ACE TA Center
2015 Needs Assessment Report

March 2016

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ACE
AFFORDABLE CARE ENROLLMENT
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Report Highlights

Though two years have passed since the first Open Enrollment period, challenges and barriers still exist for enrolling and retaining people living with HIV (PLWH), especially PLWH of color, in affordable, high-quality health insurance coverage. The Affordable Care Enrollment Technical Assistance Center (ACE TA Center) conducted needs assessments in 2013 and 2015 to collect data on Ryan White HIV/AIDS Program (RWHAP) recipients' and sub-recipients' successes and challenges with helping clients enroll in health coverage. The key findings and implications were:

#1: There was an increase in self-reported enrollment and re-enrollment capacity.

RWHAP grant recipients and sub-recipients have increased their capacity for both enrollment and re-enrollment activities since the first Marketplace Open Enrollment period in 2013. There was also an increase in the percentage of respondents who said their organization was familiar with Affordable Care Act (ACA) and coverage policies for PLWH in their state, and improved familiarity with policies related to using the appropriate RWHAP service categories for outreach, benefits counseling, and enrollment activities.

#2: Grant recipients and sub-recipients are using data to target enrollment efforts.

A majority of respondents said that they used program data to help with enrollment activities, and most said that they created lists of clients who are eligible for coverage but had not yet enrolled. Still, RWHAP grant recipients and sub-recipients can expand how they use their enrollment data to track activities and progress in engagement, enrollment, and retention in coverage, and identify populations in particular need of assistance.

#3: Challenges and barriers to enrollment still exist.

Respondents expressed the following challenges:

- Staff have limited time and training.
- Clients need support in building health insurance literacy, assessing plan affordability, and understanding the enrollment process.
- External enrollment organizations have limited capacity to assist PLWH.
- Clients mistrust the healthcare system.
- Environmental and societal barriers affect initial health coverage enrollment and long-term coverage.

In light of these barriers, there remains a demonstrated need for training, technical assistance (TA), and education of case managers and other program staff. Training and TA should focus on ACA basics, health insurance literacy, and culturally competent ways to support clients through the entire enrollment process, starting with engagement and ending with using their coverage.

Both nationally-focused and targeted training and TA should be driven by an understanding of the diverse needs and contexts of RWHAP grant recipients and sub-recipients.

Enrollment activities at the local level are greatly affected by whether a state has expanded Medicaid, whether grant recipients are able to provide clients with support for premiums and/or out-of-pocket costs, how many clients continue to need RWHAP core medical services, and what resources grant recipients are able to allocate to coverage completion services such as medical case management, transportation, housing, and food.

The RWHAP can continue to provide critical support in both expansion and non-expansion states through coverage completion services; coverage for medications and HIV medical care when there are coverage gaps, and support for premiums and out-of-pocket costs. Together, all of these resources can help keep people in care with improved rates of viral suppression.

Introduction

Today, more than 1.2 million Americans are living with HIV, with a disproportionate number being people of color.[1] Blacks/African Americans account for an estimated 44% of new HIV infections, while they represent only 12% of the U.S. population. Hispanics/Latinos are also disproportionately affected, accounting for 21% of new infections while representing 17% of the U.S. population.[2]

As the third year of Open Enrollment for the Affordable Care Act (ACA) begins, uninsured rates for Blacks and Hispanics in the general population remain higher than for whites: around 30% for Hispanics, 12% for Blacks, and 8% for whites.[3] Furthermore, more than half of states that have not yet expanded Medicaid under the ACA are located in the South, where 90% of people in the Medicaid coverage gap reside[4] and a large share of uninsured Black adults reside. Because of these factors, 24% of uninsured Black adults fall into the Medicaid gap, compared to 11% of white uninsured adults.[5] The South also accounts for 45% of new AIDS diagnoses.[6]

Serving over half a million people living with HIV (PLWH), the Ryan White HIV/AIDS Program (RWHAP) is a payer of last resort for almost half of the U.S. population living with HIV.[7] During the first ACA Open Enrollment period in 2013, RWHAP grant recipients and sub-recipients began enrolling PLWH served by RWHAP into ACA health insurance plans. The Affordable Care Enrollment Technical Assistance Center (ACE TA Center) was funded in September 2013 as a cooperative agreement with the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) to help RWHAP grant recipients and sub-recipients enroll diverse clients, especially people of color, in health insurance.

In 2013, the ACE TA Center launched its first needs assessment to collect data on RWHAP grant recipients' and sub-recipients' successes and challenges in helping clients enroll in health coverage. The key findings from that assessment were (1) there was limited knowledge of and experience with enrollment among RWHAP service providers, (2) PLWH face barriers accessing care, and (3) communication and coordination are needed for enrollment activities.

Two years after the project began, the ACE TA Center conducted a second assessment to learn about how these challenges and barriers may have changed since 2013 given the completion of two Open Enrollment periods. Grant recipients and sub-recipients were asked to share success stories about their enrollment efforts, identify how the RWHAP community has used the ACE TA Center, and identify ongoing training and TA needs. This report presents information and findings from the 2015 assessment.

A total of 172 organizations responded to the assessment, representing 41 states, plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. In total, respondents reported:

- Serving 159,659 clients in the 2014 calendar year, with 53,001 clients that were uninsured at any point during the year;
- Enrolling 14,567 new clients in a 2014 ACA insurance plan;
- Enrolling 12,724 new clients in Medicaid (both expanded and not expanded).

While results may not be fully representative of all RWHAP grant recipients and sub-recipients, assessment respondents were reflective of RWHAP organizations nationally in terms of geographic distribution, Medicaid expansion status, Marketplace type, workplace setting (e.g., health department, community health center, etc.), and the distribution of RWHAP Parts. For detail on the assessment methods, see Methods document.

The terms "grant recipient," "recipient," "sub-recipient," and "service provider" are used throughout this report. "Grant recipient" and "recipient" both refer to RWHAP directly-funded organizations, and are used interchangeably. "Sub-recipient" refers to organizations that are funded by grant recipients to provide RWHAP services. "Service providers" refer to organizations that provide RWHAP services directly to clients and may apply to grant recipients and/or sub-recipients.

Key Findings

FINDING #1

There was an increase in self-reported enrollment and re-enrollment capacity.

RWHAP grant recipients and sub-recipients have increased their self-reported enrollment and re-enrollment capacity since the first ACA open enrollment period in 2013.[8] The median enrollment capacity score increased by eight points from 75 to 83, though it was not a statistically significant change. The median re-enrollment score increased by 11 points from 67 to 78 ($p<0.0029$). Given that organizations were only doing enrollment in 2013 (not re-enrollment), this change is not surprising. The 2015 enrollment and re-enrollment capacity scores did not vary by Medicaid expansion status.

TABLE 1. Cross-sectional comparison of median capacity scores from 2013 to 2015

	2013		2015		CHANGE IN MEDIAN SCORE	P-VALUE
	N	MEDIAN (IQR)	N	MEDIAN (IQR)		
Enrollment capacity score	145	75 (67, 92)	131	83 (58, 100)	+8	NS
Re-enrollment capacity score	143	67 (44,85)	131	78 (56, 93)	+11	0.0029

NS = not significant

More organizations have assisters on staff and report improved policy understanding.

Fifty-five percent of respondents said that they had staff with enrollment assister certifications within their organization in 2015, compared to 41% in 2013 (p=0.0179). In 2015, most respondents (79%) said their state AIDS Drug Assistance Program (ADAP) evaluated qualified health plans to determine which ones are preferable for PLWH.

In addition, there was an increase in the percentage of respondents who said their organization was familiar with the policies related to:

- Using the appropriate RWHAP service categories for outreach, benefits counseling, and enrollment activities (86% in 2013 vs. 94% in 2015; p=0.0064).
- ACA/Marketplace and coverage policies for PLWH in their state (87% in 2013 vs. 94% in 2015; p=0.0304).

Low capacity respondents reported that their capacity had not changed since 2013, they had fewer resources for enrollment, and they lack knowledge about ACA basics.

A total of 27 respondents had a low enrollment capacity score (defined as below the 25th percentile). These respondents were geographically diverse, but most of them were from Medicaid expansion states (77%). Compared to moderate and high capacity direct service providers, a higher percentage of low capacity direct service providers said they had the same capacity as they did in 2013 for all enrollment activities, which included ACA basics, helping clients use their health insurance coverage, understanding the enrollment process, and health insurance plan renewals.

FINDING #1 (continued)

Table 2 shows differences between the low, moderate, and high enrollment capacity groups. Compared to the moderate and high capacity groups:

- A **higher** percentage of the low capacity group said their organization has no staff members with enrollment assister certifications;
- A **higher** percentage of these respondents said their organization refers clients to external organizations for enrollment;
- A **lower** percentage of these respondents said they use data in their enrollment efforts;
- A **lower** percentage of these respondents said they document client challenges in using their coverage;
- A **higher** percentage of these respondents said one of the top five most challenging aspects of enrollment was lack of knowledge of ACA health coverage options; and
- A **higher** percentage of these respondents said one of their top five TA needs was ACA basics.

The 2015 assessment also identified key differences between respondents from Medicaid expansion states versus non-expansion states:

- 86% of respondents from expansion states rated their organization as having high capacity in knowing how RWHAP (and ADAP) may be able to help clients pay for health insurance and related expenses, compared to 67% of respondents from non-expansion states (p=0.0159).
- 23% from expansion states said that they had low capacity in helping clients compare premiums and out-of-pocket costs for coverage options, compared to only 6% from non-expansion states (p=0.0459).
- Finally, 79% of expansion state respondents said that they had high capacity in helping clients select primary care and specialty providers, compared to 57% from non-expansion states (p=0.0396).

These questions were not asked in the 2013 assessment.

TABLE 2. Among direct service providers, differences by enrollment capacity (n=131)

	LOW CAPACITY (N=27)	MODERATE CAPACITY (N=68)	HIGH CAPACITY (N=36)	P-VALUE
Our organization has no staff members with enrollment assistor certification	70%	32%	24%	0.0013
Our organization refers to external organizations for enrollment	58%	22%	3%	<0.0001
Our organization received additional funds to help with ACA enrollment	25%	19%	61%	0.0081
Our organization uses data for enrollment efforts	61%	82%	94%	0.0087
Our organization documents client challenges in using their coverage	37%	63%	72%	0.0435
Lack of knowledge of ACA health coverage options is one of the most challenging aspects of enrollment	45%	17%	6%	0.0010
ACA basics is a top TA need for our organization	39%	20%	7%	0.0144

Successful enrollment strategies included collaboration, hiring or training staff as enrollment assisters, and partnering with navigator organizations.

Respondents were asked to share resources that they found helpful and their most successful enrollment strategies. These strategies included:

- Providing materials and information to staff and consumers
- Cross-grantee collaboration and stakeholder partnerships
- Hiring new staff or training existing staff as enrollment assisters (e.g., Certified Application Counselors (CACs), navigators, in-person assisters, or eligibility assisters) to provide one-on-one enrollment support
- Partnering with other navigator organizations

FINDING #2

Grant recipients and sub-recipients are using data to target enrollment efforts.

About one-quarter (24%) of respondents are directly funded by RWHAP but do not provide direct services themselves, and instead contract with sub-recipients for service delivery.

Among these recipients, 80% said they use data to help with enrollment activities. Most of these (82%) said they create lists of clients not yet enrolled. All (100%) of the respondents from non-expansion states who use data for enrollment efforts said that they created lists of clients who were not yet enrolled, compared to 68% from expansion states (p=0.0201).

This is likely because in states that have expanded Medicaid, nearly all clients would be eligible for coverage either under Medicaid or through the Marketplace. In non-expansion states, on the other hand, providers need to make a more concerted effort to identify clients who are eligible for Marketplace subsidies and/or clients for whom they can offer additional support (e.g., paying premium and/or out-of-pocket expenses).

> *"Providing clear guidance on ACA and what clients qualify for (handouts, charts); in-person meetings with case managers; working with a navigator organization by referring RW clients to them, and educating navigators on recommended coverages for RW clients."*
>
> - Part B grant recipient

> *"Maintaining regular communication with our providers has been key. We have conducted specific ACA trainings, and included ACA updates in other trainings. Additionally we have emailed updates to providers including regular updates in our […] newsletter. We have also sent letters to case managers with specific information about which clients are eligible for and need to enroll in Medicaid or a Marketplace plan."*
>
> - Part B grant recipient

Similarly, 72% of direct service providers said their organization uses data for enrollment activities and 80% of those create lists of their RWHAP clients who are not yet enrolled, according to their organization's records. Among direct service providers who use data to help with enrollment activities, a higher percentage from non-expansion states said that they looked at demographic data to see who might need additional support, compared to those from expansion states (58% vs. 27%; p=0.0040).

Almost two-thirds (61%) of respondents said their organization documented client challenges with the enrollment process, and of these, more than half (56%) said they informed their state RWHAP program of these challenges. Some respondents said that they track trends in those who fail to enroll and have an "in-reach" list of clients to focus on for enrollment activities. However, there are ways in which respondents were not routinely using data to monitor or improve engagement, enrollment, or retention in coverage. For example, a smaller proportion of grant recipients who contract with direct service providers (55%) and direct service providers themselves (38%) indicated that they were reviewing demographic data (e.g., race, ethnicity, age, etc.) to identify groups of clients that may need additional enrollment support. Further, just over one-quarter (27%) of grant recipients who contract with other organizations to provide services and 12% of direct service providers reported running reports on other data, including poverty level, current insurance coverage, claims, and where clients are receiving care.

> *"[…] we routinely discuss ACA challenges and resources and pass along strategies that work when dealing with call center or website, as well as keeping track of trends for those failing to enroll successfully."*
>
> - Part C, D grant recipient

FINDING #3

Challenges and barriers to enrollment still exist.

Nearly all respondents (91%) identified specific TA needs related to enrollment activities, and many provided qualitative feedback about the types of challenges they were facing.

The top five most challenging aspects of enrollment for direct service providers were:

- Lack of information about tax credits and tax filing (42%)
- Lack of staff to conduct activities (35%)
- Trouble helping clients submit all of the required documents for enrollment (35%)
- Challenges with the state and federal (e.g., healthcare.gov) enrollment websites (32%)
- Communication challenges at the state level (e.g., coordination between Medicaid and state RWHAP Part B) (27%)

Additionally, a number of open-ended questions asked respondents to further describe the challenges and barriers they encounter with their enrollment activities.

The key themes were:

- Staff have limited time and training.
- Clients need support in health insurance literacy, assessing plan affordability, and understanding the enrollment process.
- External enrollment organizations have limited capacity to assist PLWH.
- Clients mistrust the healthcare system.
- Environmental and societal barriers affect initial health coverage enrollment and long-term coverage.

Staff have limited time and training.

Respondents expressed challenges related to staff capacity, including lack of expertise in health insurance literacy, lack of dedicated on-site enrollment staff, lack of time for enrollment, limited staff knowledge about ACA, limited time for or availability of training, and staff turnover. Grant recipients who contract with other organizations to provide services also reported that their sub-recipients have limited funds to train their staff, and the capacity of existing staff to perform enrollment activities is limited.

> *"**We need funding to support enrollment staff positions and capacity building among the entire clinic staff.** Traditional staff positions (NPs, Social Workers, RNs, LVNs, etc.) cannot be expected to pick up the responsibility of helping clients with benefits navigation. The systems either need to be better coordinated so that clients can navigate them on their own, or we need additional staff who focus exclusively on benefits issues. The administrative burden of the ACA is far too great."*
>
> - Part A service provider

> *"Our sub-grantees usually manage multiple programs, and do not focus solely on RW. **Time spent on training, as well as time spent with clients is an issue**, so most of our case managers refer clients to see navigators to get them enrolled in coverage."*
>
> - Part B grant recipient

> *"The necessary training for staff who are unfamiliar with insurance coverage, client/staff understanding of cost, copay, deductible, out-of-pocket expenses etc. And the staffs/client knowledge to have the right information in order to make the best plan selection."*
>
> - Part A, B service provider

FINDING #3 (continued)

Clients need support in health insurance literacy, assessing plan affordability, and understanding the enrollment process.

Respondents said that clients need support understanding the ACA, including the importance of insurance, and health insurance literacy, specifically being able to evaluate health plans to select the best plan and then using the plan after enrollment.[9] In addition, respondents said clients are concerned about affordability and costs of ACA plans, and reported that clients have trouble keeping track of their paperwork and submitting the documents required for enrollment.

> *Our organization trains and supports case managers and benefits staff who enroll PLWH into health insurance. Challenges include the complexity of health care reform and the range and number of documents needed to apply, as well as the large number of potential plans to research and choose from.* ***Many clients and case managers lack confidence in navigating the health insurance marketplace. […]"***
>
> - Part A, B service provider

> *[…]* ***Many of our patients failed to recertify in 2014 and as such lost their insurance.*** *Education related to the need for recertification and prompt completing of required documentation is an ongoing challenge."*
>
> - Part A, B service provider

> *The greatest challenges our organization has faced in engaging and educating PLWH about ACA health coverage options have been clients'* ***limited literacy levels*** *and the length of time necessary for our state RWHAP office to approve client applications."*
>
> - Part C, D grant recipient

> *Whether it is a language barrier or reading and writing comprehension, many need a great deal of assistance navigating the path to healthcare insurance."*
>
> - Part C, D grant recipient

> ***Eligibility, cost and fear that continuity of care will be an issue****, challenge in navigating complicated and evolving health system including insurance plans, lack of education around utilization of services and benefits."*
>
> - Part C, D & F grant recipient

External enrollment organizations have limited capacity to assist PLWH.

Organizations that work with external enrollment assisters said that these external organizations had limited capacity to assist clients because they may not know enough about HIV to assist with plan selection. They also noted that enrollment support ends after the Open Enrollment period. Respondents reported that clients have not developed trusting relationships with these external organizations and have concerns about disclosing their HIV status. Logistics were also mentioned as a challenge in terms of lack of space for the external organization to sit on-site and the availability of enrollment assisters during office hours.

> *Having to refer out for enrollment into ACA.* ***People don't want to go elsewhere, they don't want another appointment, they don't want to identify as HIV positive to someone they don't know.*** *They don't understand why they are being referred to someone else."*
>
> - Part B service provider

> *Largely logistical - we don't really have space to accommodate extra staff, so the person is in a small room off to the side, etc."*
>
> - Part A service provider

Clients mistrust the healthcare system.

RWHAP clients, particularly clients of color, may have had prior negative experiences with the healthcare system and fear cultural/social stigma and discrimination. Additionally, RWHAP clients may not want to transition from a trusted provider when they move to a new insurance plan.

> *Clients are resistant [to enrolling in ACA coverage options] as RW coverage covers all HIV care. The ACA products require them to pay a share of cost for office visits and prescriptions. The RW Part A grantee has received approval to use Part A funds to cover these costs, but after 2 years has been unable to implement a process to do so."*
>
> - Part C, D grant recipient

> *Minorities have a general distrust of medical systems or have had prior negative experiences. They may not recognize that health insurance will help with other medical issues."*
>
> - Part B grant recipient

FINDING #3 (continued)

Immigrants specifically may be nervous about disclosing their citizenship status or that of an undocumented family member. Immigration issues were mentioned more often among respondents from expansion states than among non-expansion states. A possible explanation for this may be that in expansion states most people are eligible for Medicaid or Marketplace coverage so this disparity may be more salient, while in non-expansion states a variety of clients are ineligible for coverage, including clients that are too poor to qualify for Marketplace subsidies.

> *"[They] are afraid of jeopardizing] their chances of getting permanent residency later and don't pursue coverage."*
>
> - Part B Service Provider

> *"**Undocumented clients are nervous about disclosing their citizenship status.** Only one insurance carrier enrolls clients without SS numbers. They wanted to request additional documentation from these clients but backed down when issue was taken to the Insurance Commissioner."*
>
> - Part B grant recipient

> *"Being a provider in a Hispanic immigrant community, one of the challenges we face is that of providing health insurance access to our undocumented clients without a valid social security and/or legal immigration status. Additionally, **the fear and stigma related to immigration status is also a barrier to engagement of the community in enrolling in a governmental program**."*
>
> - Part A service provider

Environmental and societal barriers affect initial health coverage enrollment and long-term coverage.

Respondents said that poverty was an issue not only in terms of plan affordability, but also as a contributor to challenges completing and submitting enrollment applications.

> *"**PLWH of color are disproportionately affected by poverty,** so it can be harder to reach them (lack of access to housing, phones) to complete the enrollment."*
>
> - Part C, D grant recipient

> *"[…] those who do not qualify for state Medicaid; however, **[they] still do not make enough to pay monthly premiums**, let alone the (deductible, coinsurance, and co-pay) fees. This is why some are opting out of ACA."*
>
> - Part A service provider

> *"We found a great number of clients that **did not have an email address needed for creating online accounts.** In some cases, something as simple as a working phone was an issue, a problem that consistently impacts our client population. Even with access to technology, **clients have struggled to understand the applications** […] We saw clients having difficulty showing proof of income and residency. Many clients who are uninsured work small odd jobs and **have difficulty providing documentation of their earnings.**"*
>
> - Part C, D grant recipient

These challenges extend beyond the initial enrollment process and include supporting clients in ongoing education around using their benefits and staying enrolled.

> *"After the initial education and enrollment period there are several follow-up questions if and when a patient receives a bill for a service not covered by the insurance plan. An example is labs."*
>
> - Part A service provider

Affordability issues were emphasized more frequently in open-ended comments among non-expansion states compared to expansion states. There are a variety of possible explanations for this, including the number of clients that are in the Medicaid gap, differences between available plan options in terms of costs and coverage, and complexities related to communication about the benefits of health coverage in non-expansion states.

Structural barriers, such as geography, transportation, and housing, were also highlighted as limitations to accessing care.

> *"Generally, **access to housing, food, family resources, phone service, clothing, etc., takes precedence over insurance access** and expanded healthcare options."*
>
> - Part A service provider

> *"Transportation to services is the biggest barrier to care of our clients in general but it has been a significant barrier for our clients of color."*
>
> - Part C grant recipient

Training and Technical Assistance Needs and Implications

Top Training and TA Needs

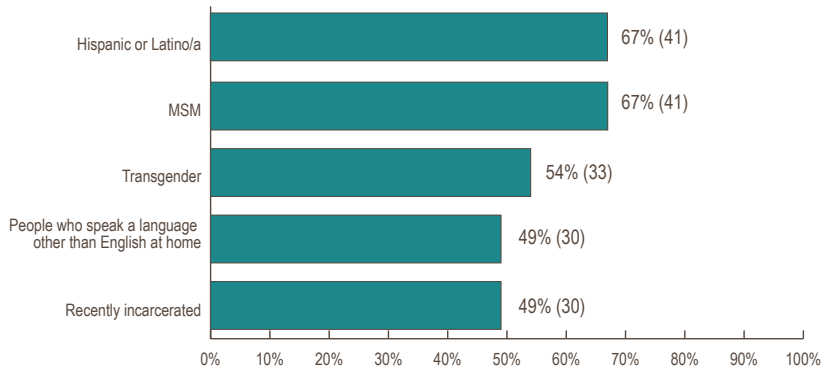
Respondents were asked to report on their enrollment-related training and TA needs, both overall and for specific populations. Almost three-quarters of the respondents said that they had training and TA needs for PLWH of color (70%).

The top needs were:

- Information about immigration and the ACA (50%);
- How to address client mistrust of the healthcare system (50%); and
- Population-specific enrollment materials and/or strategies (50%).

Figure 1 shows the top five populations chosen among those who said they needed population-specific enrollment materials. All three of these needs were also identified as themes in the findings from the 2013 needs assessment. Almost half of direct service providers in the first assessment reported that clients' fears related to immigration status and previous negative experiences with insurance were challenges for enrollment.

FIGURE 1. Specific populations, among those who needed tailored materials (n=61)

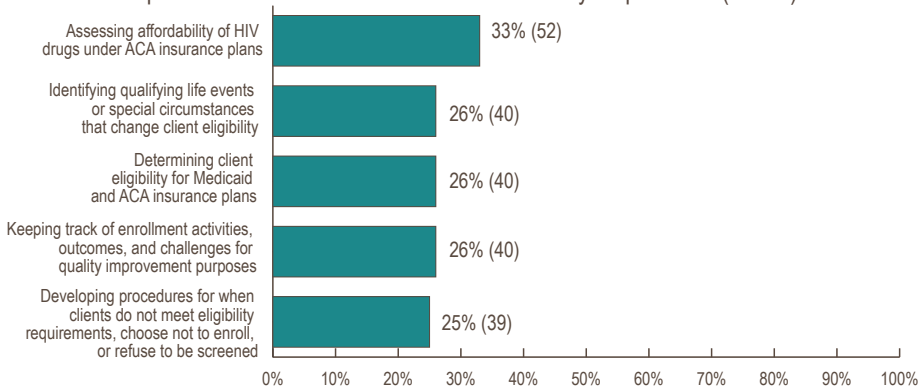


In addition, the majority said that tailored materials would be very helpful for male clients who have sex with men, clients who prefer a language other than English, and transgender clients.

In a related finding from 2015, many organizations provided cultural competency training within the last year (71%). Among those that provided training, over two-thirds trained all staff (69%). Clinical staff and front desk staff were less likely to receive training compared to case managers and program leadership.

The five most popular TA needs are shown in **Figure 2.** Affordability of HIV drugs under ACA plans was the top TA need at 32%, but it was followed by four equally popular topics that included understanding Special Enrollment Periods, determining eligibility, tracking enrollment activities, and developing procedures when clients choose not to enroll or are ineligible for coverage.

FIGURE 2. Top five technical assistance needs identified by respondents (n=156)



Implications and Next Steps

Challenges and barriers still exist for enrolling and retaining PLWH, especially PLWH of color, in affordable, high-quality health insurance coverage. Many of these challenges provide opportunities for further exploration and discussion:

- While there has been some increase in the capacity among RWHAP recipients and sub-recipients for both enrollment and re-enrollment, there remains a demonstrated need for training and education of case managers and other program staff. TA providers should continue to provide training and education in the areas of engagement, enrollment, plan renewals, helping clients stay enrolled in coverage, and using coverage. Such training should focus on ACA basics, health insurance literacy, and culturally competent ways to support clients throughout the enrollment process from discussing fears and concerns to maintaining affordable, appropriate coverage in the long term.
- Resources to support ACA outreach and enrollment should continue to emphasize training for enrollment assisters who may not routinely work with PLWH on the needs of RWHAP clients, including support for RWHAP providers to train partner organizations that are doing this work. The importance of one-on-one assistance, particularly for underserved communities, is a best practice for successful outreach and enrollment.[10] Coordinated dissemination of information and resources can help enrollment assisters learn to work with RWHAP clients and other PLWH to identify health insurance plans that meet their needs for affordability, as well as medication and provider coverage.
- RWHAP recipients and sub-recipients are creating lists of clients to monitor which clients are enrolled and which clients are eligible for coverage, but are not necessarily using enrollment data to their full advantage. Among other opportunities, enrollment data can be used to track activities and progress in engagement, enrollment, and retention in coverage; identify populations in particular need of assistance; inform organizational quality improvement efforts and planning for future enrollment activities; and demonstrate the impact of coverage on client health outcomes.
- Both nationally-focused and targeted TA strategies should be driven by an understanding of the diverse needs and contexts of RWHAP recipients and sub-recipients. There are substantial differences between states that have not yet expanded Medicaid and those that have. Within states, insurance plan options and RWHAP resource availability can vary. In particular, it will be important to pay particular attention to variations in whether grant recipients are able to provide premium and/or out-of-pocket support, how many clients continue to require core medical services through the RWHAP, and what resources recipients are able to allocate to coverage completion services such as medical case management, transportation and housing.
- The RWHAP can continue to provide critical support in both expansion and non-expansion states through coverage completion services such as medical case management, transportation, housing, and food; coverage for medications and HIV medical care when clients have coverage gaps; and through support for premiums and out-of-pocket costs. Together, all of these resources can help to keep people maintained in care with improved rates of viral suppression.

The ACE TA Center already has a number of existing tools and resources available to help grant recipients and sub-recipients with the challenges, barriers, and TA needs. Findings from this needs assessment, as well as from ongoing conversations with RWHAP grant recipients and sub-recipients, HRSA staff, and national partners, will inform future ACE TA Center activities. The ACE TA Center will continue to develop, disseminate, and promote resources; build capacity through webinars and training; and work with grant recipients and HRSA staff to expand outreach to sub-recipients.

For more information, go to targethiv.org/ace

Endnotes

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6 CDC, HIV and AIDS in the United States by Geographic Distribution. June 2012. Available at: http://www.cdc.gov/hiv/pdf/statistics_geographic_distribution.pdf

7 Ryan White HIV/AIDS Program 2012 State Profiles. 2012. Available at: http://hab.hrsa.gov/stateprofiles/Client-Characteristics.aspx

8 We conducted a cross-sectional comparison of the 2013 and 2015 enrollment capacity scores. Because the analysis was cross-sectional, the findings depend on who responded in each year; however, this analysis can identify general patterns in enrollment capacity among RWHAP-funded organizations. Each score was re-created to include only questions that were comparable across both of the assessments. For the enrollment score, 4 questions matched across the years; for the re-enrollment score, 9 questions matched. Both scores were standardized on a 0 to 100 scale for both years. The scores were not normally distributed and were compared using the non-parametric Wilcoxon-Mann-Whitney test.

9 Enroll America. February 2012. Health Insurance Literacy Resource Hub. Available at: https://www.enrollamerica.org/hil/

10 Enroll America. In-Person Assistance Maximizes Enrollment Success. March 2014. Available at: https://www.enrollamerica.org/in-person-assistance-maximizes-enrollment-success/