less likely than those in full implementation states to provide enrollment assistance across all assistance categories.

- Health centers in restrictive states reported approximately half the staffing capacity maintained by health centers in full implementation states (about 3 FTEs in restrictive states versus nearly 6 FTEs in full implementation states). A smaller proportion of health centers in restrictive states reported multilingual enrollment staff or staff assigned to assist with applications; differences approached, but did not meet significance.

- Health centers in restrictive states were also less likely to expand capacity to assist in enrollment. Although both groups of health centers received roughly equal HRSA outreach and enrollment funding to hire additional staff, health centers in restrictive states were less likely to have received additional funds to increase staffing. Only 11 percent of health centers in restrictive states reported that they had received or were seeking additional funding to hire additional staff compared with 34 percent of health centers in full implementation states.

- Health centers in restrictive states were more likely to depend on PCAs and HRSA for assistance. Health centers in full implementation states were more likely to have their questions answered by the state Medicaid agency or other local agency.

- Health centers in restrictive states were significantly less optimistic about the ultimate impact of the ACA on their patients and were more likely to expect that a greater proportion of their patients would remain uninsured. Approximately 38 percent of health centers in restrictive states anticipated that less than 10% of their patients would remain uninsured, compared with only 11.3 percent of health centers in full implementation states. More than one in ten respondents in restrictive states anticipated that 75% or more of their patients would remain uninsured.

- Health centers in full implementation states were more active in following through in the case of patients whose applications had been denied in that they were more likely to provide on-site legal aid or refer to legal aid.

Table 2: Comparison of findings for respondents from full implementation (n=247) or restrictive (n=136) states

	Restrictive %	Full implementation %	Significance*
Current types of enrollment assistance			
Notifying existing patients of potential eligibility status for new programs	64.7%	80.6%	**0.001**
Assistance in filling out paper enrollment applications for insurance (e.g. Medicaid/CHIP or subsidized coverage)	77.9%	86.2%	**0.037**
Assistance in getting the necessary documents for insurance applications	55.9%	76.5%	**0.000**
Online assistance and electronic application filing for insurance (e.g. Medicaid/CHIP or subsidized coverage)	53.7%	64.8%	**0.033**
Non-English language enrollment forms and assistance	59.6%	75.7%	**0.001**
Culturally appropriate enrollment materials or resources for the Non- English speaking population	63.2%	74.1%	**0.026**
Eligibility determination	61.0%	74.5%	**0.006**
Assistance in selecting a health plan	29.4%	51.0%	**0.000**
Assistance in selecting a primary care provider	56.6%	72.9%	**0.001**
Monitoring status of applications for coverage	42.6%	68.0%	**0.000**
Staffing, funding, and funding for new staff			
The health center has multilingual enrollment staff	69.1%	78.9%	0.052
The health center currently has staff who are assigned to assist with applications for Medicaid/CHIP or subsidized coverage	81.6%	90.7%	0.055
Mean FTEs staff who are assigned to assist with applications	3.3	5.7	**0.000**
Health center has been awarded HRSA outreach and enrollment grant funding	93.4%	95.1%	0.677
Health center plans to use HRSA Outreach and Enrollment funds to hire additional staff to assist with enrollment in Medicaid/CHIP or other health plans	84.6%	86.2%	0.846
Mean FTEs staff plan to hire with HRSA Outreach and Enrollment funds	2.8	2.5	0.307
Health center has been awarded navigator funding from CMS	2.2%	10.1%	**0.001**
Health center has received or been seeking additional other funding to hire additional staff to assist with enrollment	11.0%	33.6%	**0.000**
Mean FTEs plan to hire with other funding	1.7	3.0	0.284

***Numbers in bold text indicate significant differences between groups**

Assistance with enrollment	Restrictive %	Full implementation %	Significance
If there are questions about the (pending) new enrollment system, which agency or organization can you go to?			
State Medicaid agency	36.0%	54.7%	**0.000**
Local government or community agency	11.0%	37.7%	**0.000**
PCA	64.0%	49.0%	**0.005**
HRSA	62.5%	32.4%	**0.000**
Other	30.1%	26.3%	0.423
Don't know	5.1%	3.2%	0.357
If enrollment staff have questions as they are completing enrollment, they know where to turn to get answers	77.9%	88.7%	**0.014**
From where can they get answers?			
State Medicaid agency	34.6%	52.2%	**0.001**
Local government or community agency	8.8%	36.0%	**0.000**
PCA	52.2%	43.3%	0.095
HRSA	47.8%	24.7%	**0.000**
Other	27.9%	30.4%	0.619
Assistance with denials			
If enrollment staff are assisting someone who then gets denied, they know where they can go to get help for the denied applicant	46.3%	62.3%	**0.026**
From where can enrollment staff get help?			
State Medicaid agency	27.9%	44.5%	**0.001**
An outside organization (e.g. legal services)	11.8%	18.2%	0.099
PCA	19.1%	17.8%	0.752
HRSA	16.2%	11.3%	0.178
Other	12.5%	22.3%	**0.019**
The health center provides assistance with appeals for people whose applications are not approved	36.8%	45.7%	0.280
What kind of assistance is provided?			
Access to on-site legal aid	1.5%	5.7%	**0.049**
Referral to legal aid	19.9%	29.6%	**0.039**
Other	21.3%	21.5%	0.976

Anticipated impact of the ACA	Restrictive %	Full implementation %	Significance
The health center has already identified eligible patients within their existing patient base that may be covered under expansions	58.8%	78.9%	**0.000**
Approximately what percentage of total patients may be newly eligible for Medicaid/CHIP or subsidized coverage?	Out of 72 who answered:	Out of 184 who answered:	
Less than 10%	26.4%	12.5%	**0.026**
11-25%	41.7%	42.9%	
26-50%	23.6%	23.4%	
51-75%	5.6%	15.2%	
Greater than 75%	2.8%	6.0%	
Approximately what percentage of total patients is likely to remain uninsured?	Out of 71 who answered:	Out of 176 who answered:	
Less than 10%	11.3%	37.5%	**0.000**
11-25%	47.9%	48.3%	
26-50%	23.9%	11.9%	
51-75%	5.6%	2.3%	
Greater than 75%	11.3%	0.0%	

Discussion

As the ACA has moved into full implementation, health centers have emerged as one of the most important sources of community-based outreach and enrollment assistance because of their mission, their experience with outreach and enrollment, and their location in medically underserved rural and urban communities that stand to benefit greatly from the law. The findings presented in this analysis confirm the importance of the role played by health centers. On the eve and first stage of full implementation, health centers in all states were overwhelmingly poised to undertake major outreach and enrollment activities, including actively screening their patients for eligibility, providing assistance with both online and paper applications, providing help in a range of languages, and offering end-to-end assistance, beginning at the point at which eligibility for insurance affordability programs must be determined and continuing through health plan selection.

At the same time, our findings reveal striking and significant differences between health centers in states that have fully implemented the law -- as measured by a combination of expanding Medicaid and refraining from imposing additional regulatory requirements on outreach and enrollment – and those that have adopted policies impeding implementation, including failure to expand Medicaid and the imposition of additional regulatory restrictions on community outreach. Although state Navigator laws ostensibly are aimed at certified Navigators, the findings in this study suggest that they may be having an impact on navigation more generally, as measured by more limited assistance with plan enrollment in restrictive states.

In restrictive states, health centers were less well resourced. Their activities were more limited, their partnerships more constrained, and their access to necessary information more highly focused on their own primary care associations and the federal government. Of course, the restrictive states examined in this study also depend on the federally-facilitated Marketplace and were less likely to have direct state involvement in the expansion, which may help to explain the greater level of reliance on federal officials and health center associations. We find it notable, however, that even in the case of state Medicaid agencies, whose state-based obligations are independent of the Marketplace, health centers appeared to be significantly less likely to maintain contact.

Either as a result of or in connection with the overall implementation environment, health centers in restrictive states were less likely to have an optimistic view about the impact of the ACA on their patients and were much more likely to view the ACA as having a very limited overall effect on their patients' insurance status. Of particular interest as implementation proceeds will be monitoring the experiences of health center outreach in both types of states.

To the best of our knowledge, this is the first study to attempt to measure the downstream consequences for medically underserved communities of states' decisions to either fully implement the ACA or restrict its impact. By focusing on the experience of health centers, the study provides a view of implementation on the ground and offers insights into the challenges involved and health center strategies for overcoming these challenges. Although it goes without saying that no amount of technical support can overcome the impact of a state's decision to opt out of the Medicaid expansion or to impose regulatory restrictions on outreach, these findings do suggest the importance of strong technical assistance in helping health centers to understand the regulatory environment in which they operate and maximize the law's reach.

Limitations

This study has certain limitations. First, much of the data were collected immediately prior to the open enrollment period, which began October 1st, and continued beyond the initial open enrollment date. As outreach and enrollment efforts expand, it may be that activities will intensify in health centers located in restrictive states especially as the Healthcare.gov website functions more smoothly. Second, to the extent that the restrictive states ultimately decide to adopt the Medicaid expansion and take steps to clarify the relatively narrow reach of their Navigator laws, these findings may well shift over time. Third, because this study was based on a survey, we are unable at this point to provide deeper insights into some of its more crucial findings, such as why health centers in restrictive states are so unlikely to be offering assistance with plan enrollment or what efforts may have been undertaken to obtain additional information from a state Medicaid program.