ACE TA Center
2015 Needs Assessment Methods

March 2016

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ACE
AFFORDABLE CARE ENROLLMENT
TA CENTER

Methods

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 Ryan White HIV/AIDS Program (RWHAP) grant recipients and sub-recipients enroll diverse clients, especially people of color, in health insurance.

When the project began in 2013, the ACE TA Center conducted an initial training and technical assistance (TA) needs assessment. In 2015, the ACE TA Center conducted a second needs assessment to learn about how these challenges and barriers may have changed since 2013 given the completion of two Open Enrollment periods. Grant 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.

After being piloted by five RWHAP organizations from Colorado, Arizona, Texas, Rhode Island, and New York, the needs assessment was available to all RWHAP grant recipients and their sub-recipients from June 9 to August 12, 2015. The tool included the following domains:

- Respondent characteristics
- Familiarity with policy requirements
- Providing support to RWHAP-funded service providers
- Helping clients enroll in and use their coverage
- Training and TA needs

Open-ended questions were coded using standard, manual qualitative techniques. Responses were reviewed, coded, and grouped by theme. During quantitative data analysis, responses were stratified by respondents' state Medicaid expansion status, type of state Marketplace (Federally-facilitated, State-based or Partnership), RWHAP grantee type, and organizational enrollment and re-enrollment capacity scores.

Direct service providers were asked to rate their organization's capacity to implement a series of key enrollment and re-enrollment activities. An enrollment capacity score was developed by summing the capacity scale items (1=low capacity, 2=moderate capacity, 3=high capacity) for the enrollment activities (see **Table 1**), and a re-enrollment capacity score was developed similarly for the re-enrollment activities. Those who said they did not do the activity or provide the service were given a value of 0. All analysis was performed in SAS 9.4 (SAS Institute, Cary, NC) and differences were considered significant if the p-value was less than 0.05.

The capacity scale items were based on the ACE TA Center best and promising practices for engagement and enrollment. **Table 1** shows these key measures in the assessment. Respondents could answer low capacity, moderate capacity, high capacity, or do not offer.

TABLE 1. Capacity scale measures

ENROLLMENT	RE-ENROLLMENT/RENEWAL AND USING COVERAGE
Staff can help clients understand ACA health coverage eligibility and options, including costs and medication coverage	Notify clients about upcoming renewal requirements, including time frame and process
Staff can help clients assess the appropriateness of available health insurance plans based on their individual needs.	Help clients compare lists of prescription drugs covered by available coverage options
Staff can help clients compile the documentation needed for the application process	Help clients change health insurance plans
Staff can help clients complete the application process	Assist clients that move on/off ACA health coverage
Staff provide information to clients on how to challenge denials of coverage or coverage limits (appeal process)	Help clients report changes outside of the enrollment period (e.g., income, household size)
	Help clients interpret documents from an insurance company
	Help clients select primary care and specialty providers
	Educate clients about their ACA health coverage benefits and how to use them

NOTE: The 2013 needs assessment was open during the first Open Enrollment period, so many respondents rated their capacity for activities that they may not have done or tried to do before.

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Assessment limitations included the following:

- There may be response bias because the questions were based on self-report by a respondent representing an organization. The extent to which reported responses represent reality at that organization is unknown.
- The response rate was low, at 18% overall for directly-funded grant recipients; however, this return is expected given the high number of requests for survey participation that RWHAP organizations receive. Part B grant recipients were the most represented of the RWHAP Parts, with a response rate of 37%, while Part C recipients were the least represented with a response rate of 14%.
- The next section presents data that compare respondents to the national RWHAP community. While assessment results may not be fully representative of all RWHAP grant recipients and sub-recipients, the comparison shows that the assessment respondents are 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.

Characteristics of Needs Assessment Respondents

A total of 172 organizations responded to the assessment. Respondents represented 41 states, plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. As shown in **Figure 1**, the states with the highest number of responses were Texas (18), Maryland (15), Florida (14), California (14), New Jersey (13), and Pennsylvania (12). All of these are in the top 10 states for receiving the most RWHAP funding.[1] To provide a comparison between assessment respondents and RWHAP organizations nationally, **Figure 2** shows the geographic spread of the 1,901 organizations that receive RWHAP funding, including 589 grant recipients and 1,312 sub-recipients. The map shows the states where the highest percentage of RWHAP organizations are located, which are similar to the states with the highest percentage of assessment responses.

FIGURE 1. 2015 ACE needs assessment responses by state (N=172)

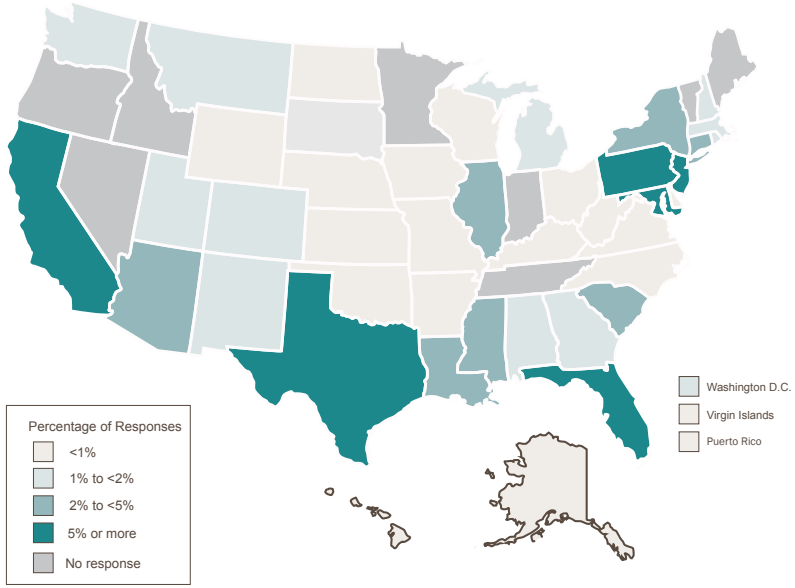
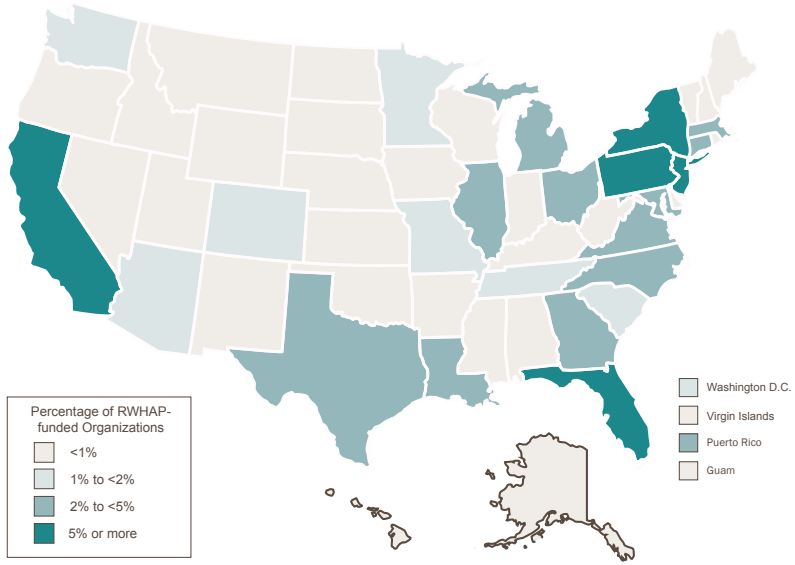


FIGURE 2. RWHAP grant recpients and sub-recipients nationally (N=1,901)



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Fifty-five percent of assessment respondents were from states that use the federal Health Insurance Marketplace (healthcare.gov) and 65% were from Medicaid expansion states. This distribution is similar to the national picture of 54% (27 of 50 states) using the federal Marketplace and 62% (31 of 50 states) with Medicaid expansion.

Direct service providers and Part A grant recipients were slightly under-represented in the needs assessment responses, while Part B, Part C, and Part D recipients were over-represented. Overall, responses included 80 directly-funded grant recipients and 128 service providers.[2]

TABLE 2. Comparison of RWHAP grant recipients and ACE needs assessment respondents by RWHAP Part

	RWHAP GRANT RECIPIENTS (N=1,901)[1]		ACE NEEDS ASSESSMENT RESPONDENTS (N=172)[2]	
	Count	Percent	Count	Percent
Part A	53	3%	9	5%
Part B	54	3%	20	12%
Part C	361	19%	51	30%
Part D	121	6%	25	15%
Service Providers	1,788	94%	128	74%

[1]Source: 2013 Ryan White Services Report
[2]Respondents may have funding from more than one Part. Service providers may include grant recipients, as well as contracted sub-recipients.

COMPARING 2013 AND 2015 RESPONDENT CHARACTERISTICS

Respondent characteristics for the 2013 and 2015 needs assessments were very similar in terms of RWHAP Part and type of organization (e.g., health department, community-based organization, Federally Qualified Health Center).

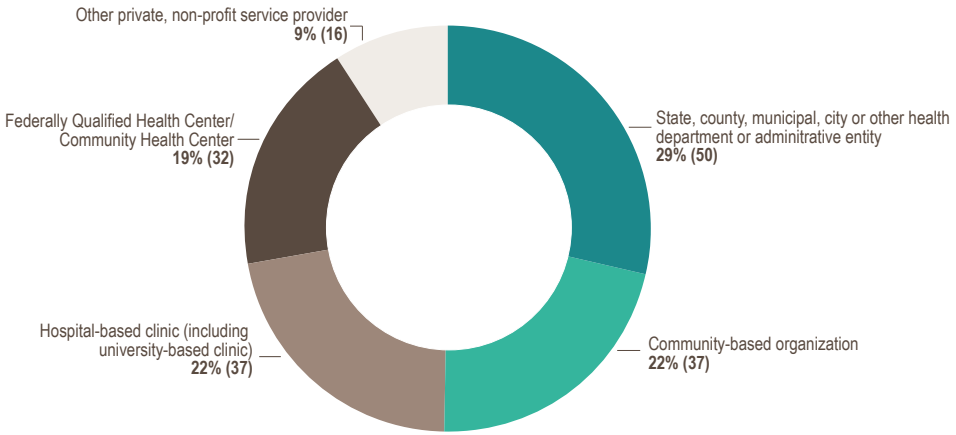
The two key differences were:

- In 2013, a higher percentage of respondents were Part C grant recipients (39%) compared to 2015 (30%).
- A higher percentage of respondents in 2013 were hospital-based clinics (27%) compared to 2015 (22%); and a lower percentage of respondents were health departments in 2013 (18%) compared to 2015 (29%).

Nearly one-third (29%) of respondents were from health departments, 22% were from community-based organizations, 22% were from hospital-based clinics, and 19% were from Federally Qualified Health Centers or Community Health Centers. **Figure 3** shows these results. Half of all respondents (52%) were program directors or managers, 12% were case managers, and 9% were case management coordinators.

In comparison, only 13% of RWHAP grant recipients and sub-recipients nationally are health departments. This group was over-represented in the needs assessment; however, recruitment specifically targeted Part A and B grant recipients, many of which are health departments, because these recipients oversee a significant number of sub-recipients. Additionally, 41% of RWHAP grant recipients and sub-recipients are community-based organizations, and therefore that group was under-represented in assessment results.

FIGURE 3. Responses by organization type (N=172)



Endnotes

1 National Alliance of State and Territorial AIDS Directors (NASTAD). Special Data Request, 2015. Available at: http://kff.org/hivaids/state-indicator/funding-by-part/#

2 These categories are not mutually exclusive. Grant recipients may also be service providers. When treated as exclusive categories, there were 80 directly-funded grant recipients and 92 service providers (sub-recipients) for a total of 172 responses.