



Community Action Agency Activities in Affordable Care Act Outreach and Enrollment: Insights from Case Studies

Key Findings for Community Action Agencies (CAAs)

- Leveraging of diverse public and private funding sources may extend the reach of Affordable Care Act outreach and enrollment efforts.
- Partnerships with other local organizations appear vital for reaching underserved groups.
- Even small community action agencies with limited or no Affordable Care Act-related funding can find creative and promising ways to share health insurance information with the populations they serve.
- Combined or integrated approaches to human services and health insurance enrollment can improve insurance sign-up rates.

Key Findings for Federal Program Officials

- CAAs' roots in their communities and access to vulnerable populations can help them effectively find and serve the uninsured.
- Addressing barriers to outreach and enrollment activities identified by CAAs may increase their involvement in community-level efforts to reduce the number of uninsured Americans.

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) put into place comprehensive health insurance reforms that are expanding health insurance coverage to millions of Americans. Through state-run or Federally-facilitated health insurance Marketplaces, consumers can compare health plans and sign up for health insurance. Middle- and low-income families can qualify for tax credits that cover a significant portion of the cost of coverage. The expanded eligibility for Medicaid in many states extends coverage to many previously uninsured Americans. The success of these reforms, however, depends on effectively identifying the uninsured, informing them of coverage options, and helping them navigate the often complex choices involved.

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A potentially important resource in this effort are community action agencies (CAAs), neighborhood-based organizations that administer federal anti-poverty block grant and other low-income assistance programs at the community level. More than 1,000 CAAs, providing services that reach almost every county in the country, work closely with low-income individuals to provide a variety of supportive services and programs that promote self-sufficiency and that are tailored to the unique needs and circumstances of the areas they serve.

This research brief presents the results of an exploratory, qualitative review of selected CAAs and the work they do to identify and reach uninsured individuals in their communities, help them enroll in health insurance, and overcome barriers to conducting ACA-related outreach and enrollment. The goals of the brief are to (1) document a variety of community-level approaches to ACA activities that can serve as examples to CAAs considering how best to help their neighborhoods achieve higher rates of health insurance coverage, and (2) provide information to federal program officials interested in encouraging and supporting CAAs' involvement in ACA implementation. Appendix A presents details on the methodology for the study.

The Affordable Care Act is Reducing the Number of Uninsured Americans

A key goal of the ACA is to reduce the number of uninsured Americans by providing access to affordable, high-quality health insurance.¹ Since the ACA was implemented, 17.6 million uninsured people have gained health insurance coverage, and between October 2013 and September 12, 2015, the uninsured rate dropped from 20.3 percent of Americans to 12.6 percent.² Pre-existing conditions can no longer disqualify someone from health insurance, recommended preventive services are covered without cost-sharing, and children can remain on their parents' insurance plans until age 26.³

The ACA also allows states to receive federal matching funds to cover 100 percent of the cost until 2016 of expanding Medicaid to non-elderly and non-disabled adults whose family income is at or below 133 percent of the federal poverty level (the match phases down to 90 percent by 2020). Although states may choose whether or not to undertake Medicaid expansion, Medicaid enrollment has grown 22.9 percent, from 57.8 million enrollees (during the baseline period of July-September 2013) to 72.0 million in July 2015.⁴ Health insurance coverage gains, which have been especially strong in Medicaid expansion states, have been concentrated among low-

¹ U.S. Department of Health and Human Services, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report." Issue Brief (Washington, DC: DHHS, Office of Assistant Secretary for Planning and Evaluation, March 10, 2015).

http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

² U.S. Department of Health and Human Services, "Health Insurance Coverage and the Affordable Care Act." Issue Brief (Washington, DC: DHHS Office of the Assistant Secretary for Planning and Evaluation, September 22, 2015). <http://aspe.hhs.gov/basic-report/health-insurance-coverage-and-affordable-care-act-september-2015>

³ U.S. Department of Health and Human Services, "Benefits of Affordable Care Act for Americans." Fact sheet (Washington, DC: DHHS). <http://www.hhs.gov/healthcare/facts/timeline/graphictextonly.html>

⁴ U.S. Department of Health and Human Services, "Medicaid and CHIP: July 2015 Monthly Applications, Eligibility Determinations and Enrollment Report." Fact sheet (Washington, DC: DHHS, September 28, 2015). <http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/july-2015-enrollment-report.pdf> http://aspe.hhs.gov/health/reports/2015/MedicaidEnrollment/ib_MedicaidEnrollment.pdf

and middle-income population groups since the beginning of the first open enrollment period in October 2013.⁵

Since the ACA was enacted, there have been two open enrollment periods for consumers to enroll in qualified health plans available through the Health Insurance Marketplace: October 1, 2013 through March 31, 2014,⁶ and November 15, 2014 through February 15, 2015.⁷ The next open enrollment period will extend from November 1, 2015 to January 31, 2016. This study reflects study sites' experiences during the first two enrollment periods. During open enrollment, individuals can enroll or re-enroll in plans, switch plans, and obtain subsidies. Individuals can enroll in Medicaid or the Children's Health Insurance Program (CHIP), and small businesses can purchase coverage through the Small Business Health Options Program (SHOP) at any time.

The Federal Government Provides a Variety of Resources for ACA Outreach and Enrollment Activities

Federal resources support state- and community-level efforts to reach and enroll individuals in health insurance in four main ways:

Navigators: In August 2013, HHS's Centers for Medicare and Medicaid Services (CMS) awarded \$67 million in grants to 105 organizations, including a number of CAAs, to hire and train staff to work as Navigators in the 34 states with a Federally-facilitated or State Partnership Marketplace. Navigators are responsible for providing unbiased information in a culturally competent manner to consumers about health insurance, the Health Insurance Marketplace, qualified health plans available through the Marketplace, and public programs including Medicaid and CHIP. An additional \$60 million in Navigator grants were awarded to 92 organizations for 2014-2015, and a three-year grant covering 2015-2018 was awarded to 100 organizations, with \$67 million of funding available for the first year. Navigator grantees must be capable of carrying out all duties required by HHS regulations, including conducting public education activities to raise awareness of the Marketplace, discussing with consumers the coverage options available to them through the Marketplace, and facilitating selection of a qualified health plan. Navigators receive extensive training from CMS prior to assisting consumers, and regularly report on their outreach and consumer education activities and accomplishments.

⁵ U.S. Department of Health and Human Services, "Health Insurance Coverage and the Affordable Care Act." May 2015 Issue Brief.

⁶ U.S. Department of Health and Human Services, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period." Issue brief (Washington, DC: DHHS, May 1, 2014). http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf

⁷ U.S. Department of Health and Human Services, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report." Issue brief (Washington, DC: DHHS, March 10, 2015). http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf. Members of federally recognized Indian tribes or Alaska Native shareholders can enroll in or change plans once per month any time of year, not just during open enrollment.

Non-Navigator assistance personnel, frequently referred to as In-Person Assisters: These individuals serve a similar function as Navigators, providing in-person assistance to consumers as they learn about and enroll in health insurance coverage. The activities of such individuals have been funded in part through Federal Marketplace establishment grants in states with state-based or state partnership Marketplaces.

Certified Application Counselors: CMS designates organizations in states with a Federally-facilitated or State Partnership Marketplace to certify counselors who perform many of the same functions as Navigators and in-person assisters, including educating consumers and helping them complete applications for coverage.⁸ Certified Application Counselors (CACs) are required to complete training prior to assisting consumers, and CMS provides supplemental training via webinars and newsletters to CACs. CACs typically have experience providing health or social services to their communities, and must comply with privacy and security standards, but they are not subject to rigorous reporting requirements. While many CACs conduct outreach to low- or middle-income populations, they are not required to do so. CACs are recognized as trained assisters in the Marketplace, but do not receive direct funding from the Marketplace.

Enrollment Assistance Personnel: Federal contractors who provide enrollment assistance in targeted cities.

Community Action Agencies Play a Key Role in Service Delivery to Low-income Americans

CAAs were established under the Economic Opportunity Act of 1964 as on-the-ground organizations empowering low-income individuals. They are private and public nonprofit organizations that receive core federal funding through states, territories, and tribes from the Community Services Block Grant program (CSBG). CSBG funds are used for a variety of antipoverty efforts, including employment, education, financial management, housing, nutrition, energy assistance, and health services. Separate from CSBG funding, many CAAs operate Head Start programs, distribute Low Income Home Energy Assistance Program (LIHEAP) funds to clients qualifying for energy assistance, and administer federal Weatherization Assistance Program funds to make low-income housing more energy-efficient. CAA boards of directors must include members of the communities they serve. As indicated in the interviews conducted for this study, one of the strengths of the CAA model of service delivery is in its intangibles, such as trust built with the community and an emphasis on face-to-face service. Not surprisingly, research has shown considerable overlap between the populations served by CAA-administered programs and those eligible for Medicaid under the expansion and for subsidized health care through the Health Insurance Marketplace.⁹

⁸ U.S. Department of Health and Human Services, "Assistance Roles to Help Consumers Apply and Enroll in Health Coverage Through the Marketplace." Information sheet (Washington, DC: DHHS, July 2013). <https://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf>

⁹ U.S. Department of Health and Human Services, "Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act" (Washington, DC: DHHS, December 2013). http://aspe.hhs.gov/hsp/14/integrationproject/rpt_integrationproject.cfm

A Variety of CAAs Are Featured in This Study

This study focused on six CAAs selected from among those volunteering to participate. Although the six are not representative of all CAAs and do not represent all regions of the country, they are diverse in size, resources, location, and in the populations they serve. For example, four of the six receive federal Navigator grant funding as either direct grantees or subgrantees and two do not; four are in Medicaid expansion states and two are not; three are predominantly rural and three are predominantly urban/suburban; and three target enrollment to specific subpopulations such as immigrants, youth, or seniors while three do no subgroup targeting. Table 1 provides summary information across sites, and site profiles at the end of this brief contain details on site activities and accomplishments. In brief, the six sites are:

- **Blue Grass Community Action Partnership**, Frankfort, Kentucky

Blue Grass Community Action Partnership (BGCAP) serves a primarily rural population across nine counties in Kentucky, a Medicaid expansion state. The agency received Navigator funding as a subgrantee to the state's CAA association. BGCP has closely coordinated its health insurance outreach and enrollment activities with the state Marketplace, called kynect, to leverage the name recognition of the state's "brand."

- **Garrett County Community Action Committee**, Oakland, Maryland

Garrett County Community Action Committee (GCCAC) serves an entirely rural population in one county in northwestern Maryland, a Medicaid expansion state. It received federal Navigator funding in both the first and second open enrollment periods as a subgrantee to a larger consortium. GCCAC uses an innovative approach to track overall client well-being that counts health insurance status as a key indicator of the ability to thrive and achieve self-sufficiency. The agency has been invited to participate in a national foundation study of two-generation approaches to addressing poverty.

- **HOPES Community Action Partnership**, Hoboken, New Jersey

HOPES Community Action Partnership, located in New Jersey, a Medicaid expansion state, serves two primarily urban counties. HOPES developed extensive partnerships with more than 50 community organizations, including churches and a university medical center, to conduct outreach and educate area residents about health insurance coverage options. HOPES received a grant from a private nonprofit citizen action group to conduct targeted Hispanic health coverage outreach, and five of their six Certified Application Counselors are bilingual. HOPES has integrated its health care outreach into other human services provided by the CAA, including its Volunteer Income Tax Assistance services.

- **Indianhead Community Action Agency**, Ladysmith, Wisconsin

Indianhead Community Action Agency (ICAA) in Wisconsin, a state that has not expanded Medicaid, serves 20 rural counties. ICAA made substantial efforts to counter local concerns about the ACA and provide its constituents with information about how to enroll in health insurance despite limited resources and the considerable poverty and isolation of the rural area it serves. ICAA has referred clients to Navigators and has hosted Navigators on site. It also has provided informational sessions with certified application counselors.

- **Oakland Livingston Human Service Agency**, Pontiac, Michigan

Oakland Livingston Human Service Agency (OLHSA) is a large community action agency providing services across two primarily urban counties in Michigan, a Medicaid expansion state. OLHSA receives federal Navigator funding as a subgrantee to a nonprofit consortium, and it leverages funding from the United Way, a local private hospital, and state CSBG funds to support health insurance outreach and enrollment activities. A small pilot project funded through a private philanthropy augments OLHSA's work by covering the costs of insurance for select uninsured individuals.

- **Western Maine Community Action**, East Wilton, Maine

Western Maine Community Action (WMCA) in rural Maine, a state that has not expanded Medicaid, is the lead agency in a statewide consortium of nine CAAs that provides ACA education, outreach, and enrollment assistance to individuals. WMCA hired a Navigator grant coordinator as a grassroots organizer and to serve as the public face of ACA enrollment and Marketplace health insurance. WMCA leveraged partnerships with a private foundation and a nonprofit health care advocacy group to augment activities funded by a Navigator grant.

Findings: Study Sites Took a Wide Variety of Approaches to Outreach and Enrollment

The study sites varied widely in their range of activities, partnerships, promising practices, and the challenges they confronted during the first and second open enrollment periods of the ACA. This section highlights key themes that emerged across sites. The successes and barriers identified are based on the impressions of the site staff interviewed; they were not validated against actual enrollment statistics. Full details on site activities are in the site profiles at the end of the brief.

While all findings are relevant for the CAA audience for this brief, some may be of particular interest to federal program officials looking for ways to support a greater role for CAAs in ACA implementation. Those findings are specifically identified below.

Leveraging diverse public and private funding sources may extend outreach and enrollment efforts. Study sites used a variety of funding approaches, including using various forms of private funding to augment public (state and federal) funds. Oakland Livingston supplemented federal Navigator resources with funding from the state’s CSBG program (as allowed under program rules), a private local hospital network, and the United Way, which helped cover some staffing costs. Western Maine augmented federal funding with grants from a private foundation, which paid for TV, print, and radio messages about the importance of health insurance coverage.

Partnerships with local organizations appear vital for reaching underserved groups. Some study sites focused on building relationships with other community organizations to extend their reach to the uninsured. Blue Grass approached a variety of large and small retailers to use their stores to hand out health insurance literature and connect directly with customers. HOPES partnered with a host of other local organizations, including churches and a community medical center, and received a grant from a nonprofit citizen action group to conduct targeted outreach to the Hispanic community.

Even small CAAs with limited or no federal funding can find creative and effective ways to share health insurance information with the populations they serve. The two sites with no federal funding, Indianhead and HOPES, worked with their clientele to make sure they had the information they needed to enroll in health insurance even without federally funded Navigators to help with direct enrollment. HOPES used mobile technology and partnerships with many other community organizations to disseminate information, and Indianhead focused on the needs of their own employees, many of whom are low-income home health aides who lack insurance themselves.

Combined or integrated approaches to human services and health insurance enrollment can support insurance enrollment goals. Several study sites integrated intake for the human services programs they offer with outreach for health insurance enrollment. Blue Grass, Garrett County, HOPES, and Oakland Livingston used intake forms that identify the uninsured when they apply for other programs – information that guided their outreach activities. Garrett County used an innovative crisis-to-thriving index, which included health insurance as an indicator of well-being, to assess clients’ needs and progress toward self-sufficiency over time. Kentucky’s Marketplace portal, which Blue Grass uses, is developing a fully integrated application to allow users to apply for Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), LIHEAP, and other services. These kinds of bi-directional referral systems allow multiple offices, including CAAs, to serve clients in a more integrated way. Program offices can refer clients to health insurance enrollment services available through the CAA, and CAA staff can connect clients to benefits available through other programs.

Key Findings of Particular Interest to Federal Program Officials

CAAs appear uniquely positioned to identify and serve the uninsured. The deep roots in their communities and access to vulnerable populations can enable CAAs to effectively find and serve those who lack health insurance. As noted before, the populations CAAs serve tend to include many of the uninsured. CAAs have established credibility with clients who already receive public services, and they often use intake and application systems to identify the uninsured. For instance, HOPES noted that its effectiveness depends in part on its door-to-door approach to outreach and the community-level expertise it brings to outreach partnerships. Western Maine also emphasized that its existing connections with eligible populations facilitated its ability to reach the uninsured.

There are some challenges to conducting formal ACA outreach and enrollment. The findings above highlight some of the many ways the six studied CAAs have met the challenges of providing health insurance information and enrollment assistance to large numbers of people. Study sites also identified a range of challenges to conducting formal ACA outreach and enrollment, including constrained budgets, lack of staff expertise, and limited knowledge of the ACA.

The Community Action Partnership (CAP), a national association of community action agencies, conducted an informal survey of its member agencies in 2014¹⁰ which, while also not representative of all CAAs nationally, provides insight into why some CAAs are not more involved in ACA outreach and enrollment. Responding CAAs identified four main disincentives to doing ACA-related work: concerns over duplication of efforts (63 percent of respondents), limited staff capacity (59 percent), inadequate funding (56 percent), and lack of alignment with current service goals (16 percent). Other barriers to conducting outreach and enrollment mentioned by CAAs were lack of knowledge of the ACA, concern about legal liability for using uncertified staff to conduct health insurance enrollment, and perceived lack of receptivity to partnerships from agencies designated to provide Navigators.

CAAs responding to the CAP survey also noted that, even if they did no formal ACA work, they used informal means to assist their clients. For instance, more than half of responding CAAs not formally involved in ACA activities indicated that they answered clients' questions about the ACA, participated in ACA-related training, shared ACA information through their Head Start and Volunteer Income Tax Assistance programs, and made referrals to Navigators. Most significantly, nearly three-fourths (73 percent) of CAAs who reported no formal ACA-related activities indicated they would consider formal outreach and enrollment activity if the barriers they identified were addressed.¹¹ This implies there is considerable potential for increasing the ACA engagement of these key grassroots organizations.

¹⁰ Community Action Partnership, "Understanding the Role of Community Action Agencies in Affordable Care Act Outreach and Enrollment," August 2014 survey of member agencies (unpublished). Appendix A provides more information on the survey.

¹¹ Ibid.

Other Findings and Themes that Emerged from the Site Visits

- **Sites vary in numbers reached.** The number of people reached through outreach events and the number who were signed up for health care through Medicaid or state health insurance Marketplaces vary widely. Some CAAs held hundreds of outreach events targeting many consumers, while others had fewer events and focused more on one-on-one assistance. Not surprisingly, the numbers reached appear to correlate with available resources, but some sites demonstrated that effective approaches to ACA education and information-sharing are possible even with little funding. For those CAAs with resources, mobile enrollment capability supported by laptop computers, printers, and cell phones helped overcome transportation barriers in rural areas and for home-bound clients.
- **CAAs prefer individual-level contacts for enrollment.** Study sites consistently reported their belief that one-on-one, in-person engagement with clients was more effective than large public meetings, mainly because clients preferred privacy and direct help with the enrollment process. Group meetings and public events were useful for disseminating general information.
- **Stigma over assistance receipt can discourage enrollment.** Local culture and political climate were important factors in a community's attitude toward the ACA and of individuals' receptivity to public assistance. Two of the more rural sites described working to overcome a general distrust of government in general and of the ACA in particular. Rural sites also indicated that a local self-sufficiency ethic made some residents reluctant to apply for assistance and to feel stigmatized if they received it.
- **Sites held outreach events at many different locations.** Sites conducted outreach events at a tremendous variety of locations in their communities, including libraries, churches, schools, hospitals, recycling centers, farmers' markets, Head Start centers, homeless shelters, county fairs, housing agencies, malls, high school football games, and businesses. Outreach efforts were held typically in locations that were either large central gathering places for the community, such as churches or schools; locations central to the CAA, such as the CAA office; or locations visited by a variety of potential clients, such as recycling centers or farmers' markets, to "reach people where they are."
- **Sites targeted specific groups for outreach.** Most sites conducted some form of targeted outreach to specific populations in their communities. Targeted groups included Hispanics, young adults, Arabic speakers, seniors, farmers, homeless individuals, and the formerly incarcerated. In addition, some CAAs targeted informational or sign-up campaigns to reach other specific groups, such as their own staff or employees and customers of a large retailer.

- ***Study sites were more likely to be Navigator subgrantees than prime grantees.*** Among study sites that received federal Navigator grant funding, most were subgrantees to larger organizations that served as prime Navigator grantees.

Conclusion

The findings from this exploratory research highlight the diversity and creativity of CAAs working to implement the ACA at the community level, as well as the many challenges they confront. CAAs with no or few dedicated resources for ACA outreach and enrollment are still able to share information and refer uninsured clients to enrollment specialists. Other CAAs are able to leverage partnerships with nonfederal funding sources and a holistic approach to health and human services delivery to augment federally funded ACA resources such as on-staff Navigators to increase their ability to get clients covered. Several sites noted obstacles that were particularly difficult to overcome, such as stigma associated with the ACA, negative media coverage, and limited ability to expand already demanding commitments to their clientele.

The information presented here is intended to help all CAAs understand how different agencies with widely varying resources and challenges can play a role in getting more uninsured Americans enrolled in health care, and possibly inform their existing efforts or contemplated changes. At the federal level, these findings may be useful for officials considering what more can be done to increase CAA capacity to do this important work. For instance, greater clarity from the federal government on how ACA goals mesh with CAA programmatic objectives may help CAAs understand how best to integrate these focuses. And supporting CAAs' efforts to explore new funding sources and partnerships may help them find the concrete resources CAAs say they need to do more in this area.

Table 1: Study Sites at a Glance

Organization	Funding Sources for ACA Outreach and Enrollment (first two open enrollment periods)		Numbers Enrolled in Medicaid and through State Marketplace (first two open enrollment periods)	Population Served	Promising Practices
	Federal Navigator Grant (in thousands)	Other \$			
Blue Grass Community Action Partnership , Frankfort, Kentucky	\$697k	\$0	2,892	Primarily rural	Active partnerships with local retailers to reach uninsured on site. Target outreach to employers with large numbers of part-time employees, who are more likely to be uninsured.
Garrett County Community Action Committee , Oakland, Maryland	\$100k	\$30k state funds	159	Rural, high poverty	Common intake process for all program applicants helps identify the uninsured. Well-being scale allows tracking of families' status after getting health insurance.
HOPES Community Action Partnership , Hoboken, New Jersey	\$0	\$30k private nonprofit funds	556	Primarily urban; targets youth, Hispanic populations, and seniors.	Focus on a door-to-door, coordinated and collaborative approach using mobile technology to conduct outreach. Has extensive partnerships with community organizations; received grant for targeted Hispanic health coverage outreach; provided integrated health and human services.
Indianhead Community Action Agency , Ladysmith, Wisconsin	\$0	\$0	Not applicable	Rural; high poverty	Conducts an internal survey of employees to assess the knowledge of the ACA and health insurance to provide accurate information. Counters local skepticism about the ACA and provided information on enrollment and referrals to Navigators. Indicates strong commitments despite limited resources.
Oakland Livingston Human Service Agency , Pontiac, Michigan	\$41k	\$13k private hospital funds, \$10k state CSBG discretionary funds	1,450	Primarily urban; some wealthier rural	Leveraging of multiple funding sources, including private philanthropy. Various partnerships support extensive outreach and enrollment.
Western Maine Community Action , East Wilton, Maine	\$995k	\$100k private foundation funds	3,587	Primarily rural; youth, homeless, Hispanic coalitions	Leverages multiple networks and community connections to conduct outreach events; engages in multiple methods of communication for outreach and enrollment coordination among CAAs. Lead agency in a statewide consortium of CAAs. Hired a Navigator grant coordinator who serves as a grassroots organizer.

*Shaded rows indicate sites that are in Medicaid expansion states.

Appendix A: Methodology and Sources

Our approach to this exploratory research was shaped by the study's objective: to identify and describe a variety of CAA models for providing ACA-related outreach and enrollment that can serve as examples for other CAAs considering adding or expanding ACA activities and to inform federal policy on how best to support such local-level activities. We intentionally chose CAAs with a range of size, capacity, and resources, including two sites that receive no federal funding for their ACA activities, rather than focusing only on agencies known to be well-funded or high-functioning. We took this approach to demonstrate that outreach and enrollment can be accomplished in many ways.

As an early step in the study, ASPE worked with the Community Action Partnership (CAP), a national association of CAAs, to develop an informal survey of their member organizations. CAP administered the survey through the Web-based platform SurveyMonkey to its entire membership of over 700 CAAs, and encouraged responses with follow-up e-mails to agencies that had not yet responded. The survey asked about the extent of agencies' involvement in ACA implementation, reasons for not engaging in ACA activities for respondents indicating no such activity, and their willingness to participate in an HHS study of CAAs' ACA involvement. CAP members' answers to questions on why they did no ACA-related activity serve as the basis for information related in this brief's section on disincentives to doing ACA-related work on page 8.

Of the 140 survey responses CAP received, 89 CAAs indicated they did some form of ACA outreach, and 37 of those indicated they were willing to participate in the study. To select sites for the study, we narrowed that field of 37 to 11 to reflect variation in activities, resources and location. ASPE staff met in person with some of those 11 CAAs at a CAP conference in Washington, DC in August 2014 and contacted the others by phone and e-mail for additional information on their activities. We chose the final six study sites based on their responses to the CAP survey, other anecdotal information on the nature and extent of their ACA activities, responsiveness to our inquiries, and their state's Medicaid expansion status. Thus, the sample of sites is not intended to be representative of the universe of all CAAs, but presents variation across study selection criteria. We did not aim for inclusion of every geographic area in the country given study resources, but the six sites are all from different states.

Information on study sites was collected primarily through telephone conversations and e-mail communications with CAA staff and relevant organizations such as Navigator prime grantees and state health exchanges as needed. ASPE used a written discussion guide to standardize questions across sites. In some cases, sites provided background documents and examples of forms and reports they use. We also conducted Web searches, consulted with federal program staff in HHS' Administration for Children and Families, and reviewed relevant studies and documents on CAA activities in the context of the ACA. ASPE staff traveled to the study site nearest Washington, DC, Garrett County Community Action Committee in Maryland, to collect information and observe activities on-site. Study sites were given the opportunity to review draft versions of the site profiles that are included in this research brief to update data and confirm factual information.

Appendix B: Site Profiles

- **Blue Grass Community Action Partnership**, Frankfort, Kentucky
- **Garrett County Community Action Committee**, Oakland, Maryland
- **HOPES Community Action Partnership**, Hoboken, New Jersey
- **Indianhead Community Action Agency**, Ladysmith, Wisconsin
- **Oakland Livingston Human Service Agency**, Pontiac, Michigan
- **Western Maine Community Action**, East Wilton, Maine

Blue Grass Community Action Partnership (BGCAP)

Location: Frankfort, KY

Population served: 80 percent rural, a few urban communities

Key characteristics: Medicaid expansion state. 13 total staff serving 9 counties.

ACA-related funding: \$34,862/month for 20 months for a total of \$697k in federal Navigator grant funding as subgrantee to Community Action Kentucky (CAK), the state community action agency association. CAK receives Navigator grant funding through a partnership with the state-based Marketplace, called kynect, and distributes those funds to multiple CAAs.

Numbers reached:

	1 st open enrollment	2 nd open enrollment	total
Outreach events held	32	36	68
# enrolled in Medicaid	1,146	980	2,126
# enrolled in Qualified Health Plans	350	416	766

Key points

- ➔ BGCAP has actively engaged with retailers and retail locations to support outreach and enrollment:
 - BGCAP particularly targeted local employers with large numbers of part-time workers given that part-time workers are more likely to be uninsured.
 - A retail chain store allowed BGCAP to put informational cards in the staff break room, and a pharmacy provided health insurance enrollment information to customers. Not all large retailers have been receptive to having Navigators on-site, however.
- ➔ BGCAP's database of all clients provides a resource for outreach efforts. Using their in-house system minimizes privacy and confidentiality concerns.

Outreach activities

- BGCAP has conducted outreach events at homeless shelters, health departments, mental health centers, fairs, schools, libraries and prisons. It uses word of mouth, existing relationships, and posters with contact information to encourage attendance. However, BGCAP has found these group events to be less effective than one-on-one outreach. Navigators make appointments with clients; go to their homes with laptops, scanners, and printers; and provide direct one-on-one enrollment assistance. Staff have served the areas where they live to help build client trust. Navigators work nonstandard hours to accommodate clients' availability and locations. BGCAP receives top-level state support for these efforts, and local newspapers have profiled Navigators to spur enrollment. Formal outreach events are held primarily outside of open enrollment periods so Navigators can focus on enrollment during those periods. A Kynector Store at a local shopping mall provides walk-in information and enrollment assistance, with Navigators and insurance agents on hand.

Health insurance enrollment activities

Navigators do at least half of enrollments in person; some enrollment is conducted over the phone. Staff often can determine in a few minutes if a client is eligible for Medicaid. Some Marketplace-eligible clients need two or three meetings to obtain counseling and help with plan choice. Navigators split their time between the BGCAP office and mobile sites, and do some sign-ups in clients' homes since not all clients are comfortable getting help in public settings or have transportation to group events. BGCAP provides clients with information on all health insurance plans, and will occasionally refer some clients to private insurance companies for further information on premiums and deductibles if they request it, although Navigators cannot recommend specific plans.

The state Marketplace sets monthly enrollment quotas for Navigator grantees to enroll individuals in both Medicaid and qualified health plans available through the state-run Marketplace during open enrollment periods; quotas vary by rate of uninsured. Some regions struggle to meet quotas, but BGCAP has always met and exceeded its quota.

Ex-prisoners are required to enroll in health coverage as a condition of probation and parole agreements. As a result, Navigators pay particular attention to this population.

Staff training resources

Federal funding pays for 13 Navigators (Navigators are called "kynectors" in Kentucky). Navigators receive training from staff at a local university through a partnership with the state Marketplace.

Subpopulations targeted

BGCAP targets specific groups both formally and ad hoc, including those leaving the prison system as noted above, homeless individuals, Hispanics, part-time workers, and those with low literacy levels. BGCAP identifies members of these groups through their work at homeless shelters and school events and by approaching shoppers at retail stores. The BGCAP intake form asks for education level, which can help identify low-literacy clients.

Partnerships

BGCAP works cooperatively with other state organizations that have Navigator funding – a primary health care association and a consortium of local governments – through conferences and phone calls.

Integration with human services programs

Navigators are also case managers and as such can integrate human services and health insurance enrollment and refer clients to other caseworkers as appropriate. The first question on the intake form is whether the client has health insurance. If not, they are referred to a Navigator. The state Marketplace portal is developing a fully integrated application that users

of the site can use to apply for TANF, SNAP, LIHEAP (provided through BGCAP) and potentially other services. These portal updates are expected to be available to the public by the end of 2015. Until then, users seeking information on these programs are directed to appropriate offices that can screen them for eligibility. Clients may also receive a letter from the state Department for Community-Based Services as follow-up to an inquiry about programs for which they may qualify.

Promising practices

- Kentucky has framed the state health care Marketplace, kynect, as a specific state brand to avoid the stigma associated with the ACA.
- Navigators provide a personal touch by giving their business cards and cell phone numbers to potential clients and relying on word of mouth to encourage more people to sign up for health insurance.
- BGCAP has successfully worked with the local business community to help with informational outreach efforts (see Key Points).

If more funding were available, BGCAP would:

- Invest in more outreach events.

Challenges and lessons learned

- BGCAP has struggled with the stigma associated with receiving government assistance.
- Being available to residents in all locations and after work hours is key to enrollment, but it is a taxing volume of work for individual Navigators and other staff (“not just a 9-to-5 job”).
- Technical problems with processing applications have been a significant hurdle for staff as well as clients.
- Staff have helped undocumented immigrants who need letters confirming they have been denied coverage through the state Marketplace so they can then receive free care from hospitals and clinics, but that means less time spent on enrolling eligible clients.
- Staff wish they had started open enrollment with more evening and weekend hours for Navigators so they could have reached more of the working uninsured.

Advice for other CAAs

- Be patient in dealing with technical issues.
- Tailor your approach to your area’s populations and needs.
- Communicate regularly with community and state organizations working on enrollment to share tactics and lessons learned.

Point of contact

LeAnna Watson, Kynect Program Manager (leanna.watson@bgcap.org)

Garrett County Community Action Committee (GCCAC)

Location: Oakland, Maryland

Population served: 100 percent rural

Key characteristics: Medicaid expansion state. 185 total staff serving one small rural county.

ACA-related funding: \$50k in Navigator grant funding for both first and second open enrollment periods, for a total of \$100k, as a subgrantee to Healthy Howard, a nonprofit focused on health and quality of life. Healthy Howard is one of six grantees in Maryland receiving Navigator funds from the state Marketplace. Other funding includes \$30k from state funds for assister training and salary and administrative costs.

Numbers reached:

	1 st open enrollment	2 nd open enrollment	total
Outreach events held	8	4	12
# enrolled in Medicaid	40	26	66
# enrolled in Qualified Health Plans	56	37	93

Key points

- ➔ GCCAC uses a comprehensive intake form and a sophisticated database to provide integrated intake for a large range of programs, including health insurance. It also uses a “crisis-to-thriving” index to assess clients’ progress toward self-sufficiency, which includes health insurance status.
- ➔ GCCAC found that enrolling uninsured clients with one-on-one assistance at their office, at one of their satellite locations, or where people congregate naturally was more effective than outreach at large public events.
- ➔ GCCAC is participating in an Annie E. Casey Foundation study of two-generation approaches to addressing both family poverty and children’s developmental needs by blending financially focused supports for parents, parenting support strategies and early childhood programs targeting children of low-income parents. GCCAC is one of four sites receiving funding to expand their two-generation approaches, and will be part of a forum to share and learn best practices across sites. GCCAC receives \$110k in each year of the three-year study, now in its second year. The Annie E. Casey Foundation sought GCCAC’s participation because of their standardized intake approach and high-performing early childhood program.

Outreach activities

GCCAC has conducted health insurance enrollment events and distributed enrollment information and materials at the state fair, farmers’ markets, local businesses, small employers, and at football games at the two high schools in the county. In 2013, GCCAC sent letters to all of their uninsured clients to encourage them to sign up.

Health insurance enrollment activities

GCCAC's main approach to enrollment is by identifying clients who lack health insurance through their comprehensive, standardized intake process and either enrolling them in Medicaid or referring them to the Navigator for help enrolling in a plan through the state-run Marketplace. The standardized intake form asks all applicants about their health insurance status. Most enrollment assistance occurs at the main GCCAC office, although some happens at satellite locations at high schools and senior centers and some enrollment assisters use laptop computers to sign up clients in their homes. From a county population of 30,000, GCCAC has enrolled 159 individuals in Medicaid and in qualified health plans through the state Marketplace.

Staff training resources

Navigators work in the GCCAC office, the county social services office, and the local health department. Navigator grants fund half of their salaries and training. Healthy Howard provides training in the region for the three Navigators in Garrett County, and the staff trainer sometimes travels to Oakland to provide training. GCCAC uses some Navigator funding to provide training for caseworkers to serve as enrollment assisters and refer individuals to Navigators. But given staff turnover and limited training opportunities, GCCAC staff sometimes lack the formal training they need to refer clients to Navigators and help with Medicaid enrollment. Garrett County also benefits from having Certified Application Counselors, funded with federal funds from HHS' Health Resources and Services Administration, located at the local Federally Qualified Health Center.

Subpopulations targeted

Garrett County is the most homogenous county in Maryland and has very few minorities or immigrants. As a result, they have not targeted outreach to any particular group other than farmers, who often lack health insurance.

Partnerships

GCCAC's main partnership is with Healthy Howard, which convenes their Navigator subgrantees twice a year to provide training resources and technical assistance with data systems and enrollment processes. GCCAC also partners with the local human services office and health department, which also have Navigators on staff, and it has teamed with local employers to reach uninsured workers and with the local hospital's charity care department which refers uninsured patients to GCCAC. The Farm Bureau has been instrumental in helping GCCAC connect with area farmers.

Integration with human services programs

GCCAC's standard intake process includes a presumptive eligibility screen for the human services they offer (Head Start, Early Head Start, LIHEAP, housing assistance, services and meals for the elderly, and transportation services). Most commonly, uninsured clients are identified

during their application for other services, but if a client comes in specifically for health insurance, they will be screened for eligibility for human services.

Promising practices

GCCAC views their common intake process for all programs as one of their most effective tools for identifying the uninsured, since all clients are asked about their health insurance status no matter what services they are seeking. In addition, the crisis-to-thriving scale they use to assess clients' self-reported progress toward self-sufficiency tracks clients' health insurance status as a key factor in family well-being. GCCAC plans to analyze the associations between getting health care coverage and progress on the scale, to document effects of coverage on improvements in client well-being. The scale, administered to all clients every six months, assesses progress along a wide range of well-being indicators, including housing, transportation, financial management, child care, nutrition, transportation, health insurance, health care, education and job skills, and employment status. Clients identify their specific goals such as buying a house or getting a degree, discuss with their caseworker specific action steps to achieve these goals, and review their progress at periodic meetings. The intake tool also can record external services that may contribute to progress. GCCAC adapted the crisis-to-thriving scale from a model developed by the Community Action Partnership to help member agencies track client outcomes. This holistic and comprehensive approach to service delivery made it relatively easy for GCCAC to incorporate the health insurance component into its daily processes. Healthy Howard provided the training and resources needed to make this integration possible.

If more funding were available, GCCAC would:

- Offer more public meetings, especially with small employers and farmers, to ensure all residents can learn about the ACA.
- Invest in sharing software and data tools with local partners, and develop standards for data exchange to facilitate that sharing.
- Improve the ability to track client well-being and insurance status.
- Provide more regular training for staff.

Challenges and lessons learned

Garrett County's population is highly rural and scattered, creating a challenge to reach many residents at one time. The county's geography and resources support only a few locations for in-person enrollment, requiring considerable travel for some residents to find in-person help with enrollment. Staff also have had to deal with considerable public frustration with technical problems associated with the state Marketplace. Also, because GCCAC is a private entity, they have had difficulties connecting their client data system with state human services and health data systems which often have strict security firewalls.

Advice for other CAAs

- Use partnerships with different organizations to better leverage the considerable outreach capacity of community action agencies. Community action agencies have unique capabilities to apply resources across multiple programs and avoid the bureaucratic silos of public agencies.

- Try not to reinvent the wheel; look for ways to incorporate health insurance outreach and enrollment into existing systems and programs.
- Take advantage of community action agency networks available through state community action associations and state CSBG offices to learn about their experiences to inform your choices.

Point of contact

Duane Yoder, President, Garrett County Community Action (dyoder@garrettcac.org)

HOPES Community Action Partnership (HOPES)

Location: Hoboken, New Jersey

Population served: 100 percent urban, two-county area

Key characteristics: Medicaid expansion state. 9 staff, 6 of whom are trained CACs (5 bilingual).

ACA-related funding: \$30k in the first enrollment period from a private nonprofit community advocacy group for a one-year grant for Hispanic outreach. CAC salaries are covered in part with CSBG funds.

Numbers reached:

	1 st open enrollment	2 nd open enrollment	total
Outreach events held	4	5	9
# enrolled in Medicaid	160	225	385
# enrolled in Qualified Health Plans	75	96	171

Key points

- ➔ HOPES developed extensive partnerships with more than 50 community organizations, including churches and a university medical center, to effectively conduct outreach and educate individuals.
- ➔ HOPES received a grant from a private nonprofit citizen action group to conduct targeted Hispanic health coverage outreach.
- ➔ HOPES has integrated health care outreach with other human services provided by the CAA, including Volunteer Income Tax Assistance (VITA) tax preparation services.

Outreach activities

HOPES held health fairs at housing authority offices and in their own office, and worked with state assembly members to refer their constituents to HOPES. The health fairs took place during open enrollment, and included a variety of services such as pap smears, cervical and breast screenings, cholesterol checks, Medicare Open Enrollment assistance, flu shots, and education on the ACA's impact on personal taxes. They hosted two media days with New Jersey Citizen Action (NJCA), a private nonprofit, and worked with local mayors to produce TV and other media interviews focusing on the ACA. HOPES also used social media to reach younger individuals. Providing information on health insurance options is integrated into all the services and programs HOPES offers, including Volunteer Income Tax Assistance (VITA), early detection cancer screening, Head Start, transportation services, ESL, and financial literacy. A standard intake form requires information on health insurance status for applicants of all HOPES' programs so the uninsured can be referred to a CAC. The philosophy for outreach is to use every available resource to share ACA information with the community. During the second open enrollment period, HOPES has observed greater receptivity among clients to help with health insurance sign-up.

Health insurance enrollment activities

HOPES' six CACs provide assistance to all clients seeking help with enrollment, whether in Medicaid or through the state's Federally-facilitated Marketplace. Staff provide one-on-one help with all steps of the sign-up process. A federal Navigator grantee organization in New Jersey offered to send Navigators, but HOPES was able to provide adequate assistance to their clients without this resource.

Staff training resources

HOPES is a CAC agency, certified by CMS, to help the uninsured population with applications. HOPES staff received CAC training from CMS via webinars and uses CMS materials in training and to disseminate to clients. HOPES uses a small portion of its CSBG funds to cover salaries of the CACs.

Subpopulations targeted

HOPES targets youth, Hispanics, and seniors. It received a one-year \$30k grant from NJCA for targeted outreach to the Hispanic population; the award was based on HOPES' experience serving these groups, especially those with limited English proficiency. The grant itself was created because one-third of the eligible uninsured before the first open enrollment were Hispanic, and there was a shortage of bilingual assisters. The universal client intake form used by HOPES includes a required section to indicate whether the client has health coverage and whether the client is Hispanic.

Partnerships

HOPES belongs to the Hudson County Community Network Association of health-related nonprofits. Association members share information on their various health and human service projects. HOPES also participates in monthly working groups convened by NJCA to coordinate ACA-related activity, as well as quarterly meetings of the CAAs in the state. NJCA views its relationship with HOPES as one in which NJCA provides the media expertise that the CAA does not have and HOPES provides the community-level touch that NJCA lacks. HOPES has collaborated with more than fifty community organizations. A partnership with Hoboken University Medical Center and another with local churches have been particularly successful in ACA outreach and enrollment. Churches send parishioners to the CAA for enrollment assistance, and the medical center provides financial literacy classes, cancer and mental health screening, and transportation services. HOPES used its recent 50-year anniversary gala to solidify and extend partnerships.

Integration with human services programs

HOPES has worked to integrate ACA outreach into all of its activities. NJCA staff indicated that HOPES' application for the Hispanic-outreach grant was well-received because of its model of integrating VITA and ACA services. The client intake form is adapted to meet various funding requirements, as well as connecting Medicaid/Marketplace applicants with human services programs.

Promising practices

HOPES focuses on a door-to-door, coordinated and collaborative approach to outreach and enrollment efforts. Use of laptops, wifi hotspots and mobile printers have allowed HOPES staff to be mobile in their community outreach, including in local public housing complexes. Other technological outreach includes the use of robo-call services to announce outreach events.

If more funding were available, HOPES would:

- Expand the number of staff and provide them with CAC certification.
- Conduct focus groups with constituents to learn about their experiences with and needs related to the ACA.

Challenges and lessons learned

- Limited funding for ACA outreach and enrollment activities has limited the ability to buy media and to pay staff overtime.
- There is a lack of understanding of the tax penalty among consumers, although there is now more receptivity and a greater understanding of the law's expectations.
- ACA partnership efforts with local entities - counties, cities, and townships – are particularly important.

Advice for other CAAs

- Ensure that the CAA has the staff capacity and knowledge to engage most effectively in ACA outreach.
- Try to weave ACA outreach into existing programs and services outreach, which can be done even with little or no funding.

Point of contact

Evelyn Mercado, Manager of Community Services (emercado@hopes.org)

Indianhead Community Action Agency (ICAA)

Location: Ladysmith, Wisconsin

Population served: 100 percent rural, very low income, 20-county area

Key characteristics: Non-Medicaid expansion state. 450 staff, 150 of whom engage in ACA-related outreach, although none are Certified Application Counselors or Navigators who can enroll clients in health insurance directly.

ACA-related funding: none

Numbers reached:

ICAA hosted 4 outreach events and provided ACA-related information through their website, flyers and newsletters at a number of locations. They do not assess the number of clients who may have enrolled from these general education and awareness initiatives.

Key points

- ➔ Despite limited resources and no ACA-specific funding, Indianhead has made substantial efforts to counter local skepticism about the ACA and provide information about how to enroll in health insurance. Limited resources have not dampened the commitment of ICAA leadership to provide accurate information about the ACA to clients and employees.
- ➔ ICAA refers clients to trained Navigators funded through other organizations, provides physical office space for Navigators, and has offered open informational sessions with CACs.
- ➔ A defining characteristic of ICAA is the considerable poverty and isolation of the rural area it serves. Many of ICAA's employees work at wages low enough to qualify them as clients of the programs they offer. Half of the employees are home health aides or personal care workers who earn very low wages, and many have no health insurance coverage themselves. Their incomes are too high to qualify for Medicaid (Wisconsin did not expand Medicaid) but too low to afford the subsidized insurance available through the state's Federally-facilitated Marketplace.

Outreach activities

ICAA hosted four events – two at the CAA headquarters (for CAA employees and non-employee clients, and for small business entrepreneurs), one at a home health satellite office targeting home health workers, and one at a thrift store/food pantry targeting the public. ICAA staff distributed flyers and information at thrift stores and food pantries, and made referrals to Navigators employed by Northwest Wisconsin Concentrated Employment Program (NWCEP), a local clinic, and the rural critical access hospital staff who are certified counselors. These staff relied on an ad hoc, word-of-mouth system. The leadership wrote a letter to the editor of the local paper as a way to counter negative perceptions of the ACA. ICAA also provides links from their website to reputable sources for ACA information. As noted below, ICAA has found one-on-one, direct contact with clients to be by far the most effective outreach and education strategy for the rural population they serve.

Health insurance enrollment activities

ICAA opened its facilities to Navigator enrollment specialists funded through NWCEP, and provided support by sharing information on the ACA to its clients and employees.

Staff training resources

ICAA worked with AmeriCorps and NWCEP, a Navigator grant recipient serving the northwestern and western parts of Wisconsin. The partnership allowed them to secure training on the ACA for staff, though they had no direct funding mechanism for the training. An AmeriCorps representative helped get trained Navigators into the rural areas served by ICAA, and also assisted in convening representatives from the state Department of Health and Human Services, the Aging and Disabilities Resource Center, a rural primary clinic, a critical access hospital, local school districts, a library, and others to identify ways to provide ACA information to community members in need of health care access.

Subpopulations targeted

ICAA employees

Partnerships

Although ICAA has staff who are in direct contact with the population in need, they lack the resources to connect with larger umbrella groups conducting training and enrollment, and there is limited sharing of best practices across the state. ICAA did, however, collaborate with local schools, libraries, rural access hospital, clinics, and community health centers. ICAA leadership hopes to continue collaborating with NWCEP, the regional employment agency that received Navigator funds, on anti-poverty efforts supported through the Workforce Innovation and Opportunity Act.

Integration with human services programs

ICAA provides a broad range of services including weatherization, legal assistance for victims of domestic violence, Head Start, home healthcare, transportation, literacy instruction, food security initiatives, rural health network initiatives, jobs and entrepreneur business development, vocational rehabilitation services, parenting resources, and youth alcohol and drug prevention initiatives. Although no staff had official health insurance enrollment duties because none were trained as CACs or Navigators, they provided one-on-one assistance and made referrals to Navigators.

Promising practices

ICAA leadership is committed to helping their employees obtain health insurance themselves as well as ensuring those employees can assist clients. ICAA conducted an internal survey of its employees in summer 2013 to assess knowledge of and attitudes toward the ACA and health insurance coverage in general. The survey aimed to determine how important availability of health insurance is to ICAA employees, whether age is a factor in that determination, and the level of knowledge of the ACA among employees. Of the 134 who answered, 19 percent indicated they had neither private health insurance nor Medicaid. The highest rates of

uninsured were among those aged 34-55 (26 percent), while the younger group (18-34) had the lowest rate (8 percent). Most employees without insurance are either barely meeting monthly expenses or are unable to meet monthly expenses. The survey also indicated that most employees are highly knowledgeable about the ACA.

If ACA-specific funding were available, ICAA would:

- Create more informational flyers to inform and educate community members about the ACA's benefits to lower-income Americans to counteract negative perceptions.
- Partner with the business community by framing the need for health care coverage as a mental health issue and as promoting stability for employees.
- Facilitate outreach in the form of face-to-face interaction in locations that are easily accessible to community members.

Challenges and lessons learned

- A lack of technological capacity (internet and computers were only available at the CAA headquarters) and the rural setting (especially long distances between clients and services) created high barriers to engagement with the CAA.
- ICAA clients have been slow to utilize the Health Insurance Marketplace. The rural population values one-on-one, in-person connections and validation from family members on what is necessary government assistance.

Advice for other CAAs

- Providing employees with thorough, accurate information on the ACA is key to successful referrals, given that CAA staff are the primary point of contact with clients. Good training can help counter any misinformation or skepticism about the benefits of health coverage.
- Collaborative partnerships with other state and local organizations can help leverage limited CAA resources to serve more individuals.

Point of contact

Pamela Guthman, Chief Executive Officer (pamela.guthman@indianheadcaa.org)

Oakland Livingston Human Service Agency (OLHSA)

Location: Pontiac, Michigan

Population served: primarily urban, some rural areas

Key characteristics: Medicaid expansion state. 275 total staff serving two counties.

ACA-related funding: \$41k in federal Navigator funds (\$22k in 2013, \$19k in 2014) as a subgrantee to Michigan Consumers for Healthcare, a nonprofit consortium focused on health care access. Federal funding is augmented with \$13k from St. Joseph Mercy Hospital and \$10k from state CSBG discretionary funding, and United Way funding helps cover staff costs. A privately funded philanthropy subsidizes health insurance costs for participants in a pilot program.

Numbers reached:

	1 st open enrollment	2 nd open enrollment	total
Outreach events held	100	50	150
# enrolled in Medicaid	1,200	100	1,300
# enrolled in Qualified Health Plans	100	50	150

Key points

- ➔ OLHSA’s federally funded ACA activities are augmented with funds from the state’s CSBG discretionary funds and with funding from the United Way and a local private hospital, representing a creative example of funding partnerships. The United Way funds help pay the salaries of intake staff, all of whom are certified application counselors or Navigators.
- ➔ United Way also provides \$141k for a “bundled services” pilot project, in which one caseworker remains the single point of contact for a client and works with various program staff on behalf of the client. OLHSA has served 20 clients through this model, and hopes to expand to 50 people in 2016. Clients needing multiple services are invited to participate in the pilot, which covers services for utility and weather assistance, Head Start, services for the elderly, those returning to their communities after incarceration, asset-matching accounts, and financial literacy.
- ➔ The Michigan Universal Health Care Network, a private charity, helps select Michigan residents with their insurance costs through its Health Insurance Assistance Program (MHIAP). This pilot program subsidizes the cost of insurance plans purchased through the Marketplace (a federal-state partnership), providing up to \$100 a month for individuals and \$150 for families for insurance purchased through the Marketplace. As of early 2015, 50 people were enrolled in the pilot, with plans to increase the number served in 2016. MHIAP partners with organizations and programs that serve low-income families as a way to get referrals for the program. Individuals can apply for the pilot if they are uninsured, cannot access insurance through an employer, are employed

or receive a pension, and fall within the income limits set by MHIAP. OLHSA has referred some of its clients to MHIAP, but none have yet enrolled in the pilot.

Outreach activities

OLHSA has held a variety of community events, including a week-long health fair targeting the uninsured. It has conducted outreach at local housing agencies, housing developments, churches, clinics, a hospital, libraries, local colleges, hair salons, outlet malls, and Head Start sites. OLHSA's eight clinics providing Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits have mobile equipment for on-site enrollment. At weekly farmers' markets, OLHSA has provided bags of fresh fruits and vegetables to everyone who sought information on health insurance coverage. They have used media campaigns including signs, flyers, newspaper announcements, and web site announcements to advertise events and encourage sign-up. OLHSA tried unsuccessfully to partner with a few local big-box retailers. One such store chose instead to have representatives from a private insurance company on site to sign up customers for health insurance. OLHSA also published articles in the local paper about benefits of the ACA.

Health insurance enrollment activities

OLHSA provides one-on-one, in-person assistance to those seeking information and sign-up help. Navigators focus on Marketplace sign-ups while CACs helped mainly with Medicaid enrollments.

Staff training resources

OLHSA has 15 staff trained to do ACA intake: three Navigators and 12 CACs. Volunteers who are trained as CACs help as well. Michigan Consumers for Healthcare, the primary Navigator grantee, provides training resources and a blog for CACs.

Subpopulations targeted

During the second open enrollment period, OLHSA focused on Hispanics and other minorities by working with a local Hispanic cultural group and targeting Early Head Start centers that enroll many Hispanic children. The agency also plans to reach out to the area's large Arabic population by working with a local Arab/American association.

Partnerships

OLHSA has partnered effectively with St. Joseph Mercy Hospital, health care clinics, and the local workforce and housing agencies to identify the uninsured and assisting them with enrollment. The hospital lent OLHSA eight staff members to help with outreach efforts. The agency plans to approach a smaller local hospital to expand this partnership approach.

Integration with human services programs

All OLHSA clients seeking human services benefits begin at a welcome center, where they are asked about their health insurance status during the eligibility determination process for other programs. Caseworkers can do program intake simultaneously with health insurance enrollment, depending on the client's circumstances and eligibility.

Promising practices

As described above, OLHSA has succeeded in braiding diverse funding sources together, including federal, state and private funds, to support ACA outreach and enrollment. This ability to leverage funding has helped them establish multiple effective partnerships with diverse groups, primarily local health care organizations. The latter can play a key role in identifying the uninsured and referring them to OLHSA.

If more funding were available, OLHSA would:

- Focus any additional resources on enrollment fairs to serve hard-to-reach groups, and hire more staff to help more clients with the health insurance enrollment process.

Challenges and lessons learned

- Not all attempts to partner were successful. For example, large retailers were reluctant to have OLHSA staff on the premises.

Advice for other CAAs

- Provide training on ACA enrollment for as many intake staff as possible.
- Work to leverage different funding sources.
- Use the key strength of CAAs, the ability to provide multiple services and programs, to integrate health insurance coverage into enrollment activities.

Point of contact

Lynn Crotty, Chief Operating Officer (lynn@olhsa.org)

Western Maine Community Action (WMCA)

Location: East Wilton, Maine

Population served: 100 percent rural

Key characteristics: Not a Medicaid expansion state. 78 staff involved in ACA outreach and enrollment.

ACA-related funding: \$475,000 and \$520,376 in direct federal Navigator grantee funding for the first and second open enrollment periods, respectively. \$25k and \$75k from a private foundation for media resources in first and second enrollment periods, respectively.

Numbers reached:

	1 st open enrollment	2 nd open enrollment	total
Outreach events held	474	175	649
# enrolled in Medicaid	143	69	212
# enrolled in Qualified Health Plans	2,025	1,350	3,375

Key points

- ➔ WMCA is the lead agency in a statewide consortium of nine CAAs that provides ACA education, outreach, and enrollment assistance to individuals across the state.
- ➔ WMCA benefited from having a Navigator grant coordinator who served as a grassroots organizer and acted as the public face of ACA enrollment and Marketplace health insurance. The coordinator appeared in local, state, and national TV, radio, and print media to advocate for health insurance coverage.
- ➔ WMCA uses effective partnerships with a private foundation and nonprofit health care advocacy group to augment Navigator grant funding, share enrollment information, and build trust among the uninsured. WMCA has direct relationships with staff at these partner organizations, who serve as trusted messengers.

Outreach activities

During the first open enrollment period, WMCA conducted more than 470 outreach events statewide, at locations such as libraries, colleges, bridal fairs, recycling centers, ski resorts, flea markets, hospitals, and businesses. WMCA hosted a telethon and relied on CMS-provided flyers, brochures, webinars, and weekly newsletters for information. The outreach goal was to blanket the state with information, which was assisted by media coverage of enrollment activities.

Health insurance enrollment activities

WMCA acted as a lead agency of and Navigator grant recipient for a consortium of Maine community action agencies working on ACA outreach and enrollment. In the first enrollment cycle, WMCA successfully made 19,300 direct consumer contacts via phone, outreach events and in-person appointments; helped consumers create 2,862 profiles (i.e., online Marketplace accounts at healthcare.gov); helped 3,399 consumers understand their eligibility for

affordability programs such as premium tax credits and cost-sharing reductions; and assisted 2,556 consumers in obtaining eligibility determinations through Marketplace applications. Through the first open enrollment period alone, WMCA distributed information on Medicaid and Marketplace eligibility to more than 30,000 individuals. WMCA's Navigators were able to provide an initial assessment for Medicaid eligibility, but had to rely on the state Department of Health and Human Services to follow up with the client directly for final eligibility determination. During the first open enrollment cycle, the Maine state legislature changed the Medicaid eligibility threshold for parents of minor children from 133 percent of the federal poverty level to 100 percent and also eliminated existing Medicaid coverage for about 10,000 "non-categorical" enrollees. This latter change caused more Maine residents to fall into the coverage gap of having incomes too high to qualify for Medicaid but below the lower limit for tax credits through Maine's Federally-facilitated Marketplace.

Staff training resources

WMCA directly employed eight Navigators in 2013 and nine in 2014. The consortium of nine CAAs employs 69 staff and volunteers who completed a Navigator certification course provided by CMS in 2013 and 44 staff who were certified in 2014. WMCA chose to certify fewer Navigators in 2014 because they learned over time that it worked better to have fewer Navigators who focused primarily on health insurance enrollment, and thus were able to keep current with program rules, than to have more Navigators whose responsibilities were spread across multiple caseworker functions. In addition to CMS materials, WMCA used a Robert Wood Johnson Foundation question-and-answer guide on the ACA to train staff and teamed up with local hospitals and federally qualified health centers so that the CACs from the hospitals were able to shadow WMCA Navigators.

Subpopulations targeted

WMCA conducted focus groups with a group they termed "young invincibles," including men at tattoo parlors, to develop messaging strategies to reach the younger population. In the second enrollment cycle, WMCA targeted homeless populations and worked with *Mano en Mano*, a coalition that reaches Hispanic groups.

Partnerships

WMCA casts a wide net to target uninsured populations through extensive partnerships, including with Maine People's Resource Center, a nonprofit engaging Mainers in social change on community issues; Maine Consumers for Affordable Health Care (CAHC), a private nonprofit advocating for health care access; and Maine Health Access Foundation (MeHAF), a private foundation also dedicated to health care access and quality. WMCA uses physical office locations throughout the state, especially WIC and Head Start centers, which help with leveraging pre-existing relationships with people who may qualify for Medicaid or health care coverage in the Marketplace. MeHAF provided commercial media resources to WMCA and its other grantees; invested in a website, enroll207.com, which publicizes outreach events; and facilitated the sharing of best practices at grantee meetings. CAHC arranged meetings statewide for assisters and Navigators, facilitated internal troubleshooting, hosted regional meetings, and supported information-sharing and activity coordination. When a large

manufacturing center closed its doors, WMCA was able to deploy a rapid response team to ask dislocated workers questions about eligibility and coverage. Partnerships with career centers have connected them with the unemployed.

Integration with human services programs

WMCA considers clients' needs holistically, although there is no formal integration across health and human services programs. All WMCA program intake forms include questions on health insurance coverage so human services program applicants can be referred to Navigators if needed, and clients coming to WMCA for health insurance may be referred to other programs if they appear eligible.

Promising practices

WMCA indicates that their success stems, in part, from the natural connection that CAAs have with the eligible population. Clients trust the CAA, given its decades of community connections. Through strong relationships with MeHAF and CAHC, WMCA built a strong network for getting the word out about outreach events. WMCA approached the enrollment process as a statewide team of a dozen organizations, without turf competition, in which each group communicated well with the others. Weekly check-in calls provided encouragement and information, and constant communication helped staff remain energized and feel supported. Ongoing means of communication include MeHAF grantee communiqués, a statewide assister listserv, regional listservs, information-sharing through Google groups, and conference calls among the nine CAAs participating in the state consortium. Although hospitals initially adopted a wait-and-see approach to disseminating Marketplace information, many now have CAC staff in their offices. WMCA believes that change stems from the narrative emerging in Maine as one of success in outreach and enrollment. In addition, WMCA assisters conducted outreach in atypical places such as community trash and recycling locations.

If more funding were available, WMCA would:

- Buy paid advertising rather than relying solely on free media and MeHAF's advertisements.
- Fund more Navigators to help with enrollment since current funding only pays for one position.
- Integrate the WMCA brand into the work that Navigators do to better integrate health and human services through WMCA.

Challenges and lessons learned

WMCA found that group enrollment events are challenging because of the lack of privacy at enrollment stations. Regional meetings with other CAAs helped provide a venue for mutual technical assistance, and helped make the second open enrollment period go much more smoothly than the first.

Advice for other CAAs

- Develop a collaborative network and peer support system.

- Conduct listening sessions with community partners to develop effective messaging and outreach strategies.

Points of contact

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