A Trusted Voice:
Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act

April 2011

CALIFORNIA COVERAGE & HEALTH INITIATIVES

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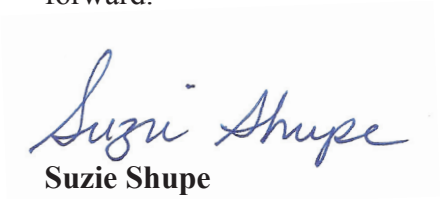
Foreword from the Executive Director

As California embarks upon the historic yet daunting task of enrolling the roughly five million Californians who will gain access to health insurance under the Affordable Care Act (ACA), opportunities abound to both build upon and improve already successful efforts to find and enroll Californians in coverage. Last year, the Schwarzenegger Administration asked CCHI to explore how community-based outreach can be harnessed to speed the success of this effort. Through this report, CCHI offers thoughts on the research, current best practices in California and recommendations to policymakers on how to leverage community-based outreach to fulfill the promise of the Affordable Care Act.

We at CCHI are proud of the creative and effective outreach and enrollment work that the Children's Health Initiatives perform across our state. We are excited about the new directions our CHI members are undertaking: serving new populations, connecting clients to care when coverage is not available and integrating with local community support networks. These experiences prepare them to serve many different types of Californians now and in the coming years. CHIs can also provide valuable insights about how we create and grow an infrastructure that can successfully reach and enroll the newly eligible. While their experience has much to offer, this report does not propose the CHI as the only model for community-based outreach. Instead, we see the CHIs as one model for achieving solid enrollment results.

This report is intended to remind California policymakers about the essential role to be played by community-based outreach and enrollment in implementing the ACA in our state. It includes recommendations for harnessing the existing talent and networks so they will be in place and ready to go for each stage of implementation, from the present through 2014 and beyond. As the CHIs have tremendous expertise in doing the hard work of finding and enrolling people in health coverage, CCHI and the CHIs anticipate playing leading roles in fostering a culture of coverage in local communities across California. We encourage policymakers to draw on community-based organizations as strong partners in designing enrollment systems and innovative outreach strategies. This report outlines the issues and suggests a constructive path forward.



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Executive Director

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in the community

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Executive Summary

The passage of the federal Affordable Care Act (ACA) offers California enormous opportunities, including the chance to develop a "culture of coverage" in which health insurance is available, affordable, and expected. Achieving such a culture will require changes in every part of the health care system, from eligibility simplification to delivery system redesign. In the area of outreach and enrollment, this culture will mean the further development and adoption of electronic enrollment systems, targeted media campaigns, and sustained, creative community-based outreach and enrollment—public and individual education and direct assistance provided to consumers at the local level by trusted community organizations.

This report focuses on community-based outreach and enrollment in California: how it has been best used to date, and how it can be most effectively employed in the ACA world. Its goal is to inform and make recommendations to policymakers who will be making important decisions about the structure of a community-based outreach and enrollment system as California engages in very important planning for 2014 and beyond.

KEY FINDINGS

California has a long history of organized community-based outreach and enrollment in its public health insurance programs. In response to the establishment of the Healthy Families Program, as well as the initiation of county-based Children's Health Initiatives (CHIs) in 28 counties of the state, community-based organizations (CBOs) and health care providers created a strong outreach network that has been responsible for significant progress in enrolling children, and keeping them enrolled, in health insurance programs. Unfortunately, fading state support for community-based outreach and enrollment has limited these advances in recent years.

Published research on California and other states, as well as interviews with outreach and enrollment workers and other observers, lead to the following key findings about the most effective use of community-based outreach and enrollment:

1. Community-based entities that are **trusted and knowledgeable about local circumstances** and opportunities provide the most effective outreach and enrollment.
2. The most successful outreach and enrollment efforts employ a **variety of approaches and strategies** simultaneously.
3. Community-based outreach and enrollment succeeds when it is **culturally and linguistically competent.**
4. Outreach and enrollment efforts are most successful when they involve a **broad network of organizations** and include strong linkages to county and state agencies.
5. Outreach using an **"umbrella strategy"** that offers something for everyone, as opposed to addressing only specific programs, is critical to enrollment success.

6. Community-based outreach and enrollment can utilize and **extend the reach of web-based and other technological enrollment strategies,** and provide essential assistance in negotiating those systems to individuals who need it.
7. Outreach and enrollment efforts require adequate, reliable, and continuous **financial support.**
8. Outreach and enrollment workers need **comprehensive, interactive and ongoing training.**
9. Person-to-person outreach and enrollment efforts are effective in **promoting retention and utilization,** helping people remain insured and access care appropriately.

RECOMMENDATIONS

Realizing the opportunities that the ACA offers will require California to invest in community-based outreach and enrollment in thoughtful and strategic ways. The existing community-based outreach system has many strengths, but is under-resourced and needs new direction, enhanced training, and better coordination in order to operate most effectively in an ACA environment. The following recommendations are essential to maximizing the benefits of community-based efforts as the state moves forward:

Build on Outreach and Enrollment Strategies That Have Proven Effective

- **Use the Existing Community-Based Infrastructure as the Basis for New Enrollment Efforts and Build on It to Meet the Additional Scope and Complexity of ACA.** California should work with the community-based networks already in place, and these structures should innovate (via expansions and updated training, among other strategies) in order to meet the needs of the expansion populations under ACA. Technological tools and community supports that are locally responsive and culturally competent must be available in order to ease the task of moving millions of previously uninsured individuals into coverage.
- **Involve Existing OERU Entities in Planning.** The full range of community-based outreach and enrollment entities—including Children's Health Initiatives (CHIs), community health centers, hospitals and other providers, and non-CHI community-based organizations (CBOs), as well as consumer assistance programs (CAPs)—should be involved in planning outreach and enrollment strategies for the ACA environment.

Establish a Statewide (or Regional) System of Outreach and Enrollment Assistance

A single (or several regional) synthesized, organized OERU system(s) could increase the success of California's outreach and enrollment efforts by creating a stable network of individuals and groups engaged in common work and providing an opportunity to standardize ongoing training. Development of a systematized statewide approach to outreach and enrollment could also improve evaluation and spread data-driven methodologies; provide a central point of contact for the state; establish and apply standards; and help develop a reliable, sustainable funding stream.

Maximize the Impact of the Navigator Program in the New Exchange

- Allow Participation of a Broad Array of Organizations and Individuals in the Navigator Program. California should make participation in the Navigator program open to a wide range of entities, looking carefully at the newly-eligible populations and how best to reach them and casting a wide net while maintaining high standards for participation. The state should encourage the participation of existing local enrollment entities in the Navigator program, taking advantage of their community connections and experience with low-income populations in particular, but recognizing that many are also experienced with commercial insurance options.
- Ensure that Navigators are Knowledgeable about and Can Assist with Both Public Coverage Programs and Qualified Plans in the Exchange. In order to best support the development of a cohesive culture of coverage, California's Navigator program should address both public and private coverage options. The interactions between these options will be extremely complex. The Exchange Board must carefully tailor a Navigator training and certification program that supports the knowledge and skills necessary to enroll Californians into the full range of coverage options.
- Plan for and Support Outreach and Enrollment Functions Independent of and in Addition to the Navigator Program. The Navigator Program, while important, cannot be the only means of outreach and enrollment for state health insurance programs. Some organizations may not meet the requirements to qualify as Navigators or have the infrastructure to participate in the program, but the state will still have an interest in encouraging them to educate their clients and the public about health insurance options.

Develop Targeted Outreach Strategies for Medicaid-Eligible Adults

While many of the strategies that have been successful in enrolling children in California will apply to newly-eligible adult populations, some new approaches and new messages will be required. Connections with health and behavioral health providers who already serve adults will be an important strategy, as will coordination with social services and Medicaid agencies at the state and county levels. Message development must convey the major changes in eligibility that make adults eligible for programs that have traditionally been closed to them.

Focus on Retention and Utilization

Community-based outreach workers encourage retention and appropriate utilization by educating people at enrollment about how to use their insurance coverage, making follow-up contacts to ensure that they have an identified primary care provider and attend an initial health care appointment, and letting them know when and how they are required to renew their enrollment and how to navigate other changes that can lead to the interruption or denial of coverage. Community-based outreach and enrollment entities, working with state and county Medi-Cal offices, will need to focus on comprehensive strategies to keep newly-enrolled individuals from losing coverage, and to ensure that they access timely and appropriate care.

Develop Outreach Strategies for Moderate-Income Individuals and Families

New strategies and approaches will be essential to reaching individuals eligible for Exchange subsidies, particularly in the individual market. Potential partners to assist in reaching this population include existing community-based outreach and enrollment entities, as well as schools, tax preparers, retail outlets, faith organizations, community colleges, insurance agents and brokers, and sports and entertainment outlets.

Identify Funding Streams to Support Community-Based Outreach and Enrollment

Sustainable, ongoing sources of funding are essential to the success of outreach and enrollment efforts. California must maximize all federal funding opportunities for outreach and enrollment. The state, counties, providers, employers, and private sector and philanthropic partners must work together aggressively to identify funding streams that are adequate to the task and sustainable in the long term.

CONCLUSION

The insurance expansions and simplified enrollment system that are cornerstones of the ACA mean that the large majority—approximately two-thirds—of California's uninsured may have access to health insurance coverage as soon as 2014. These newly-eligible populations will be hard to reach, however, and even as the state moves toward a unified, seamless electronic enrollment system, as required by ACA, community-based outreach and enrollment will remain a critically important component of that system. Community-based outreach workers, deploying a range of strategies that are tailored to particular neighborhoods and populations, are effective in enrolling people in health insurance programs and keeping them there—particularly when the individuals or groups in question are hard to reach. Community-based outreach and enrollment—smart strategies based on close community ties—are an essential piece of making the promise of health care reform a reality.

"Community-based outreach and enrollment—smart strategies based on close community ties—are an essential piece of making the promise of health care reform a reality."

Introduction

The passage of the Affordable Care Act (ACA) offers enormous opportunities for transformational change in California's health insurance and health delivery systems. Under the ACA, the state has begun implementing an ambitious insurance expansion through Medi-Cal and the California Health Benefit Exchange (the Exchange). This expansion, along with other policy changes that include the development of a consumer-centered, seamless enrollment system based on the "no wrong door" concept, promote the goal of a culture of coverage. In such a culture, "coverage is available and affordable, the processes and rules of enrolling and maintaining enrollment in publicly-funded or subsidized coverage are simple and efficient, and everyone accepts the responsibility to obtain and maintain coverage." [1]

The involvement of community-based organizations (CBOs), trusted entities who can work with the state and with their local communities to "move the needle" and change the way Californians view and interact with health insurance and the health care system, is essential to achieving a culture of coverage. One specific role for CBOs in this larger effort is in the area of outreach and enrollment. This report provides an overview of the use of community-based outreach and enrollment to assist low-income individuals in learning about and enrolling in health insurance programs, and in accessing health care. It provides a history of California's experience in community-based outreach and enrollment, with a particular focus on enrolling children, including the unique experience of the Children's Health Initiatives (CHIs). The report draws lessons from the past 15 years of experience in California and work in other states to identify best practices that are applicable to the ACA world. It also includes recommendations for policies and activities that California should consider as it implements the ACA. Community-based outreach and enrollment—smart strategies based on close community ties—are an essential piece of making the promise of health care reform a reality.

TERMINOLOGY: COMMUNITY-BASED OUTREACH AND OERU

Community-based outreach and enrollment includes 1) public awareness and individual education to promote new and existing programs to individuals and families, 2) direct enrollment assistance at the local level, and 3) the training, resources and infrastructure to support public education and enrollment assistance.

Community-based outreach and enrollment is frequently considered under the rubric of Outreach, Enrollment, Retention and Utilization (OERU), which includes outreach and enrollment as described above, as well as a broader set of strategies to ensure that, once enrolled in health insurance programs, individuals remain enrolled and use their insurance benefits appropriately to access needed care.[2] This report, while discussing the broad range of strategies employed by community-based OERU entities, is primarily focused on outreach and enrollment activities.

Although in the California context, many individuals who provide OERU are Certified Application Assistants (CAAs—the California CAA program is described briefly in the next section),

this report refers to "community outreach and enrollment workers," recognizing the very broad field of community-based OERU and the wider roles that may develop under the ACA.

A full description of the variety of strategies and activities that community outreach and enrollment workers employ is beyond the scope of this report. A 2010 survey conducted jointly by Community Health Councils (CHC) and California Coverage & Health Initiatives (CCHI) asked CAA Enrollment Entities (organizations registered with the state to engage CAAs to conduct outreach and enrollment activities)[3] to identify the best practices and most important elements for successful OERU in their communities. Essential elements included:

- outreach and eligibility workers who are well-trained and have a natural connection to the community they serve;
- collaboration with other organizations, especially county health and human services agencies; and
- providing services at places and times that work for the clients.

A list of best practices generated by survey respondents in the areas of outreach, enrollment, retention and utilization is included as Appendix A.

COMMUNITY-BASED OUTREACH IN PUBLIC HEALTH INSURANCE PROGRAMS: HEALTHY FAMILIES, THE CAA NETWORK AND THE CHIS

Community-based organizations (CBOs), health care and social service providers and others have long assisted families and individuals in enrolling in public health insurance programs. The passage of the State Children's Health Insurance Program (SCHIP) in 1997 (which was reauthorized in 2009 as the Children's Health Insurance Program, or CHIP) allowed California to expand Medi-Cal and implement the Healthy Families Program. Formal systems of outreach and enrollment assistance were established in some counties. At the same time, the state, along with several philanthropic organizations, began to engage CBOs and other public and private stakeholders to find and enroll millions of eligible but uninsured children.

Despite these efforts, enrollment in Healthy Families proceeded more slowly than intended, and over 1 million eligible children remained uninsured. The state augmented its media marketing efforts first through outreach contracts with local organizations, counties, school districts, and community health centers, and later with payments to Certified Application Assistants (CAAs).[4] CAAs were trained by state contractors to help families complete and submit the joint Healthy Families Program/Medi-Cal mail-in application or, later, the internet-based Health-e-App, to keep families informed about program changes, and to help them maintain their coverage. They also helped families who did not qualify for no-cost Medi-Cal or Healthy Families by referring them to other available programs. As a result of California's worsening budget crisis, CAA fees were reduced in 2003, restored in 2005, and then eliminated entirely as of July 2009. While many CAAs have continued to provide assistance without financial incentives,[5] the loss of funding has significantly limited the CAAs' reach, as evidenced by a large drop in enrollment in Healthy Families from 2009 to 2010.[6]

Beginning around 2000, community-driven coalitions in a number of counties began to develop a more cohesive model for outreach and enrollment to children and families and to establish health coverage programs, many known as Healthy Kids, to bridge the gap for children ineligible for federal- and state-funded programs. These actions led to the development of Children's Health Initiative (CHI) programs across California. Formed by local public-private partnerships among county governments, First 5 Commissions, health plans, hospitals and local providers, health advocates, community organizations and foundations, CHIs are currently active in 28 of California's 58 counties, representing approximately 75 percent of the state's uninsured population.[7] In many counties, the establishment of a CHI corresponded with the launch of new or expanded outreach and enrollment efforts, typically coordinated across many providers by CHI-convened local coalitions. The CHIs have inspired practices, innovations and opportunities for advancement in outreach, enrollment, retention and utilization (OERU).[8] Recent years have seen a loss of funding for outreach and enrollment and for Healthy Kids coverage programs, but most CHIs have maintained significant levels of outreach efforts despite these cuts.

Although the community-based outreach and enrollment networks in California have continued to function, the system is showing serious strain and requires additional investment to keep it from unraveling. Looking ahead to the implementation of the new federal health care law and the expansion of coverage to new populations, it is essential to identify resources to maintain and upgrade the network of community outreach and enrollment workers and ensure a quick and effective implementation of the ACA.

The Changing Landscape: ACA and the Medi-Cal Waiver

The new federal health care law fundamentally redraws the landscape of health insurance in California. Approximately 2/3 of California's seven million uninsured under the age of 65 are expected to become eligible for Medi-Cal or for subsidized coverage through the Exchange. The Affordable Care Act (ACA) also requires states to redesign their enrollment systems—and in the process rewrites the script for community-based outreach and enrollment.

ACA ELIGIBILITY EXPANSION

ACA expands enrollment in health insurance through five major avenues that will take effect beginning in 2014:

1. Medicaid eligibility for all citizens and legal immigrants under the age of 65 with incomes below 133% of the federal poverty level (FPL)
2. Premium and cost-sharing subsidies for those with incomes between 133 and 400% FPL to purchase coverage through a Health Insurance Exchange
3. Tax credits for small businesses that purchase health insurance coverage through a Health Insurance Exchange
4. Individual mandate requiring coverage for all U.S. citizens and legal residents

5. Health coverage consumer protections that require insurers to cover all who apply and pay for coverage and that limit out-of-pocket costs

The impact of these changes on Californians' eligibility for health insurance coverage is tremendous: under the first two provisions, an estimated three million low-income Californians could qualify for MediCal under the ACA, while an additional 1.7 million could be eligible for subsidies in the California Health Benefit Exchange. In total, 4.7 million nonelderly adults and children—of the seven million Californians who were uninsured for all or part of 2009—could be eligible for insurance in 2014.[10]

OUTREACH AND ENROLLMENT PROVISIONS IN ACA

In general, while the ACA does recognize the importance of community-based outreach, it does not include many specific requirements or meaningful funding for implementing this outreach. One of the most significant provisions of the law is the requirement that states simplify their enrollment processes, including through development of a single application for all programs (Medicaid, CHIP, and the refundable tax credits for purchase of plans in the Exchange); allowing web-based application and enrollment; and concurrent screening and enrollment for multiple programs. The federal legislation does not clearly define the role of community-based outreach in relation to this new streamlined system, but does include explicit outreach requirements related to the state Health Insurance Exchanges, the agencies that will organize health insurance markets for individuals and small employers.

The federal legislation also provides a funding stream for independent consumer assistance programs (CAPs) or ombudsman programs, which, while typically not operating primarily as outreach and enrollment providers, are important partners in a successful community-based OERU system.

State Exchanges must establish Navigator programs

The Exchanges have a defined responsibility for outreach and public education, through operation of a "Navigator" program to increase awareness about the Exchange and health insurance subsidies and to facilitate enrollment in qualified health plans.[11]

Section 1311(i) of the ACA states that Exchanges will set up a Navigator grant program to:

- Conduct public education activities that raise awareness of qualified health plans
- Distribute fair and impartial information concerning enrollment in qualified health plans
- Facilitate enrollment in qualified health plans
- Provide referrals to an appropriate agency for any enrollee with a grievance, complaint, or question regarding a health plan
- Provide information that is culturally and linguistically appropriate to the population being served.

Funding for Navigator programs is to come from the operational funds of the Exchange at the state level and not from federal funds received by the state to establish the Exchange.[12]

The statute allows for a wide variety of organizations and individuals to

be "navigators"—in addition to non-profit organizations, navigators may include trade, industry and professional associations; fishing, ranching and farming organizations; chambers of commerce; unions; resource partners of the Small Business Association; licensed insurance agents and brokers and "others." The federal Secretary of Health and Human Services is required to establish standards for navigators, which may include licensing or certification requirements. The statute prohibits health insurance issuers from serving as navigators, and prohibits all navigators from receiving direct or indirect consideration from health insurance issuers in connection with enrollment in a "qualified health plan."[13]

California's Health Benefit Exchange bill includes language that mirrors the federal requirements and requires the Exchange Board to establish the Navigator program.[14] Specific details about the structure of the Navigator program within the California Health Benefit Exchange were not clear at the time of this writing, and the Secretary of Health and Human Services is expected to issue federal guidelines in Spring 2011.

Consumer Assistance Programs (CAPs) receive grant support under ACA

The ACA provides substantial new support for independent consumer assistance programs (CAPs) or ombudsman programs. ACA §1002 establishes a new grant program to states or states' exchanges to establish, expand, or provide support for an independent state-designated office of health insurance consumer assistance or ombudsman programs.[15] The designated office must, directly or in coordination with state health insurance regulators and consumer assistance organizations, receive and respond to inquiries and complaints concerning health insurance coverage with respect to federal and state health insurance requirements.[16] The Secretary must establish criteria for carrying out the duties of these offices, which must include:

- Assistance with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;
- Collecting, tracking, and quantifying problems and inquiries encountered by consumers;
- Educating consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;
- Assisting consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and
- Resolving problems with obtaining premium tax credits under §36B of the Internal Revenue Code of 1986. (§1002(c)(1) thru (c)(5)).

The CAP program is funded with an initial $30 million allocation in 2011, with further funding amounts "as may be necessary" to be determined by the Congressional appropriations process.[17]

The California Department of Managed Health Care (DMHC), in partnership with the California Office of the Patient Advocate (OPA), applied for and was awarded $3.4 million grant.[18] According to the grant proposal, the funds will be used to:

- Develop and promote a coordinated consumer-friendly website and corresponding toll-free number that consumers can call with questions about health care coverage, and to receive assistance with the filing of complaints and appeals.
- Conduct a statewide media campaign, in partnership with consumer organizations, to educate consumers about their rights and responsibilities and to provide assistance with enrollment in group health plans or health insurance coverage.
- Evaluate the effectiveness of the initiatives, and collect, track and quantify consumer problems and inquiries for reporting to state and federal policymakers.

California's grant proposal allocates most of the funding to the State, with some to be used for contractors to develop and promote the website, establish a toll-free number, conduct a statewide media campaign, and evaluate the initiatives. More recently, DMHC has announced that they will reallocate some of the funding from the public education campaign to grants for community-based organizations.[19]

Proposed legislation (AB 922, Monning) would establish an Office of Consumer Health Assistance within the Department of Managed Health Care that would coordinate many of these functions. Replacing the Office of the Patient Advocate, the Office of Consumer Health Assistance would be responsible for outreach and education about health care coverage of all kinds, and would contract with community organizations to provide those services. The Office would also receive and respond to consumer questions and complaints across all health insurance programs.[20]

ACA promotes special efforts for vulnerable populations

Finally, section 2201 of the ACA charges states with establishing procedures for conducting outreach to and enrolling vulnerable populations in Medicaid and CHIP, and defines these populations to include children, homeless youth, children and youth with special health care needs, pregnant women, ethnic and racial minorities, rural residents, victims of abuse and violence, people with mental health and substance abuse needs, and people with HIV/AIDS.

MEDI-CAL WAIVER: COUNTY LIHP PROGRAMS

Even before the Medicaid eligibility expansions and the Exchanges are implemented in 2014, California's new "Bridge to Reform Section 1115(a) Medicaid Demonstration Waiver," approved on November 1, 2010, creates new structures that will allow counties to enroll some low-income adults in health coverage. The Low-Income Health Program (LIHP) is a county-based elective program that consists of two components: the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE gives counties the option to provide coverage to uninsured adults 19-64 with incomes up to 133% FPL, while the HCCI allows counties to cover individuals between 134 and 200% FPL (though counties may set lower income eligibility standards). The MCE provides a broader range of medical assistance than the HCCI and, unlike the HCCI, is not subject to a cap on federal funding.[21]

"Overall, the research literature demonstrates that well-trained people who understand the local community context and can walk applicants through complex enrollment processes are extremely effective in increasing enrollment and retention in health insurance programs."

Depending on the level of county participation, a number of adults who will become eligible for Medi-Cal in 2014 could be enrolled in these programs over the next three years. To the extent that enrollment in the LIHP programs is successful, the transfer of these populations to Medi-Cal coverage in January 2014 will be greatly simplified. However, given funding limitations—counties must put up their own dollars in order to draw down federal match—the LIHP programs are likely to be fairly modest in scope, and outreach will in most cases initially be directed toward those uninsured currently receiving care at participating community health centers and hospital emergency rooms. The role of community-based outreach in the LIHP programs is therefore uncertain, though in some counties the LIHP programs may provide an opportunity to develop and test strategies for reaching and enrolling low-income childless adults. In any case, there is no state role in or funding for LIHP outreach, which will be solely a county responsibility.

Community-Based Outreach and Enrollment: Findings from the Research

California's fifteen years of organized outreach efforts in children's enrollment have yielded a wealth of data on successful approaches to community-based outreach and enrollment. On a national basis, the experience of other states in CHIP implementation as well as the efforts of states that have made significant insurance expansions to adults, are also instructive regarding best practices in this area.

STATUS OF THE RESEARCH

Community-based outreach and enrollment have been studied extensively over the last 15 years. The majority of these studies are descriptive and qualitative, though some quantitative evaluations comparing various outreach approaches do exist. Overall, the research literature demonstrates that well-trained people who understand the local community context and can walk applicants through complex enrollment processes are extremely effective in increasing enrollment and retention in health insurance programs. One of the significant values of the community-based approach is its ability to cater to specific local conditions, with the result that the particular strategies for the deployment of outreach workers are constantly evolving and vary from place to place (thus complicating evaluation efforts at this level of detail).

Much of the relevant research centers on children's enrollment, reflecting the focus on CHIP implementation and other efforts to increase children's enrollment.[22] This literature is instructive and relevant in many ways, but does not map exactly to the adult populations that will make up the majority of newly-eligible individuals in California under ACA. There is far less published information about successful strategies to reach "childless" adult populations, though some evidence has emerged from states that have created adult coverage options through Section 1115 waivers or in separate state programs, as well as from the first round of HCCI programs in ten California counties.[23]

"Locally-organized outreach and enrollment efforts allow policymakers and practitioners to make decisions about where, when, how and to whom to target their efforts."

KEY FINDINGS

The state and national experience in community-based outreach and enrollment supports the following key findings about how community outreach can be most effective:

1. Community-based entities that are trusted and knowledgeable about local circumstances and opportunities provide the most effective outreach and enrollment.

One key benefit of community-based outreach and enrollment is its local focus—the fact that it can respond to the specific circumstances and cultures of a community and adapt strategies and tools to best meet the needs of the population in question, and that the organizations and individuals providing the outreach and enrollment assistance have the trust of the communities they work in. The importance of these aspects of community-based outreach and enrollment is borne out in a number of studies, as well as in discussions with California practitioners:

- A study of the Massachusetts insurance expansion credited community-based outreach and enrollment, along with data-driven eligibility, an integrated eligibility system, and public education, as a primary reason for the rapid and near-comprehensive enrollment of the state's uninsured population into Commonwealth Care and other insurance programs.[24]
- An evaluation of the Robert Wood Johnson Foundation's Covering Kids and Families program found that state grantees believed that one of the essential criteria for effective outreach was that it be conducted through a trusted community organization.[25]
- A 2008 analysis of the California HealthCare Foundation's Step by Step initiative, which provided funding of various types to 25 local entities across California, noted the importance of local flexibility in the funding, which allowed grantees to adapt resources to their specific needs, including launching new insurance products and increasing enrollment in existing programs.[26]

Locally-organized outreach and enrollment efforts allow policymakers and practitioners to make decisions about where, when, how and to whom to target their efforts. For example, they can make enrollment workers available at places that the target populations frequent and can access easily; they can provide services at times that families are available to get help. They can craft messages that are linguistically and culturally relevant to the population in question, and take account of the health provider landscape of the local area. *(See sidebar.)*

In a report about Consumer Assistance Programs (CAPs), the Community Service Society makes a cogent argument

Healthy Kids Mendocino:
The CHI in Mendocino County works to reach people in the very small towns in distant parts of the county. Uninsured individuals in these communities are isolated even within a rural context, and they need a person in their community to meet them where they are—sometimes literally, as many do not have reliable private transportation, bus service has been cut back, and while families may have phones, they typically buy only a month of service at a time and change numbers frequently. Internet access is also limited, as library hours have been reduced. Outreach workers affiliated with community-based organizations that are part of the CHI structure travel to small towns throughout the county, and assist people in person and over the phone in gathering necessary documentation and filling out applications for health insurance as well as other public benefit programs.

"These 'trusted messengers' understand how to reach and assist diverse, low-income, and vulnerable populations—the people who will be most dramatically affected by health reform."

—COMMUNITY SERVICE SOCIETY

for the importance of local efforts:[27] *We argue that nonprofit community-based consumer assistance programs, with their local knowledge, connections, and expertise, are best positioned to explain the new law to individuals and families in the neighborhoods in which they live and work. Whether helping a retired teacher in California or a low-waged immigrant worker in East Harlem, these locally-based programs know the unique needs of their constituents. These "trusted messengers" understand how to reach and assist diverse, low-income, and vulnerable populations—the people who will be most dramatically affected by health reform.*[28]

Yolo County CHI augmented their existing services in West Sacramento, located in Department of Social Services offices, by providing outreach and application assistance in coordination with a food distribution program. Every Friday, CAAs go to a neighborhood school site where families can receive 10 pounds of fresh food as well as a range of other services. The food distribution reaches 150 families a week, and the number of people enrolling and re-enrolling in health insurance in that area has doubled since the program began.

2. The most successful outreach and enrollment efforts employ a variety of approaches and strategies simultaneously.

The specific strategies that community-based OERU entities engage in run the gamut from one-on-one assistance at homeless shelters, to innovative programming in collaboration with schools and school districts, to community-based media campaigns using local print and broadcast sources. Most organizations employ multiple strategies.[29]

A recent study of outreach and enrollment strategies in the CHIs found that, when it comes to outreach and enrollment, more is more. Discussing the value of multiple strategies for identifying and enrolling uninsured children, the authors state that using several strategies simultaneously is likely to produce "a significantly higher yield as compared with less comprehensive approaches that depend on media and other nontechnology enrollment assistance."[30] Conversely, an earlier study found that person-to-person outreach is especially effective when states also used brochures, web sites and toll-free lines. The report noted that personal contact "allows face-to-face interaction for the purpose of making customized presentations, answering questions, and explaining the application process."[31]

The California CHI study went further than most in attempting to quantify the impact of particular outreach strategies. It found that school-linked strategies were the single most effective intervention, resulting in a 12 percent increase in new enrollments compared to "county quarters" (each quarter from 2001—2007 for 25 counties studied) without school-based deployments,[32] but that the most dramatic impacts came from the use of multiple strategies used in concert: *Deploying several strategies simultaneously is likely to produce a significantly higher yield as compared with less comprehensive approaches that depend on media and other nontechnology enrollment assistance. During site visits, coalition leaders often described not only how strategies were deployed simultaneously but also how they often worked together. For example, it was often described how school-based personnel and community health workers in many counties increasingly used One-e-App as a tool for enrolling children into the three health insurance programs.*[33]

"…uninsured Latino families in Boston who received intensive application assistance from community-based, bilingual case managers who identified potentially eligible families, helped them fill out application forms, and tracked the applications through to completion, trouble-shooting as necessary, were enrolled at a rate of 96 percent. Standard outreach methods, by contrast, enrolled only 57 percent of eligible children."

—Pediatrics

Several local program experiences illustrate how outreach entities take advantage of opportunities and adapt their strategies to different populations *(See sidebar.)*

Because community-based outreach and enrollment assistance is so closely identified with the CAA system in California, application assistance is often taken as a given in discussions of outreach and enrollment strategies. It is important to note, however, just how valuable this particular form of enrollment assistance is. One study found that uninsured Latino families in Boston who received intensive application assistance from community-based, bilingual case managers who identified potentially eligible families, helped them fill out application forms, and tracked the applications through to completion, trouble-shooting as necessary, were enrolled at a rate of 96 percent. Standard outreach methods, by contrast, enrolled only 57 percent of eligible children.[34]

Health care providers also have been key players in California outreach and enrollment efforts, with a model based on "in-reach," or contacts with individuals who are already receiving health care services at the site. Larger providers, including hospitals and community health centers, may partner with county eligibility departments to host out-stationed workers who can determine eligibility on-site; smaller providers may have front-office staff who are trained as CAAs. While many individuals are motivated to apply for health insurance at the service site, clinic-based outreach and enrollment workers report that they sometimes face challenges convincing individuals who are already receiving services without insurance that they should go on to enroll in a program. This is particularly true for more marginalized populations, such as homeless individuals. *(See box.)*

Provider-based in-reach is also a leading mechanism for reaching adults. For example, in Sonoma County, one in three CAAs affiliated with the CHI are employed at health centers, where they process applications for Medi-Cal and the County Medical Services Program (CMSP) for adults. In general, strategies that have been successful with children are likely to work for adults as well, though additional and amended approaches may be needed to reach these populations. According to a recent national review of the subject, outreach venues that may be important for reaching adults include "unemployment offices, assisted housing programs, job training programs, homeless and domestic violence shelters, food stamp offices and food banks, programs serving migrants or seasonal hires, child support enforcement agencies, one-stop career centers, community colleges, literacy/GED programs, and employer/

Venice Family Clinic employs five outreach and enrollment staff who provide screening, application assistance and trouble-shooting to patients on a walk-in basis. They have found that enlisting health care providers in this effort can be very effective, and many of the physicians and other providers at VFC now ask patients directly about their health insurance status, encouraging them to talk to the CAAs if they are uninsured or having problems with insurance. Still, some people are not interested in applying, either because of negative experiences they've had with public programs, mistrust of the system, or because health insurance does not offer them anything they don't already have access to. (As free and low-cost health care services have diminished in Los Angeles County, VFC outreach staff have found that people are more willing to apply for insurance.) Specialty care is a critical need for many adult patients, and outreach staff anticipate that it will be easy to interest this population in the Medi-Cal expansion.

"The strategies developed by local outreach organizations and coalitions respond to California's linguistic, cultural, and geographic diversity in a way that state-level approaches cannot, regardless of the number of languages in which translated materials or telephone assistance is provided."

employee organizations."[35] Partnering with SSI offices has been identified as an important strategy for reaching those adults who do not qualify as disabled, but who may still be income-eligible for Medicaid under the new expansion.[36]

3. Community-based outreach and enrollment succeeds when it is culturally and linguistically competent.

The strategies developed by local outreach organizations and coalitions respond to California's linguistic, cultural, and geographic diversity in a way that state-level approaches cannot, regardless of the number of languages in which translated materials or telephone assistance is provided. Cultural competence is at the core of community-based outreach: a 2009 national study found that state Covering Kids and Families grantees and projects consistently targeted Latino/Hispanic Americans, African-Americans and immigrants in their work.[37] This is true throughout the California community-based outreach system: for example, the Children's Health Initiative of Kern County recently worked with Visión y Compromiso, a community-based organization, to train and certify fourteen of that organization's *promotoras de salud* as CAAs.[38] Kern has also worked with the Farmworker Institute for Education and Leadership Development (FIELD) to make CAAs available to that population.

This kind of targeting works: one study found that bilingual community-based application assistance helped increase enrollment in Medicaid.[39] Community-based outreach appears to be an essential element of successful efforts to enroll specific ethnic minority populations that are under-enrolled in programs for which they are eligible, as well as children in families in which English is not a first language. The 2009 NASHP review of the literature found that "[t]he positive impact of community-based outreach on enrollment of eligible uninsured children appears to be especially true for racial and ethnic minority populations or immigrant groups, because community organizations frequently have the trust of community members."[40]

4. Outreach and enrollment efforts are most successful when they involve a broad network of organizations and include strong linkages to county and state agencies.

One of the key findings across all reviews of community-based outreach efforts is that there is particular value in building local networks that can coordinate efforts, share information, and amplify best practices. A recent survey of CAA Enrollment Entities conducted by Community Health Councils (CHC) and CCHI found that a formal, coordinated network of agencies that provide OERU services exists in over half of the counties (12 of 22) represented by the responding organizations, and that some form of a network of OERU agencies—with or without formal coordination—exists in 77 percent of those counties. In the parts of the state where they operate, CHIs have typically led the way in coordinating efforts with county and city public agencies, community and faith-based organizations, providers, and schools to support increased efficiency of outreach efforts by reducing duplication, gaps and disparities in health insurance enrollment assistance services.

While the specific value added by networking and community partners is difficult to quantify, it is universally

"CHIs have typically led the way in coordinating efforts with county and city public agencies, community and faith-based organizations, providers, and schools to support increased efficiency of outreach efforts by reducing duplication, gaps and disparities in health insurance enrollment assistance services."

seen as an effective strategy. A 2009 University of Southern California report on CHIs found that: *[m]ost counties qualitatively attribute the success of identifying and enrolling eligible uninsured children into public health insurance programs to their relationships with community based organizations and the use of trustworthy, on-the-ground [community health workers] or CAAs. The administrators indicated that because the community based organizations provide a wide range of helpful services to the target population, these organizations already have established relationships with clients, who are then more inclined to complete the enrollment process.*[41]

Confirming these observations, a national study of outreach to enroll eligible children found that "partnering with other organizations" was the second most commonly reported successful outreach strategy for both state grantees and local projects. (School-based outreach ranked first.)[42] Grantees also reported that they responded to limited resources for community-based outreach by partnering with organizations whose resources complemented their own: for example, working with health plans on media outreach and with schools to reach large numbers of potentially eligible families.[43] *(See sidebar.)*

A strong outreach and enrollment system has good linkages to county and state agencies, enabling CAAs to troubleshoot effectively in complex cases or when applications go awry. This function is critical to the success of both new applications and retention efforts. Local programs offer multiple examples of the importance of their outreach and enrollment workers having connections with colleagues in county or state offices who can assist with questions and exceptional cases.

5. Outreach using an "umbrella strategy" that offers something for everyone, as opposed to addressing only specific programs, is critical to enrollment success.

From the early days of Healthy Families, the goal of the state's OERU efforts was to serve the entire family and provide linkages to all relevant programs. This has remained a central tenet of many outreach and enrollment entities, even as funding has become constrained and in some cases limited to particular populations. According to Maternal and Child Health Access (MCHA), a Los Angeles-based program, even though a family might have only one child eligible for a state program, and the county Healthy Kids program may have an age cap, there is a positive impact on the entire family's health when they enroll as many members as possible into the programs for which they qualify.

Similarly, the CHIs' ability to reach out to the public with a simple and inclusive message—that health insurance is available for all children—has been one of the key strengths of those programs. In reality, the shifting fortunes of county-based Healthy Kids programs as well as the Healthy Families Program have meant that the CHIs sometimes fall short of this promise. There is, however, widespread agreement that an outreach message that invites families to bring children in, without first requiring them to assess whether or not they are eligible for a particular program, has been critical to the CHIs' enrollment successes.

"A strong outreach and enrollment system has good linkages to county and state agencies, enabling CAAs to troubleshoot effectively in complex cases or when applications go awry."

In the ACA environment, with expanded eligibility, this message can be even more potent. One of the state's primary goals under ACA is promoting the "culture of coverage." Through the individual mandate to obtain coverage, Californians will have an expectation that they will carry health insurance coverage, whether public or private, and understand how to use insurance and health care services both responsibly and effectively.[44] An outreach strategy that welcomes all comers, whether they qualify for Medi-Cal or for subsidies for the Exchange, whether they are childless or part of families, will be best aligned with the culture of coverage concept.

In an extension of this concept, outreach and enrollment structures that link applicants to other, non-health insurance, public benefit programs—such as food stamps, the Earned Income Tax Credit, SSI, WIC, housing programs, and cash assistance—are important ways both to create incentives for health insurance enrollment and to encourage overall health improvement.

6. Community-based outreach and enrollment can utilize and extend the reach of web-based and other technological enrollment strategies, and provide critical assistance in negotiating those systems to individuals who need it.

New technologies hold great promise for simplifying health insurance enrollment processes and increasing coverage. Among other requirements related to streamlining and simplification of enrollment, the ACA requires states to establish a website that permits individuals to apply for, enroll in, and renew enrollment in MediCal and to use an electronic signature for enrollment or re-enrollment as well as an internet portal through which individuals can apply for publicly-sponsored health care programs. There is federal money available to implement this requirement: under draft federal regulations, 90 percent of the state's MediCal related information technology costs would be paid by the federal government in 2011.[45] In addition, the Exchange Establishment grants can be used to fund a portion of the enrollment system. These grants are not capped.[46]

During the 1990s and 2000s, California made significant strides in simplifying eligibility rules and enrollment processes for children, and piloted the use of web-based "middleware" solutions (internet portals that play an intermediary role between the user and the enrollment functions of a variety of assistance programs) to facilitate screening for multiple programs. A study of outreach and enrollment strategies in the California CHIs from 2001-2008 found that technology-based approaches were very successful in enrolling children in health insurance. New enrollments increased by 10–11 percent over baseline when online application systems (including One-e-App, Health-e-App, and county data systems) were used, making this among the most effective enrollment approaches studied.[47]

Experience also shows that community-based outreach and enrollment practices are necessary complements to these technologies in many cases. Research on the Massachusetts experience found that more than 50 percent of new Medicaid and Commonwealth Care enrollments since the advent of the state health reform law were completed by CBOs and providers (but not individuals) via the state's "Virtual Gateway" internet

"An outreach strategy that welcomes all comers, whether they qualify for Medi-Cal or for subsidies for the Exchange, whether they are childless or part of families, will be best aligned with the culture of coverage concept."

portal.[48] Similarly, a recent report from the California HealthCare Foundation finds that community outreach is important even when simplification strategies are also in play.

Local staff and advocates continued to emphasize that there will always be individuals who need more help or who will need to be walked through the process. It is important to design a system that allows flexibility so that all individuals are able to navigate it.[49]

In December 2010, California launched public access to the Health-e-App program, and early results show rapid uptake even without the benefit of a media or public education campaign. A full evaluation, including analysis of error rates and user surveys, will be conducted in 2011-12.[50] Preliminary reports indicate that some proportion of applicants has needed the help of a CAA to complete applications they had begun on their own.

CBOs have shown themselves adept at using technology solutions creatively to improve enrollment and retention. Many CHIs and CAAs leverage the electronic Health-e-App and One-e-App; in addition, some CHIs are experimenting with text message alerts to assist families in completing re-enrollment procedures. CBOs also have played an important role in developing electronic strategies in California and other states. Researchers at Mathematica, Inc. who studied enrollment simplification in four states, found that government agency respondents cited the assistance they received from community partners in providing input on policy and technology changes as very useful.[51]

7. Outreach and enrollment efforts require adequate, reliable, ongoing financial support.

A strong and successful outreach and enrollment program requires funding. Research on children's enrollment in California found that increased funding for outreach through application assistants, CBOs, and schools was associated with measurable increases in children's enrollment.[52] Discussing Medicaid expansion on a national level, the Kaiser Commission has called for investment in enrollment assistance in particular: *Often, it is the most vulnerable people (e.g., the poorest, those with language or other barriers) who need the extra support that in-person enrollment processes can offer. Funding for enrollment assistance by the states can help ensure that, in particular, those facing the most barriers receive needed support in securing coverage. Community-based organizations play a vital role as partners in outreach and enrollment assistance, particularly (but not only) with regard to populations with no previous experience with public programs.*[53]

Massachusetts is one state that has made such an investment, and observers say that the funding that the state and its partners has provided has contributed to the success of the insurance expansion there. One significant aspect of the Massachusetts model has been to fund CBOs[54] to engage in outreach and enrollment work. Even before the passage of the legislation in 2006, and continuing into the implementation period, the state crafted a grant program totaling between $2.5 and $3.5 million annually to support outreach and enrollment efforts at CBOs. Vermont and Wisconsin are other

"Research on children's enrollment in California found that increased funding for outreach through application assistants, CBOs, and schools was associated with measurable increases in children's enrollment."
—UCLA CENTER FOR HEALTH POLICY RESEARCH

states that have used "mini-grants" to CBOs to assist with the enrollment of adults as well as children. Oregon cites the combination of $75 payments to application assistors and outreach grants to 27 CBOs as key to the enrollment successes in its state-funded Healthy Kids program.[55]

The structure of funding is also important. California's model of funding, which paid a fee per successful application to the coverage programs for children and pregnant women, was successful in increasing enrollment into those particular programs. The fees did not, however, provide strong incentives for workers to refer to other systems, case manage cases, or assist individuals with retention and utilization. As California begins planning in earnest for the implementation of ACA, designing a financing mix and structure that provides the right incentives to CBOs and other entities to drive enrollment and retention and support a culture of coverage will be crucial to its success.

8. Outreach and enrollment workers need comprehensive, interactive and ongoing training.

Good training for outreach workers includes standardized instruction on the federal and state programs; interview skills; tailored instruction on the local environment; and guidance on cultural competency, including appropriate translation of technical terms for all languages used in the community. Opportunities for peer exchange, such as during in-service training sessions or by having new workers shadow experienced ones on the job, enhance the acquisition of skills and knowledge.

In California, the state's only involvement in training CAAs is via an online tutorial program required for CAA certification. All other training is provided by other agencies, without state support. Most CHIs provide ongoing in-person training for their affiliated CAAs, as do other CBOs. For example, Maternal and Child Health Access (MCHA) has provided extensive training to CBOs in Los Angeles about the workings of health insurance and other benefit programs. MCHA trainers and outreach workers know to assess whether clients are already on any insurance programs, whether they have already submitted an application elsewhere, whether they are known to the system through another channel, and other relevant issues. Another Los Angeles based organization, the National Health Foundation, provides training for CAAs and outreach workers on many aspects of the enrollment process through its Children's Health Access & Medical Program (CHAMP).

The ACA expands the array of health insurance options, making high-quality, ongoing training critical to the success of community-based outreach and enrollment. In Massachusetts, in addition to the initial training required for access to the "Virtual Gateway" (which allows agencies to act as authorized representatives for applicants, receiving copies of state requests for additional documentation, educating consumers about applicable procedural requirements, and completing application forms online), grantees received ongoing briefings and education about the reform process as it unfolded, and continue to receive assistance through a quarterly in-person training program.[56]

"The ACA expands the array of health insurance options, making high-quality, ongoing training critical to the success of community-based outreach and enrollment."

9. Person-to-person outreach and enrollment efforts are effective in promoting retention and utilization, helping people remain insured and access care appropriately.

Keeping people enrolled in health insurance programs is critical both to individuals' health and to a culture of coverage that promotes cost containment through early and appropriate care. California studies of children who lose health insurance coverage even though they are still eligible, requiring them to re-enroll (also known as "churning") have shown that when children are covered continuously, they are more likely to have a usual source of care and less likely to have unmet medical needs. By contrast, children who experience gaps in coverage do not fare better than children with no insurance at all.[57] Churning is also expensive: in addition to the costs of delayed medical care, the administrative costs to the state of re-enrollment average $140 - $160 per person.[58]

Community-based outreach and enrollment is an important avenue toward improving these statistics and avoiding the interruptions in care (and their associated costs). In California, community-based outreach workers employ a wide variety of strategies to encourage families and individuals to complete the necessary paperwork to re-enroll in their health insurance program or to transfer to another when changes in their circumstances mean a change in eligibility. These strategies—follow-up calls and visits, trouble-shooting upon request, referral to other resources, pre-populated re-enrollment forms, and case management, among others—are based on ongoing relationships between clients and individual outreach workers or the CBOs where they work.

For example, outreach and enrollment workers at Maternal and Child Health Access (MCHA) in Los Angeles offer their clients extensive assistance when it comes to utilization of health care services. This may involve education about how to use managed care plans, or advocacy on their behalf to maintain relationships with existing providers, if necessary. Clients are encouraged to come in and call if they need assistance with renewal forms or have questions, and some return to MCHA from across the county to receive help with complex access needs.

Recommendations

Realizing the opportunities that the ACA offers will require California to invest in community-based outreach and enrollment in thoughtful and strategic ways. The existing OERU system has many strengths, but it needs new direction and training, as well as additional support, in order to operate most effectively in an ACA environment. The following recommendations are essential to maximizing the benefits of community-based efforts as the state moves forward:

BUILD ON OUTREACH AND ENROLLMENT STRATEGIES THAT HAVE PROVEN EFFECTIVE

- **Use the Existing Community-Based Infrastructure as the Basis for New Enrollment Efforts and Build on It to Meet the Additional Scope and Complexity of ACA.** California has demonstrated success with enrolling children through community-based efforts led by CHIs, other CBOs, providers, and others. Existing

"…community-based outreach workers employ a wide variety of strategies to encourage families and individuals to complete the necessary paperwork to re-enroll in their health insurance program or to transfer to another when changes in their circumstances mean a change in eligibility."

structures must innovate (via expansions and updated training, among other strategies) in order to meet the needs of the expansion populations under ACA, but a new system is not needed and would be expensive and inefficient to build from scratch. The Department of Health Care Services and the Health Benefit Exchange Board should look to the existing community-based outreach and enrollment infrastructure as a central player in ACA enrollment efforts and as a key adjunct to electronic enrollment avenues.

- **Involve Existing OERU Entities in Planning.** The full range of community-based outreach and enrollment entities—including CHIs, community health centers, hospitals and other providers, and non-CHI CBOs—should be involved in planning outreach and enrollment strategies for the ACA environment. The input of consumer assistance programs (CAPs) should also be sought because of the close relationship between and overlapping functions of those programs and OERU organizations.

ESTABLISH A STATEWIDE (OR REGIONAL) SYSTEM OF OUTREACH AND ENROLLMENT ASSISTANCE

To date, the OERU network in California consists of individual organizations and coalitions that, while they often communicate in statewide groups, have not been woven together into an organized, synthesized OERU system. A single (or several regional) synthesized, organized OERU system(s) could increase the success of California's outreach and enrollment efforts by creating a stable network of individuals and groups engaged in common work and providing an opportunity to standardize ongoing training. Development of a systematized statewide approach to outreach and enrollment could also:

- Disseminate information effectively
- Improve evaluation and spread data-driven methodologies
- Help develop and manage a reliable, sustainable funding stream
- Develop and apply standards
- Provide a central point of contact for the state
- Allow for economies of scale in training, purchasing, and IT development.

MAXIMIZE THE IMPACT OF THE NAVIGATOR PROGRAM IN THE NEW EXCHANGE

- **Allow Participation of a Broad Array of Organizations and Individuals in the Navigator Program.** The federal legislation includes a long list of potential Navigators, among them non-profit organizations; trade, industry and professional associations; chambers of commerce; unions; and licensed insurance agents and brokers. California should make participation in the Navigator program open to all these entities and more, looking carefully at the newly-eligible populations and how best to reach them, and casting a wide net while maintaining high standards for participation. In this way, individuals applying for coverage can be confident that wherever they enter the system,

they will receive comprehensive and accurate information. The state should encourage the participation of existing local enrollment entities in the Navigator program, taking advantage of their community connections and experience with low-income populations in particular, but also in recognition of the fact that many have familiarity with commercial insurance options as well.

- **Ensure that Navigators are Knowledgeable about and Can Assist with Both Public Coverage Programs and Qualified Plans in the Exchange.** In order to best support the development of a cohesive culture of coverage, California's Navigator program should address both public and private coverage options. Specifically, the Navigator Program requirements and training should encompass not only Exchange coverage, insurance market reforms, premium tax credits and cost-sharing reductions, but also provide assistance with, understanding of, and enrollment into appropriate programs such as Medicaid, CHIP, and other local, state, and/or federal public health programs. The Exchange Board must carefully tailor a training and certification program for navigators that supports the knowledge and skills necessary to enroll Californians into the full range of coverage options.
- **Plan for and Support Outreach and Enrollment Functions Independent of and in Addition to the Navigator Program.** The Navigator Program, while important, cannot be the only means of outreach and enrollment for state health insurance programs. Some organizations may not meet the requirements to qualify as Navigators or have the infrastructure to participate in the program, but the state will still have an interest in encouraging them to educate their clients and the public about their health insurance options. Resources should be directed to this purpose outside of the Navigator Program.

DEVELOP TARGETED OUTREACH STRATEGIES FOR MEDICAID-ELIGIBLE ADULTS

A significant component of coverage expansion is to be achieved through the expansion of Medi-Cal. Over the years, California's fiscal challenges and other factors have limited this program's capacity to engage in outreach or eligibility simplification. Medi-Cal expansion now offers an opportunity to strengthen outreach, enrollment and retention efforts for the overall Medi-Cal program. This is an area in which California's existing community-based outreach and enrollment entities will be particularly useful and important.

The people who will be newly eligible for Medi-Cal include very low-income adults who have relied on under-resourced safety net services to meet health care needs. According to a recent Kaiser Commission study, "[l]ow-income, uninsured adults without children, in particular, are a population largely unfamiliar with and unfamiliar to Medicaid, and every channel for reaching them will be needed."[59] One strategy that will be particularly important in reaching the newly-eligible adult population will be connecting with the health and behavioral health providers who serve them already. Close coordination with

social services and Medicaid agencies at the state and county levels will also be required if enrollment in health insurance is to become a reality for this group.

Message development in both media campaigns and community-based outreach must be designed to convey the major changes in eligibility that make adults eligible for programs that have traditionally been closed to them. Discussion of eligibility should avoid the term "childless adults," since many of the target population are, in fact, parents, though for Medicaid eligibility purposes they may not be part of a family unit. Adults may be more responsive to enrollment and retention messaging that emphasizes available services, particularly specialty care, rather than the prevention messages that have been used to encourage parents to enroll their children.[60]

Many existing outreach and enrollment entities say they are ready to work with this expanded population: currently, approximately one-third of the CHIs work to enroll adults in a variety of health insurance programs and to link them to care. Outreach experts at the Inland Empire Children's Health Initiative, housed at the Inland Empire Health Plan, say that reaching newly-eligible adults would not require significant changes to their existing child-focused model, although they would need to initiate partnerships with new organizations. The theory—reaching eligible individuals where they are—remains the same.

FOCUS ON RETENTION AND UTILIZATION

Retention of health insurance is a complex issue, driven above all by eligibility simplification and other policy changes. However, community-based outreach workers can (and do) encourage retention and utilization by educating people at enrollment about how to use their insurance coverage appropriately, making follow-up contacts to ensure that they have an identified primary care provider and attend an initial health care appointment, and letting them know when and how they are required to renew their enrollment and how to navigate other changes that can lead to the interruption or denial of coverage.

These tasks arguably become more important in the ACA context, because some of the newly insured will have limited experience dealing with insurance programs and thus will need guidance and education. Because the provider network in many communities is expected to be so heavily impacted, the efficient and appropriate utilization of health care services will be crucial. Community-based outreach and enrollment entities, working with state and county Medi-Cal offices, will need to focus on comprehensive strategies to keep newly-enrolled individuals from losing coverage, and to ensure that they access timely and appropriate care.

DEVELOP OUTREACH STRATEGIES FOR MODERATE-INCOME INDIVIDUALS AND FAMILIES

In general, existing community-based outreach entities in California have more experience with low-income populations than with higher-income populations. There are exceptions: those counties that participate in the County Children's Health Insurance Program (C-CHIP) all have experience enrolling moderate income populations, while the CHIs with Healthy Kids programs and those

that enroll in Kaiser Child Health Plan have worked with children in higher-income families. While outreach to moderate-income groups has declined over time nationally and in California,[61] the recession has given California outreach workers increased experience with higher-income populations, as the recession has affected families and individuals who have never before sought to enroll in public insurance programs. Some of these people have also turned to community health centers for the first time. Outreach staff at Venice Family Clinic say that in contrast to their usual patient population, many of whom are immigrants, these individuals are more likely to be English speakers and are more wary of government programs, expressing both privacy concerns and frustration with the inefficiencies of the application process.

New strategies and approaches will be essential to reaching individuals eligible for Exchange subsidies, particularly in the individual market. In addition to CBOs and the CAA network, potential partners to assist in reaching this population are tax preparers, retail outlets, faith organizations, colleges and trade schools, insurance agents and brokers, and sports and entertainment outlets. Schools can continue to play an important role in reaching moderate-income parents, as they have for low-income children. Massachusetts' experience shows that mass media can be an effective outreach strategy, and that publicizing the individual insurance mandate in particular also played a significant role in encouraging interest and applications.[62] In Vermont, uninsured young adults have been targeted through outreach to community colleges and trade schools.

IDENTIFY FUNDING STREAMS TO SUPPORT COMMUNITY-BASED OUTREACH AND ENROLLMENT

Sustainable, ongoing sources of funding are essential to the success of outreach and enrollment efforts. California's own experience with CAA payments has shown that financial incentives encourage applications, making it possible for multi-functioning CBOs to direct resources to this purpose. The loss of these funds has had an undeniable negative impact on the pace of children's enrollment and retention in the state. Other states' experience with "mini-grants" for CBOs also clearly demonstrates the impact of ongoing funding in building a healthy network of local projects that can advance the state's goals.

California must maximize all federal funding opportunities for outreach and enrollment. Available sources include funds for state information technology projects, with 90 percent of costs to be paid by the federal government;[63] Exchange Establishment and Consumer Assistance grants; and Medicaid and CHIP administrative funds, with more opportunities expected to arise as the ACA is further developed at the federal level. CHIPRA grants can also be helpful in outreach and enrollment efforts, but are not adequate for the major task of ACA implementation.

The state, counties, providers, employers, and private sector and philanthropic partners must work together aggressively to identify funding streams that are adequate to the task and sustainable in the long term.

Conclusion

Realizing the opportunities that the ACA and other insurance expansions offer will require California to move in a variety of directions: toward policies that simplify enrollment and eligibility processes, toward greater use of technology to speed and standardize enrollment, and toward development of sustainable financing to support these changes.[64] Community-based outreach and enrollment is one component, and a critically important one, of a modernized, streamlined enrollment system. Community-based outreach workers know where to find eligible people, how to talk to them, how to direct them to the systems that they need to enter, and how to keep them engaged. Fifteen years of sustained effort to enroll children across the state in health insurance programs has shown that community-based outreach workers, deploying a range of strategies that are tailored to particular neighborhoods and populations, are effective in enrolling people in health insurance programs and keeping them there—particularly when the individuals or groups in question are hard to reach.

As California moves forward in designing an enrollment system for 2014 and beyond, community-based outreach and enrollment must be a central element of it, and community-based outreach workers must be closely involved in its design and implementation.

Abbreviations

ACA	The Affordable Care Act
CAA	Certified Application Assistant
CAP	Consumer Assistance Program
CBO	Community-Based Organization
CCHI	California Coverage & Health Initiatives
C-CHIP	County Children's Health Insurance Program
CHAMP	Children's Health Access & Medical Program
CHC	Community Health Councils
CHI	Children's Health Initiative
CHIP	Children's Health Insurance Program
CMSP	County Medical Services Program
DMHC	(California) Department of Managed Health Care
FIELD	Farmworker Institute for Education and Leadership Development
FPL	Federal Poverty Level
GED	General Educational Development
HCCI	Health Care Coverage Initiative
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
LIHP	Low-Income Health Program
MCE	Medicaid Coverage Expansion
MCHA	Maternal and Child Health Access
NASHP	National Academy for State Health Policy
OERU	Outreach, Enrollment, Retention and Utilization
OPA	Office of the Patient Advocate
SCHIP	State Children's Health Insurance Program (now CHIP)
SSI	Supplemental Security Income

Appendix A:

RESULTS OF THE CHC/CCHI SURVEY OF CAA ENROLLMENT ENTITIES

In 2010, Community Health Councils (CHC) and California Coverage & Health Initiatives (CCHI) jointly conducted a survey of organizations that conduct OERU in California. (Survey documentation forthcoming.) Sixty-five individuals responded to the survey, representing 22 of the 58 counties in California and including 19 Children's Health Initiatives. The responding organizations together employ about 600 Certified Application Assistants. Based on their experience, the survey respondents cited the following as the best practices and most important elements for successful OERU:

Outreach

- Devising specialized strategies for reaching particular target groups
- School-based strategies
- Public awareness information, events, and activities
- Clinic-based outreach/in-reach

Enrollment

- Being able to offer coverage to entire family
- Being clear when an event is for enrollment so clients know what documentation they will need to bring
- School-based assistance
- Piggy-backing on outreach events, usually drawing on interest lists they generate that must include contact info
- Clinic-based assistance

Retention

- Client education at enrollment
- Reminder postcards/letters/phone calls
- Technology
- Database tracking system/tickler

Pre-populated forms

- Case management approaches
- Collaboration with other community organizations, particularly county agencies

Utilization

- Database tracking/monitoring system
- Client education at enrollment
  - ~ special materials
  - ~ show an educational video
  - ~ focus groups and seminars
- Case management approach
- Having a system of follow-up phone calls at set times throughout the coverage year
- Acting as a liaison between client/coverage/providers, including making the first appointment with the client

Essential Elements

- Outreach/eligibility workers who are well-trained and have a natural connection to the community they serve
- Collaboration with other organizations, especially county health and human services agencies
- Locating services where clients are at times that work for the clients

Endnotes

[1] California Health and Human Services Agency, *Implementation of the Affordable Care Act in California: A Window of Opportunity for State Policy Makers,* December 2010 at 6.

[2] Community Health Councils, *Policy Framework for OERU for Health Care Coverage in California* (May 2006) at 6.

[3] Every CAA must be associated with an enrollment entity. An Enrollment Entity can be a school, health care provider, hospital, faith-based organization, insurance agent or broker, tax preparer, clinic, health plan, county or city agency, or community-based program. Enrollment entities relay enrollment and informational materials from the state to the CAAs for which they are responsible, provide the resources needed to perform outreach to target populations, use CAAs to perform enrollment assistance, and agree to uphold specified privacy and ethical standards.

[4] The state payment to CAAs, originally $25, was increased to $50 per successful application and $60 per successful electronic application, and to $25 for a renewal to Healthy Families. Since the application had to be successful for the payment to be made, there was no risk to the state.

[5] As of the end of 2010, there were approximately 23,000 registered CAAs statewide, although it is not known how many of these are currently active. The CAAs are affiliated with approximately 4,000 Enrollment Entities, which include non-profit social service agencies, health care providers including clinics and hospitals, faith-based organizations, schools, and local and county government offices, among other organizations. Personal communication from Larry Lucero, Special Project Section Manager, Managed Risk Medical Insurance Board, to Alison Lobb, Project Coordinator, CCHI, February 2011.

[6] 100% Campaign, "Healthy Families Enrollment Drops When Families Need it Most," (n.d.), available at http://www.100percentcampaign.org/fs/resource:id/_a_/disposition=attachment/_a_/xkozkudej1hlrk/z2mlcuhj3k5c4b?_c=zbemiwj4d35rj3.

[7] Analysis of 2009 California Health Interview Survey data comparing "currently insured" in 28 CCHI counties to those in the state as a whole. Conducted March 4, 2010 at www.chis.ucla.edu. Colusa and Del Norte counties were excluded from the CHI sample because they are grouped with other (non-CHI) counties in the CHIS database.

[8] Michael Cousineau et al., Use of *Outreach and Enrollment Strategies in California*, State Health Access Reform Evaluation (SHARE), January 2009 at 4.

[9] Shana Alex Lavarreda and Livier Cabezas, UCLA Center for Health Policy Research, *Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform*, January 2011.

[10] *Ibid*.

[11] Patient Protection and Affordable Care Act, Section 2793 of the Public Health Service Act; 42 U.S.C. 300gg-91 et seq.), §1311(d)(4)(K).

[12] PPACA §1311(i)(6).

[13] PPACA §1311(i).

[14] *See* AB 1602 (Perez) (Chapter 655, Statutes of 2010) at § 6.

[15] PPACA §1002(a). This discussion is based in part on Lorraine Jones, National Health Law Program, "Consumer Assistance Programs in the PPACA," October 2010.

[16] PPACA §§1002(b) and (c).

[17] The Congressional Budget Office CBO estimates a total of $340 million for these programs between 2011 and 2019.

[18] DMHC Application for ACA Consumer Assistance Program Grants, September 10, 2010, available at http://www.healthcare.ca.gov/Portals/2/Priorities/Documents/consumer%20assistance%20abstract.pdf

[19] Announcement by Ellen Bradley, Program Specialist, Office of Legal Services, DMHC, at "The Pre-Existing Condition Insurance Plan and the Consumer Assistance Program: Two New Programs for Californians," Sacramento, CA, February 24, 2011.

[20] AB 922 (Monning), as introduced February 18, 2011.

[21] Centers for Medicare and Medicaid Services, *Special Terms and Conditions, California Bridge to Reform Demonstration, Number 11-W-00193/9* (November 1, 2010).

[22] The most comprehensive recent review of the national literature on outreach and enrollment for children was published in 2009 by the National Academy of State Health Policy and the Robert Wood Johnson Foundation. Victoria Wachino and Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children*, NASHP/RWJF, February 2009 (hereafter Wachino and Weiss).

[23] *See generally* Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences*, July 2010; Nadereh Pourat *et al., Interim Evaluation of Health Care Coverage Initiative in California*, August 13, 2009, available at http://www.dhcs.ca.gov/provgovpart/Documents/UCLA%20HCC%20Interim%20Evaluation%208-10-09.pdf.

[24] Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, State Health Access Reform Evaluation (SHARE)/Robert Wood Johnson Foundation, November 2009 (hereafter Dorn 2009).

[25] Mathematica Policy Research, Inc., The Urban Institute, Health Management Associates, *Performing Outreach With Limited Resources: CKF Grantees' Successes and Challenges Over Three Years*, September 2009 at 13 (hereafter *CKF Grantees* 2009).

[26] Annette Gardner and Patricia Mintz, "Lessons From The Field: Expanding Health Insurance Coverage One County At A Time," *Health Affairs* 27 (5), July 2008 at 1458. Also of note were the ways that networking and coordination activities supported by the grants' investments "helped form effective working partnerships among grantees" and between grantees and health plans.

[27] In California, the Consumer Health Alliance (CHA), developed by a coalition of legal aid organizations, operates a consumer assistance program in nine counties. CAP programs typically focus more on grievance resolution than on primary outreach and enrollment, though their functions vary from state to state and program to program.

[28] Community Service Society, *Making Health Reform Work: State Consumer Assistance Programs*, September 2010 at 4.

[29] *CKF Grantees* 2009 at 5.

[30] Michael R. Cousineau, Gregory D. Stevens, and Albert Farias, "Measuring the Impact of Outreach and Enrollment Strategies for Public Health Insurance in California," *HSR: Health Services Research* 46:1, Part II, February 2011 at 332-33.

[31] Wachino and Weiss at 28, citing D.J. Ringold, T.M. Palmer Olson, and L. Leete, *Managing Medicaid Take-Up: CHIP and Medicaid Outreach: Strategies, Efforts and Evaluation*, Federalism Research Group at the Nelson A. Rockefeller Institute of Government, 2003 at 103. This evaluation was conducted through a literature review and case studies of 18 states.

[32] Cousineau 2011 at 331.

[33] Cousineau 2011 at 332-33.

[34] Wachino and Weiss at 27, citing Glenn Flores, et al., "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116 (6) December 2005) at 1433-1441.

[35] Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences* (July 2010) at 9.

[36] *Ibid*. at 10.

[37] *CKF Grantees* 2009 at 16.

[38] *Promotoras de salud* are lay health workers, health promoters, or community health workers who are trained to conduct health education, counseling, and outreach in Latino communities.

[39] Wachino and Weiss, citing Anna Aizer, "Public Health Insurance, Program Take-Up, and Child Health," *The Review of Economics and Statistics* 89 (3), August 2007 at 405.

[40] Wachino and Weiss, citing Susan Williams and Margo Rosenbach, "Evolution of State Outreach Efforts Under SCHIP," *Health Care Financing Review* 28 (4), 2007 at 102.

[41] Cousineau 2009 at 7.

[42] *CKF Grantees* 2009 at 6.

[43] *Ibid*. at 24.

[44] See CHHS, Implementation of the Affordable Care Act in California at 6-7.

[45] Ibid. at 5.

[46] Comments by Eliza Bangit, Division Director, Consumer Assistance, Office of Consumer Support, Center for Consumer Information and Insurance Oversight, CMS, Sacramento, CA, February 24, 2011.

[47] Cousineau 2011 at 331. School-linked systems were found to be equally effective in this study.

[48] Dorn 2009 at 5.

[49] Mathematica Policy Research, Inc., *Simplification of Health and Social Services Enrollment and Eligibility: Lessons for California from Interviews in Four States*, California HealthCare Foundation, November 2010 at 59.

[50] Len Finocchio, DrPH, Senior Program Officer, California HealthCare Foundation, personal communication, March 7, 2011.

[51] *Ibid*. at 59. The four states studied were Florida, Pennsylvania, Texas, and Washington.

[52] Jennifer Kincheloe and E. Richard Brown, *The Effect of County Outreach Environments on Family Participation in Medi-Cal and Healthy Families*, UCLA Center for Health Policy Research, July 2007 at 7.

[53] Kaiser Commission on Medicaid and the Uninsured, *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform*, April 2010 at 7.

[54] Dorn 2009 at 5-6.

[55] Remarks of Cathy Kaufmann, Administrator, Oregon State Office of Healthy Kids, Children's Health Coverage Briefing: National Scope & State Models, Sacramento, CA, March 4, 2011.

[56] Dorn 2009 at ii.

[57] Gerry Fairbrother and Joseph Schuchter, Child Policy Research Center, Cincinnati Children's Hospital Medical Center, *Stability and Churning in Medi-Cal and Healthy Families*, The California Endowment, March 2008 at 2.

[58] *Ibid*. at 9.

[59] *Optimizing Medicaid Enrollment* at 6-7.

[60] Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences*, July 2010 at 8-9.

[61] *CKF Grantees* 2009 at 16-17.

[62] Dorn 2009 at 6.

[63] Federal guidance on development of IT systems refers specifically to cost allocation between the Exchanges and Medicaid and/or CHIP for "activities in which Medicaid programs are likely to benefit." Some of the functions that may need cost allocation "include but may not be limited to eligibility, enrollment, and possibly, consumer assistance." HHS Office of Consumer Information and Insurance Oversight and Centers for Medicare & Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 1.0*, November 3, 2010 (OCIIO/CMS Guidance).

[64] For an overview of these issues, see Kaiser Family Foundation, *Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act*, October 2010.