Health Centers' Important Role In Outreach and Enrollment

By
Jessica Kendall
Jennifer Sullivan

Starting in 2014, millions of Americans will become eligible for health coverage offered through health insurance exchanges and through Medicaid, which will dramatically alter the landscape for health centers. Health centers have long played a crucial role in providing affordable, high-quality, community-based care to vulnerable populations. Based on interviews with staff from health centers and primary care associations in four states (Arizona, Michigan, Texas, and Washington), this piece and its companion, "Best Practices in Outreach and Enrollment for Health Centers," highlight the crucial role health centers play in outreach and enrollment and the best practices they can implement as health coverage opportunities are expanded.

Introduction

As a result of the Affordable Care Act, all states will have the opportunity to expand Medicaid coverage with generous federal financial support, and a health insurance exchange will exist in every state (run by the state, the federal government, or a partnership between the two). The majority of people who are uninsured will become eligible for some form of coverage.[1]

Health centers will play a critical role in making sure that the uninsured patients they serve, as well as the new patients who come through their doors in 2014 and beyond, can connect to the new coverage options. Doing so will help their patients get the health coverage they need, and it will bring in additional funding to support health centers' work.

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Health Centers and Enrollment: A Natural Link

Ensuring that the uninsured learn about the coverage that will be available to them, believe that the new forms of coverage are right for them, and take the necessary steps to enroll in coverage will take a great deal of work. Recent research funded by CVS Caremark found that 78 percent of those who are likely to be eligible for coverage through a health insurance exchange had never heard of the term.[2] Once the term was explained, 60 percent said that they expected they would need help with learning how to enroll in coverage through an exchange. Research in three states on those who are likely to be newly eligible for Medicaid found a similar lack of awareness among this group: People do not know or expect that they will ever qualify for Medicaid, and they perceive the enrollment process to be daunting.[3]

People who become newly eligible for coverage will need to hear about their options from trusted messengers who can guide them through the enrollment process, from learning about coverage to getting help with the application to enrolling in a health plan. Health centers are one of the most logical partners in any enrollment effort, since they already provide health services to such a large portion of the uninsured. Consumers trust health centers with their health care, so trusting them to provide assistance with getting health coverage is a natural fit. In fact, research suggests that health care settings are one of the most popular places people would like to go for enrollment help.[4]

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Health centers' current role in promoting enrollment takes many forms, including providing access to traditional outstationed eligibility workers, using technology to maintain strong connections with key populations, and/or training staff to conduct outreach and serve as application assisters.[5] Health centers can also serve as "qualified entities" that are allowed to determine whether a child or a pregnant

woman is temporarily eligible for Medicaid or the Children's Health Insurance Program (CHIP) while a full application is being processed. This opportunity will be expanded in 2014, when states will have the option to allow presumptive eligibility for anyone who qualifies for Medicaid because of their income.[6]

Under the Affordable Care Act, states are required to use a simple, streamlined application process for Medicaid, CHIP, and coverage through health insurance exchanges starting with open enrollment in 2013. They will also need to use a simple, streamlined renewal process for all of these programs (regardless of whether or not the state expands Medicaid). However, these simplifications will not diminish health centers' important role in making sure that people get enrolled and stay enrolled. Many enrollees will need special assistance with the renewal process to ensure that they keep their coverage for as long as they remain eligible. In particular, lower-income individuals experience more frequent fluctuations in income, which can cause changes in eligibility, potentially resulting in bigger gaps in coverage.[7] Health centers' efforts to enroll people should be coupled with strategies to ensure that people retain coverage over time.

Enrollment and the Bottom Line

Heading into 2014, health centers' participation in outreach and enrollment will be absolutely critical. Not only is it part of health centers' mission to connect their patients to health coverage, it also makes good business sense. Health centers are reimbursed for the services they provide at a higher rate if a patient is enrolled in Medicaid than if the patient is uninsured and paying on a sliding scale.[8]

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And although reimbursement rates for patients who will be enrolled in coverage through health insurance exchanges have not yet been determined, the Affordable Care Act suggests that these rates will be at least equal to the rates for Medicaid enrollees.[9]

The per-patient revenues that health centers collect is much higher for patients enrolled in Medicaid than it is for those paying on a sliding scale (who are uninsured). Table 1 on pages 6 and 7 shows per-patient revenues for Medicaid compared to sliding scale patients in each state. Differences vary by state, but on average, health centers collected nearly $500 more per Medicaid patient in 2011 than they did for each sliding scale patient. The lower per-patient revenues for sliding scale patients are to be expected. Patients who pay on a sliding scale and whose incomes fall below the federal poverty level ($11,070 for an individual in 2012) are not required to pay more than a nominal amount, and those with incomes between 100 and 200 percent of poverty (between $11,070 and $22,340 for an individual in 2012) still may not be able to afford to pay very much. Many of these individuals will become eligible for Medicaid in 2014, which creates the opportunity for a significant financial boost for health centers across the country.

Table 2 on pages 8 and 9 shows the number of uninsured patients who were served by health centers in each state in 2011, as well as the percentage of health center patients who were uninsured. Nationally, 36.5 percent of the patients that health centers served in 2011 were uninsured. A significant number of these patients will likely be eligible for Medicaid or for exchange coverage beginning in 2014.[10] The more patients who are successfully enrolled in coverage, the better the financial outlook for health centers. For example, the Michigan Primary Care Association estimates that health centers in Michigan could see up to $47.7 million in additional reimbursement if all the patients who will likely be eligible for Medicaid in 2014 are enrolled.[11]

Maximizing coverage among eligible patients will be particularly important in future years, since research suggests that, as coverage is expanded, demand for health center services will grow.[12] Getting eligible people enrolled will allow health centers to continue to serve those who are ineligible for coverage and expand services for those who need them most.

Conclusion

Health centers and primary care associations both have a vested interest in reaching out to people who will be newly eligible in 2014 and helping them enroll in coverage. This is consistent with their mission, and it is essential to their bottom line. Around the country, health centers are already doing this important work, and there are numerous lessons to be learned from groups that have been actively reaching out to and enrolling people in existing programs. By streamlining internal systems, using innovative technology, and coordinating outreach activities now, health centers will be better prepared to reach and serve the millions of newly eligible people in 2014.

Table 1.

Health Center Per-Patient Revenues: Medicaid Compared to Sliding Fee Scale, 2011

State	Total Medicaid Patients Served In 2011	Total Uninsured Patients Served In 2011	Average Revenue per Medicaid Patient	Average Revenue per Self-Pay Patient	Difference in Per-Patient Revenue Between Medicaid And Self-Pay Patients
Alabama	92,500	152,400	$412	$68	$344
Alaska	23,900	32,200	$1,058	$272	$786
Arizona	168,500	118,300	$907	$178	$729
Arkansas	42,200	65,900	$466	$157	$308
California	1,307,400	1,287,400	$729	$87	$642
Colorado	187,400	191,600	$678	$157	$521
Connecticut	184,400	74,000	$810	$108	$702
Delaware	16,200	15,100	$458	$122	$336
District of Columbia	67,400	20,100	$494	$32	$462
Florida	393,700	504,400	$529	$96	$433
Georgia	86,200	162,300	$373	$124	$249
Hawaii	66,400	33,900	$862	$154	$708
Idaho	26,100	65,300	$605	$141	$464
Illinois	578,600	339,800	$491	$65	$426
Indiana	119,000	102,100	$573	$86	$487
Iowa	68,900	61,900	$536	$137	$399
Kansas	38,700	75,700	$440	$101	$339
Kentucky	84,800	105,400	$675	$127	$549
Louisiana	91,700	87,000	$487	$113	$374
Maine	55,800	26,400	$673	$355	$318
Maryland	125,200	61,600	$828	$139	$690
Massachusetts	258,200	131,100	$677	$139	$539
Michigan	240,500	178,900	$675	$126	$549
Minnesota	67,000	65,100	$708	$98	$610
Mississippi	99,800	134,200	$319	$86	$234
Missouri	178,800	145,300	$656	$130	$527
Montana	16,900	50,800	$568	$122	$446
Nebraska	18,500	33,700	$458	$162	$296
Nevada*	–	–	–	–	–
New Hampshire	15,300	19,300	$738	$148	$590

Table 1 cont'd.

Health Center Per-Patient Revenues: Medicaid Compared to Sliding Fee Scale, 2011

State	Total Medicaid Patients Served In 2011	Total Uninsured Patients Served In 2011	Average Revenue per Medicaid Patient	Average Revenue per Self-Pay Patient	Difference in Per-Patient Revenue Between Medicaid And Self-Pay Patients
New Jersey	203,100	196,500	$491	$65	$425
New Mexico	79,500	111,200	$636	$139	$497
New York	682,900	373,600	$838	$75	$762
North Carolina	85,700	214,200	$487	$119	$369
North Dakota	8,700	9,000	$484	$298	$186
Ohio	199,900	162,400	$418	$76	$342
Oklahoma	49,400	54,500	$605	$138	$468
Oregon	122,600	110,400	$1,155	$143	$1,012
Pennsylvania	279,900	164,900	$499	$95	$404
Rhode Island	52,500	39,000	$627	$98	$529
South Carolina	106,600	129,800	$462	$155	$307
South Dakota	16,100	21,300	$492	$156	$335
Tennessee	123,000	150,400	$453	$85	$368
Texas	267,600	501,300	$679	$119	$560
Utah	20,900	62,800	$850	$124	$726
Vermont	33,400	12,400	$687	$519	$167
Virginia	63,800	108,300	$458	$150	$308
Washington	346,900	278,400	$944	$159	$786
West Virginia	90,000	91,300	$608	$215	$394
Wisconsin	163,100	67,800	$1,132	$154	$978
Wyoming	3,000	7,500	$623	$69	$554
Total	**7,718,600**	**7,208,200**			
U.S. Average			**$630**	**$140**	**$490**

Source: Uniform Data System (UDS) 2011 data, Bureau of Primary Health Care, Health Resources and Services Administration, HHS.

* Nevada does not report data in the UDS because there are only two federally recognized health centers in the state. States are not required to report data in the UDS unless they have at least three federally recognized health centers.

Table 2.

Uninsured Population Served by Health Centers, 2011

State	Uninsured Patients Served in 2011	Total Patients Served in 2011	Percent of Patients That are Uninsured
Alabama	152,400	320,000	47.6%
Alaska	32,200	91,000	35.4%
Arizona	118,300	408,700	28.9%
Arkansas	65,900	156,200	42.2%
California	1,287,400	3,104,200	41.5%
Colorado	191,600	474,200	40.4%
Connecticut	74,000	316,000	23.4%
Delaware	15,100	38,900	38.9%
District of Columbia	20,100	122,900	16.4%
Florida	504,400	1,080,700	46.7%
Georgia	162,300	317,300	51.2%
Hawaii	33,900	137,300	24.7%
Idaho	65,300	126,400	51.7%
Illinois	339,800	1,098,500	30.9%
Indiana	102,100	273,500	37.3%
Iowa	61,900	179,100	34.6%
Kansas	75,700	147,500	51.3%
Kentucky	105,400	278,200	37.9%
Louisiana	87,000	223,100	39.0%
Maine	26,400	181,200	14.6%
Maryland	61,600	282,800	21.8%
Massachusetts	131,100	615,700	21.3%
Michigan	178,900	546,200	32.8%
Minnesota	65,100	165,500	39.3%
Mississippi	134,200	324,000	41.4%
Missouri	145,300	420,100	34.6%
Montana	50,800	101,400	50.1%
Nebraska	33,700	63,500	53.0%
Nevada*	–	–	–
New Hampshire	19,300	65,500	29.5%

Table 2 cont'd.

Uninsured Population Served by Health Centers, 2011

State	Uninsured Patients Served in 2011	Total Patients Served in 2011	Percent of Patients That are Uninsured
New Jersey	196,500	454,200	43.3%
New Mexico	111,200	285,700	38.9%
New York	373,600	1,489,100	25.1%
North Carolina	214,200	411,000	52.1%
North Dakota	9,000	32,400	27.8%
Ohio	162,400	484,600	33.5%
Oklahoma	54,500	135,300	40.3%
Oregon	110,400	289,700	38.1%
Pennsylvania	164,900	637,900	25.8%
Rhode Island	39,000	123,100	31.7%
South Carolina	129,800	326,800	39.7%
South Dakota	21,300	58,000	36.7%
Tennessee	150,400	372,400	40.4%
Texas	501,300	975,500	51.4%
Utah	62,800	112,800	55.7%
Vermont	12,400	121,700	10.2%
Virginia	108,300	285,400	38.0%
Washington	278,400	794,500	35.0%
West Virginia	91,300	379,700	24.0%
Wisconsin	67,800	281,600	24.1%
Wyoming	7,500	18,000	41.6%
Total	**7,208,200**	**19,729,000**	**36.5%**

Source: Uniform Data System (UDS) 2011 data, Bureau of Primary Health Care, Health Resources and Services Administration, HHS.

* Nevada does not report data in the UDS because there are only two federally recognized health centers in the state. States are not required to report data in the UDS unless they have at least three federally recognized health centers.

Endnotes

[1] In most states, Medicaid will be available for people with annual incomes up to 138 percent of the federal poverty level ($15,415 for an individual and $31,809 for a family of four). People with incomes higher than this will be eligible to purchase health coverage through health insurance exchanges. Those with incomes between 138 and 400 percent of poverty will qualify for tax credits to help offset the cost of their premiums. A health insurance exchange will exist in every state. However, some states may not expand Medicaid, as the Supreme Court ruled that the Secretary of Health and Human Services is prohibited from withholding federal financial assistance for Medicaid in states that do not expand coverage.

[2] CVS Caremark, *CVS Caremark Research Finds 78 Percent of Consumers Who Qualify for Health Care Reform Subsidies Never Heard of State Insurance Exchanges* (Woonsocket, RI: CVS Caremark, June 2012), available online at http://info.cvscaremark.com/newsroom/press-releases/cvs-caremark-research-finds-78-percent-consumers-who-qualify-health-care-ref.

[3] Lake Research Partners, *Preparing for 2014: Findings from Research with Lower-Income Adults in Three States* (Washington: Robert Wood Johnson Foundation, June 2012), available online at http://www.rwjf.org/files/research/74456fullreport.pdf.

[4] Ibid.

[5] The degree to which outstationed eligibility workers are present in health centers varies significantly by state.

[6] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 2, Subtitle C, Section 2202.

[7] Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges," *Health Affairs* 30, no. 2 (2011): 228-235.

[8] National Association of Community Health Centers, *FQHC Prospective Payment System: Essential to the Health Center Model* (Washington: National Association of Community Health Centers), available online at http://www.nachc.org/client//Health%20Center%20PPS%20Fact%20Sheet_final.pdf, accessed on July 27, 2012.

[9] National Association of Community Health Centers, *Health Centers and Health Care Reform: Payment and Participation* (Washington: National Association of Community Health Centers, April 2010), available online at http://www.nachc.com/client/Health%20Reform%20Fact%20Sheet%20-%20Payment%20%20Participation.pdf.

[10] Eligibility is based on a number of factors in addition to income, including citizenship/immigration status.

[11] The Michigan Primary Care Association generated this estimate based on data from the Uniform Data System. They examined the populations that health centers in the state currently serve and estimated the number of people who have incomes below 138 percent of the federal poverty level, then multiplied that number by the state average revenue per visit and the average number of visits per patient per year.

[12] Leighton Ku, Emily Jones, Brad Finnegan, Peter Shin, and Sara Rosenbaum, *How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2009), available online at http://www.kff.org/healthreform/upload/7878.pdf.

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Available online at
www.enrollamerica.org

1201 New York Avenue NW, Suite 1100
Washington, DC 20005
Phone: 202-737-6340
Fax: 202-737-8583
Email: inquiries@enrollamerica.org
Website: www.enrollamerica.org