



Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage

A Case Study on West Virginia

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Key findings

- The Kanawha–Charleston Health Department is a strong advocate for outreach and enrollment in West Virginia.
- The Kanawha–Charleston Health Department educated stakeholders about Patient Protection and Affordable Care Act (ACA) implementation and publicly encouraged Medicaid expansion.
- The West Virginia Department of Health and Human Resources inROADS system permitted federally approved fast-track enrollment to make Medicaid enrollment more efficient.
- DHHR market research showed that programs should frame outreach and enrollment in terms of increased coverage and access to care and that in-person assisters (IPAs) should not reference terms considered politically sensitive, such as Obamacare or the ACA.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)¹ laid the groundwork for a substantial increase in the number of people who have access to health insurance through Medicaid expansion or health insurance marketplaces.² During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible people. Typically, federal and state funding was used to develop navigator programs in each state. The design of these programs differed by location,³ and, although many stakeholders were involved in these efforts, state and local health departments (LHDs) were, and remain, a relatively untapped resource.⁴ This is somewhat surprising, given that LHDs serve as trusted entities in communities, can reach the most-vulnerable populations, and have access to data and resources that might facilitate ACA outreach and enrollment.

This is one in a series of reports designed to highlight innovative models and best practices that leverage LHD involvement in ACA outreach and enrollment and to facilitate knowledge transfer to other geographic regions looking to leverage the full range of roles for LHDs in ACA outreach and enrollment. Potential roles include serving as a coordinator for community activities, being a trusted source of health care information for consumers, and leveraging community partners to increase capacity for outreach and enrollment. These reports identify compelling models for how LHDs can implement similar activities in their own communities. Further, they provide guidance and insight into the role LHDs can play now, and help redefine that role in the future, as states continue to

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enroll residents in health insurance coverage. Each case study was designed to capture nuanced differences in how health departments support these efforts in their communities, identify facilitators and barriers to these approaches, and develop lessons learned from these activities.

CONTEXT OF HEALTH CARE REFORM IN WEST VIRGINIA

West Virginia began exploring health care reform before the passage of the ACA. In 2006, a grassroots effort began in the state to pass health care reform legislation similar to that already enacted in Vermont and Massachusetts. Although the state legislature and governor did not support health care reform at that time, these early efforts established a foundation for education, advocacy, and partnership that have informed West Virginia's efforts to implement the ACA, including outreach and enrollment.

According to discussants, the ACA is a polarizing issue in West Virginia, and decisions about whether and how to implement it were politically sensitive. After the ACA was passed, administrators in the West Virginia state government researched different options for expanding health care coverage. After an actuarial study was conducted and state administrators, state legislators, and the governor debated the options, West Virginia created a partnership exchange model and expanded Medicaid in 2013. Many political decisionmakers in West Virginia considered a state exchange too costly and politically difficult to support because it was affiliated with the ACA, which has low overall support in the state. However, state elected officials and administrators supported Medicaid expansion because, according to the actuarial study, the expansion promised a \$14-to-\$1 return on investment.

In a partnership exchange, the federal government manages the exchange but the state coordinates plan management and consumer assistance, which, in West Virginia, the Office of the Insurance Commissioner conducted. The Office of the Insurance Commissioner received a \$1 million planning grant

and two level 1 establishment grants totaling approximately \$20 million.⁵ The Office of the Insurance Commissioner convened stakeholder meetings to inform West Virginia's partnership exchange and in-person assister (IPA) program. The Office of the Insurance Commissioner also contracted with MAXIMUS to oversee the IPA program.

West Virginia's outreach and enrollment efforts have been very successful. In one year, 147,000 out of 175,000 uninsured people enrolled in health insurance. About 86 percent of newly covered people received health insurance through Medicaid. Approximately 20,000 people enrolled in the partnership exchange. The state greatly exceeded its initial estimate of enrolling 63,000 uninsured people.

METHODS

Identification of Case-Study Sites and Activities

RAND researchers and National Association of County and City Health Officials (NACCHO) staff identified state and local health departments that represented a range of models for participation in outreach and enrollment activities. An initial environmental scan, which included literature reviews, website analysis, and semistructured interviews with national and local stakeholders, identified a range of activities. Discussions with key staff at 15 health departments were conducted to learn more about their specific approaches and to understand more about the community and population context. In consultation with staff at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), we selected seven sites that highlight a variety of models of LHD involvement and contexts in which the public health departments were operating. The sites reflect differences in expansion status, urbanicity, region, use of public health data, participation of public health in partnerships, and leadership by public health: Boston, Massachusetts; Eagle, Pitkin, and Garfield counties, Colorado; Houston, Texas; Illinois (state and local); New Orleans, Louisiana; Tacoma and Pierce County, Washington; and West Virginia (state).

Site Visits

Site visits were conducted over two- or three-day periods between June and October 2014 with LHD leadership or staff and other key players in regional outreach and enrollment efforts (e.g., health care systems, social services, community-based organizations, or state or local government officials). RAND and NACCHO staff conducted four of the case studies; RAND staff alone conducted two; and NACCHO staff alone conducted one. Prior to arriving on site, RAND and NACCHO staff conducted telephone and email discussions to coordinate logistics and plan the topics to be covered in the in-person meetings. The discussions used an open-ended discussion guide that provided a consistent structure to each interview while allowing sufficient flexibility to capture all relevant information from participants. Discussions focused on implementation strategy (e.g., outreach and enrollment activities, funding, partnerships, and resources), evaluation, sustainability, and replicability. In a few cases, follow-up phone calls were made to staff who could not attend the in-person meetings.

West Virginia Case Study

For West Virginia, the site visit took place September 17–18, 2014. Our team conducted seven meetings with representatives involved in outreach and enrollment activities, which included people from West Virginians for Affordable Health Care (WVAHC), West Virginia Department of Health and Human Resources (DHHR), the DHHR-sponsored Health Innovation Collaborative, Office of the Insurance Commissioner, West Virginia Hospital Association, West Virginia Primary Care Association, and Kanawha–Charleston Health Department. On September 17, 2014, the team also attended a meeting of a coalition made up of local and state entities that were engaged in outreach and enrollment across the state.

Rationale for Selecting This Case Study

We selected West Virginia as a case study for several reasons. First, West Virginia serves many rural communities, and this case study examines the challenge of engaging rural populations in outreach and enrollment. Second, the state used “fast-track” enrollment, which automatically enrolls in Medicaid anyone who participates in certain public programs. Third, at the state level, West Virginia demonstrated how collaboration and advocacy could result in the enrollment of 85 percent of its uninsured population. At the local level, the Kanawha–

Charleston Health Department demonstrated how local LHDs could advance the ACA through public health advocacy.

MODEL OF LOCAL HEALTH DEPARTMENTS' INVOLVEMENT AND HOW THEY CAME TO BE IN THIS ROLE

DHHR provides public health services at the state level, and 49 local LHDs serve counties throughout the state. DHHR is made up of the Bureau of Public Health, Bureau for Behavioral Health and Health Facilities, Bureau for Child Support Enforcement, Bureau for Children and Families, and Bureau for Medical Services (Figure 1). DHHR created the Health Innovation Collaborative, which consisted of partnerships with groups that supported ACA implementation, outreach, and enrollment. These major players included the WVAHC advocacy group, the Office of the Insurance Commissioner, hospitals, health plans, community health centers, the West Virginia Primary Care Association, and LHDs, such as the Kanawha–Charleston Health Department. Only a few of the local LHDs across the state, including the Kanawha–Charleston Health

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Department, had the capacity, leadership, and resources to support outreach and enrollment.

West Virginia had IPAs, certified application counselors, and navigators, all of whom helped people enroll in qualified health plans.⁶ The Office of the Insurance Commissioner received funding from the Centers for Medicare and Medicaid Services (CMS) to develop an IPA program. The office placed IPAs at the DHHR county offices. The DHHR county offices are extensions of the state DHHR and provide human services to counties. Community health centers received funding from the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) for certified application counselors. The federal government placed navigators in 105 organizations across the state,⁷ including the Kanawha–Charleston Health Department. Although the partnership did not choose the grantees, it did work to ensure that these organizations coordinated their activities.

OUTREACH AND ENROLLMENT OVERVIEW

DHHR, which includes public health at the state level, developed and led the use of fast-track enrollment and engaged in market research, cross-sector collaboration, and advocacy efforts that resulted in high enrollment. The Kanawha–Charleston Health Department, an active LHD in the state, was a key partner in advocating for public health and supporting outreach and enrollment.

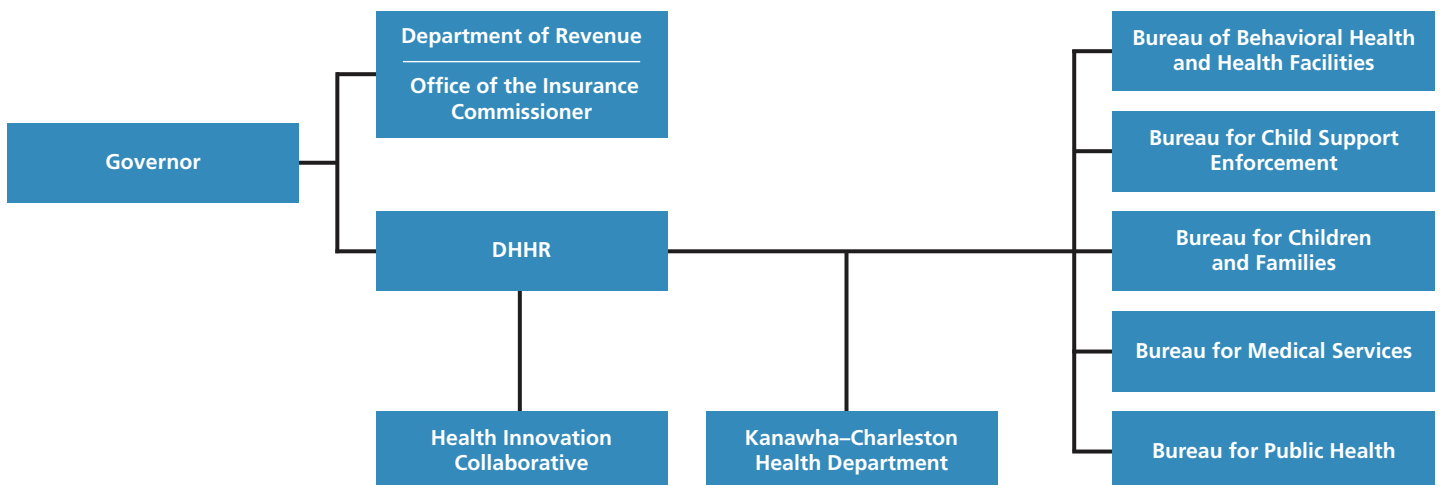
Support for Outreach and Enrollment Supported Fast-Track Enrollment

DHHR developed and managed Medicaid expansion using the CMS-approved fast-track enrollment, which allowed the state to quickly enroll people receiving Supplemental Nutrition Assistance Program (SNAP) and Children’s Health Insurance Program (CHIP) benefits. DHHR manages an online system, inROADS, that assesses individual eligibility and enrolls people in such programs as SNAP, CHIP, and Medicaid. Because SNAP, CHIP, and Medicaid all fall under DHHR and inROADS already existed prior to Medicaid expansion, West Virginia was able to quickly institute fast-track enrollment for those eligible for Medicaid under expansion. The DHHR fast-track process involved employees identifying people through inROADS, mailing letters to people informing them about their Medicaid eligibility, and calling eligible people and reminding them to enroll. Consumers then indicated whether they wanted to enroll in Medicaid. Fast-track enrollment resulted in approximately 70,000 new Medicaid enrollees.

Conducted Market Research

DHHR conducted market research on ACA implementation, which informed outreach and enrollment communication strategies. The research led decisionmakers to conclude that they should frame outreach and enrollment in terms of increased coverage and access to care and that IPAs should not reference “Obamacare” or the ACA. IPAs experienced instances in which people declined coverage even though they needed

State and Local Organizations Involved in Outreach and Enrollment in West Virginia



Even before the ACA became law, the Kanawha–Charleston Health Department worked on health care reform with DHHR, the Office of the Insurance Commissioner, Senator Rockefeller, and other stakeholders. As one participant stated, “We’ve been able to be proactive because we are out front. You can’t lead from behind.”

health insurance because they learned that it was associated with “Obamacare.”

Collaborated in Partnerships to Support Outreach and Enrollment

Representatives from DHHR and the Kanawha–Charleston Health Department actively participated in WVAHC and were key members of WVAHC’s Implementation Coalition. As one discussant stated, “Public health here has always been part of the safety net. We see ourselves as complementary and not competitive with others.” The Implementation Coalition worked to ensure that the ACA was successfully implemented across the state. The Kanawha–Charleston Health Officer also chaired the WVAHC Public Health Committee. WVAHC provided education to the public on the ACA through town meetings and training in communities across the state. WVAHC also created a citizen’s guide to enrollment. Further, WVAHC pooled \$150,000 from four foundations, which it used to provide minigrants to 31 nonprofits that were working on outreach and enrollment. WVAHC provided grantees with technical assistance and resources.

DHHR and the Kanawha–Charleston Health Department engaged in partnerships to support outreach, enrollment, ACA implementation, and overall improvements in health. DHHR created the Health Innovation Collaborative, which it structured around the triple aim of improved population health through better patient care at lower cost. The Health Innovation Collaborative created forums for experimentation and pilot-testing of ideas. The forums also improved knowledge exchange among different sectors, such as hospitals, health plans, Medicaid, public health, and primary care providers. A representative from the Kanawha–Charleston Health Department participated in the Health Innovation Collaborative.

DHHR and Kanawha–Charleston Health Department representatives also worked closely with the Office of the Insurance Commissioner and participated in stakeholder meetings that informed the design of the exchange. In all these state forums, the Kanawha–Charleston Health Department ensured that public health was represented and brought attention to health care reform as a public health issue.

The Kanawha–Charleston Health Department often hosted collaborative activities to support outreach and enrollment. The LHD hosted partnership meetings, WVAHC trainings, navigators, and celebrations involving Sen. Jay Rockefeller. Because the LHD is independent from state governance, the Kanawha–Charleston Health Department was able to host events that would be politically sensitive at the state level.

Educated Policymakers About Supporting ACA Implementation

The Kanawha–Charleston Health Department played a strong role in educating state policymakers about the importance of supporting ACA implementation. Even before the ACA became law, the Kanawha–Charleston Health Department worked on health care reform with DHHR, the Office of the Insurance Commissioner, Senator Rockefeller, and other stakeholders. As one participant stated, “We’ve been able to be proactive because we are out front. You can’t lead from behind.” In 2010, the LHD was a formal member of the committee charged with exploring a state-based exchange. The Kanawha–Charleston Health Department ensured that a public health officer would be eligible to serve on the board of the state health care exchange if such an exchange were created. When the state decided not to create a state-based exchange, the Kanawha–

Charleston Health Officer wrote an op-ed piece in the local newspaper encouraging the governor to expand Medicaid.

CHALLENGES TO OUTREACH AND ENROLLMENT

Medicaid expansion in West Virginia resulted in a large number of new enrollees; however, the partnership exchange did not meet the state's expectations because of four major challenges. Discussants shared that describing the exchange to consumers was difficult. Communication about the exchange was not as straightforward as explaining Medicaid expansion. Second, navigators, certified application counselors, and IPAs spent only a few hours each week out in the community and instead spent most of their time at county DHHR offices, hospitals, or community health centers. As a result, hard-to-reach populations were difficult to enroll. Third, only one qualified health care plan was offered through the exchange, and many consumers felt that it was not affordable. Perceived affordability could have been related to the reputation of the only qualified health care plan provider, Highmark, which is considered a high-quality and expensive health care plan in the state. People who were not eligible for Medicaid under expansion did not feel that they could afford Highmark's high premiums and cost-sharing. Finally, according to several discussants, "Obamacare" is unpopular in the state, which discouraged people from enrolling. Discussants described people working for the coal industry as particularly unsupportive of "Obamacare." In the first year, only 20,000 West Virginians enrolled in the exchange, not the expected 40,000 to 60,000 enrollees.

Although the Kanawha–Charleston Health Department played a strong advocacy role in ACA implementation, other LHDs in the state did not have the capacity, resources, or leadership to actively support outreach and enrollment. Only two of the 49 LHDs had full-time health officers, and many LHDs had only two or three employees. IPAs were housed in county departments of health and human services rather than LHDs because the county offices are considered "one-stop shops" for beneficiaries.

Even before the ACA became law, West Virginia explored health care reform to address the ill health of residents across the state. Discussants noted that West Virginia is fifth in health care spending in the United States but second to last in health outcomes in the country.

ENABLERS TO THE LOCAL HEALTH DEPARTMENTS' ROLE IN OUTREACH AND ENROLLMENT

The dire health conditions in West Virginia motivated leaders from different sectors to work together to support outreach and enrollment. Even before the ACA became law, West Virginia explored health care reform to address the ill health of residents across the state. Discussants noted that West Virginia is fifth in health care spending in the United States⁸ but second to last in health outcomes in the country.⁹ Members of the DHHR-sponsored Health Innovation Collaborative expressed their commitment to work together to improve the health of West Virginians.

Strong interpersonal relationships further supported outreach and enrollment. As one person noted, West Virginia is a "person-driven state." Most people in West Virginia have known each other for years and in diverse settings, thus forging strong bonds of trust. People involved in outreach and enrollment feel accountable to one another. A representative from the West Virginia Primary Care Association commented on how fast and responsive DHHR was in helping health centers determine the eligibility status of individual cases. DHHR employees also followed up by phone with each person who qualified

for Medicaid. Many outreach and enrollment efforts involved one-on-one interactions with consumers either by phone or in person. Coordination between DHHR and the Office of the Insurance Commissioner, and therefore between Medicaid and the partnership exchange, also succeeded because of strong relationships between leaders at various agencies.

The Kanawha–Charleston Health Department effectively advocated for public health’s role in health care reform because of its reputation in the community and in the state capital. Local health officials are seen as well-informed, credible, and trusted sources of information. Leaders at LHDs are well-connected with state elected officials and are the main players involved in ACA implementation.

FUTURE PRIORITIES: WHAT COMES NEXT?

West Virginia will work to enroll the hardest-to-reach people and to improve utilization of health care services. About 30,000 people in the state remained uninsured after the first enrollment period and are difficult to reach and enroll.

New strategies will have to be used to enroll these remaining uninsured. State and local leaders also focus efforts on helping people use health care. For instance, there are efforts to reduce emergency room use and to encourage healthy behaviors. As one person noted, “Access to care [alone] will not improve horrible statistics.”

DISCUSSION

This case study illustrates the role of public health in a rural state and the challenges and facilitators to enrollment. The case study also describes how state and local public health used existing resources, collaboration, and advocacy to achieve success in outreach and enrollment. The state succeeded in enrolling 85 percent of its uninsured in the first year by leveraging DHHR’s existing inROADS system to identify people eligible under Medicaid expansion. When challenges in outreach and enrollment arose, partnership organizations worked together to solve problems. Moving forward, the state faces the challenge of enrolling the hardest-to-reach uninsured people into qualified health care plans that many consider to be too expensive.

NOTES

¹ Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010. As of February 13, 2015:
<http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html>

² A health insurance marketplace, also sometimes called an exchange, is a resource to help consumers choose and enroll in health insurance plans. Some states operate their own marketplaces, and others use the federal marketplace, called the Health Insurance Marketplace, to help their residents get coverage.

³ Enroll America, “Certified Application Counselor Program: Early Lessons,” Washington, D.C., June 2014. As of February 13, 2015:
<http://www.enrollamerica.org/certified-application-counselor-program-early-lessons/>

⁴ National Association of County and City Health Officials, *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014. As of February 13, 2015:
<http://www.naccho.org/topics/research/forcesofchange/upload/Navigators.pdf>

⁵ Henry J. Kaiser Family Foundation, “State Marketplace Profiles: West Virginia,” updated October 24, 2013. As of April 24, 2015:
<http://kff.org/health-reform/state-profile/state-exchange-profiles-west-virginia/>

⁶ IPAs, certified application counselors, and navigators help consumers determine their eligibility for and enroll in marketplace insurance. The three types of roles differ in terms of how they are funded (e.g., state or federal grant), how they are trained, and whether they are located in states with federally facilitated partnerships, state partnerships, or state-based marketplaces. For more information, visit Centers for Medicare and Medicaid Services, “Assistance Roles to Help Consumers Apply and Enroll in Health Coverage Through the Marketplace,” Product 11647-P, July 2013. As of April 24, 2015:
<https://www.cms.gov/cciiio/resources/files/downloads/marketplace-ways-to-help.pdf>

⁷ West Virginia Hospital Association, “WV Health Insurance Navigators Helping Uninsured Explore Their Options,” *WVU Health News*, November 19, 2013. As of April 24, 2015:
<http://www.wvha.org/Media/NewsScan/2013/November/11-19-WV-health-insurance-Navigators-helping-unins.aspx>

⁸ United Health Foundation, “Public Health Funding: West Virginia—Rank: 5,” undated. As of April 24, 2015:
http://www.americashealthrankings.org/WV/PH_Spending

⁹ United Health Foundation, “All Outcomes: West Virginia—Rank: 48,” undated. As of April 24, 2015:
<http://www.americashealthrankings.org/WV/Outcomes>

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