2013–2015 *CONNECTING CONSUMERS WITH CARE* GRANT AREA EVALUATION

Assessing Grantee Outreach, Enrollment, and Consumer Self-Sufficiency Efforts

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EXECUTIVE SUMMARY

Since 2001, the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) has supported community-based organizations, federally qualified health centers, and public agencies through its *Connecting Consumers with Care* grant program. During the October 2013 through September 2015 grant cycle, 16 organizations across Massachusetts received awards to help low-income and vulnerable consumers enroll in and maintain access to publicly subsidized health insurance coverage, and to help consumers navigate systems of coverage and care with increasing independence. This period coincided with the state's implementation of key components of the Patient Protection and Affordable Care Act (ACA).

This report describes findings from the evaluation of the 2013–2015 grant cycle. The aims of the evaluation were to 1) assess progress made on select outreach and enrollment measures, 2) describe the practices grantees adopted to reach out and enroll consumers in insurance, and 3) characterize efforts and challenges in defining, promoting, and evaluating consumer self-sufficiency.

GRANTEES CONTINUED TO PLAY A CRITICAL ROLE IN REACHING AND ENROLLING THE UNINSURED

Grantees served consumers across the Commonwealth in a variety of ways, most frequently by helping to complete applications for publicly subsidized health insurance. They also reported on the number of individuals that received individualized assistance with any part of the enrollment process (e.g., creating an account, selecting a plan, making an appointment with a primary care physician). Grantees submitted quantitative data over a 15-month period that reflected the efforts of all enrollment staff at their organizations, not just the staff supported by this grant program. Collectively, they reported:

- Assisting nearly 90,000 consumers in submitting health insurance applications;
- Supporting 35,675 consumers each quarter with any aspect of the enrollment process; and
- Providing more than 290,000 encounters over the reporting period.

Grantees achieved these results by making creative use of media campaigns; partnering with local organizations, including correctional facilities, career centers, and food pantries; and providing in-person assistance with the application

process both on-site and at off-site community-based locations. Given the challenges associated with ACA implementation, grantees also added staff and hours to manage the demand for services, completed paper applications when the online system was not functioning, and made efforts to reach those on temporary coverage when the time came to re-enroll.

GRANTEES IMPLEMENTED KEY PROGRAMMATIC STRATEGIES TO PROMOTE CONSUMER SELF-SUFFICIENCY

In this grant cycle the Foundation emphasized the concept of consumer self-sufficiency, defined as consumers navigating systems of health coverage and care with increasing independence. The concept of self-sufficiency not only emphasizes the importance of securing health insurance, but also maintaining and using that coverage. Grantee strategies to advance consumer self-sufficiency included providing consumer education, developing written materials and guides, assigning "homework" to encourage consumers to try new tasks and take an increasingly active role in their own health coverage and care, and providing access to and training on computers and online platforms for insurance enrollment and maintenance. Central to these strategies across grantees was having culturally competent staff who were knowledgeable about the evolving eligibility and enrollment landscape associated with the ACA rollout. The strategies also meant having staff out in the community, which often depended on grantees cultivating partnerships with other local organizations. This enabled staff to reach more consumers, strengthen relationships, and build trust.

GRANTEES EXPERIENCED BARRIERS TO ADVANCING CONSUMER SELF-SUFFICIENCY

While grantees were successful overall, the evaluation also spotlighted common factors that hindered grantees' efforts to advance consumer self-sufficiency. Glitches with the initial ACA rollout generated more demand than expected from consumers needing application assistance, which left less time for self-sufficiency efforts. Likewise, even after many of the challenges with the eligibility and enrollment systems were resolved, the complexity of the process itself was cited as a barrier to consumers becoming more independent. Finally, the lack of communication from state agencies in languages other than English and Spanish made it hard for some consumers to navigate coverage on their own. While grantees minimized this barrier by hiring linguistically and culturally diverse staff and developing written materials in multiple languages, grantees still reported ongoing challenges.

GRANTEES EVALUATED THEIR CONSUMER SELF-SUFFICIENCY WORK

Along with the Foundation's new emphasis on consumer self-sufficiency came expectations that grantees would develop evaluation plans to assess the effectiveness of their strategies. Grantees were encouraged to include both process and outcome measures in their plans, which the Foundation defined, respectively, as measures indicating counts of activities and measures indicating potential changes in consumer knowledge and/or behaviors associated with a grantee's consumer self-sufficiency strategies. This was the first grant cycle in which grantees were required to design and implement evaluation plans, and as such, this component of the program

was not without challenges, particularly ones related to grantees' ability to define outcomes measures and collect related data. The Foundation responded by partnering with the Massachusetts Area Health Education Center (MassAHEC) Network at UMass to provide technical assistance. Over the course of the grant period, all grantees were able to define, track, and report on one or more process measures; 10 of the 16 grantees developed the capacity to define and collect data assessing outcomes.

Despite the challenges, it is possible to point to some select preliminary indicators of performance that suggest grantees are playing a key role in advancing consumer self-sufficiency. One grantee, for instance, reported providing 1,250 one-to-one education sessions over an eight-month period. To better understand the organization's impact, the grantee conducted a brief exit survey with a sample of clients. Among other findings, 67 percent of consumers reported feeling "very confident" and 33 percent reported feeling "somewhat confident" in their ability to select a health plan after their session.

The experience of the *Connecting Consumers with Care* grantee organizations is valuable to entities engaging in outreach, enrollment, and post-enrollment work both in Massachusetts and across the nation, as well as to state and federal policy makers. Much can be learned from the progress made by the grantees, and as well as factors that facilitate accomplishments and the barriers that persist.

SECTION 1: BACKGROUND

From October 2013 through September 2015, the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) invested in 16 community-based organizations, federally qualified health centers, and public agencies through its *Connecting Consumers with Care* grant program (see table and map below). Its goals were to help low-income and vulnerable consumers enroll in and maintain access to publicly subsidized health insurance, and to help consumers navigate systems of coverage and care with increasing independence.

2013–2015 CONNECTING CONSUMERS WITH CARE GRANTEES

ORGANIZATION	TYPE*	LOCATION	REGION OF MASSACHUSETTS
Boston Public Health Commission/Mayor's Health Line	Public agency	Urban	Greater Boston
Brockton Neighborhood Health Center	FQHC	Urban	Southeast
Codman Square Health Center	FQHC	Urban	Greater Boston
Community Action Committee of Cape Cod & Islands, Inc.	CBO	Suburban/Rural	Southeast/Cape and Islands
Community Action of the Franklin, Hampshire and North Quabbin Regions	CBO	Suburban/Rural	Western
Community Health Center of Franklin County	FQHC	Suburban/Rural	Western
Community Health Connections	FQHC	Suburban/Rural	Central
Community Health Programs	FQHC	Suburban/Rural	Western
Ecu-Health Care	CBO	Suburban/Rural	Western
Family Health Center of Worcester	FQHC	Urban	Central
Fishing Partnership Health Plan	CBO	Suburban/Rural	Northeast & Southeast
Hilltown Community Health Centers	FQHC	Suburban/Rural	Western
Joint Committee for Children's Health Care in Everett	CBO	Urban	Greater Boston
Lynn Community Health Center	FQHC	Urban	Northeast
Vineyard Health Care Access Program	Public agency	Suburban/Rural	Southeast/Cape and Islands
Whittier Street Health Center	FQHC	Urban	Greater Boston

*FQHC = Federally Qualified Health Center; CBO = Community-Based Organization

The grant period was a historic time for public health insurance reform in Massachusetts, as the Commonwealth merged the gains it had achieved under Chapter 58 of the Acts of 2006 with those of the Patient Protection and Affordable Care Act (ACA). Grantee organizations were particularly challenged during the 2013–2014 open enrollment period due to high client volumes and glitches in the online health insurance exchange and integrated eligibility system. They served as trusted brokers of information for their communities in an uncertain environment, and as partners to the Massachusetts Medicaid Program (MassHealth) and the Massachusetts Health Connector in troubleshooting and relaying the client experience to state decision makers. Likewise, the

Massachusetts Health Care Training Forums and Health Care For All's "In the Loop"online community served as important mediums for the state to share new developments and solicit feedback from enrollment specialists.

In this grant cycle, recognizing that access to health care is more than just the receipt of a health insurance card, the Foundation emphasized the concept of consumer self-sufficiency, defined as consumers assuming a more active role in their own health coverage and care and navigating systems with increasing independence. Grantees were charged to develop and implement strategies tailored to the unique needs of their client populations, as well as collect and analyze data to inform programmatic improvement and to help understand the outcomes of their work.

IN THE LOOP—MASSACHUSETTS

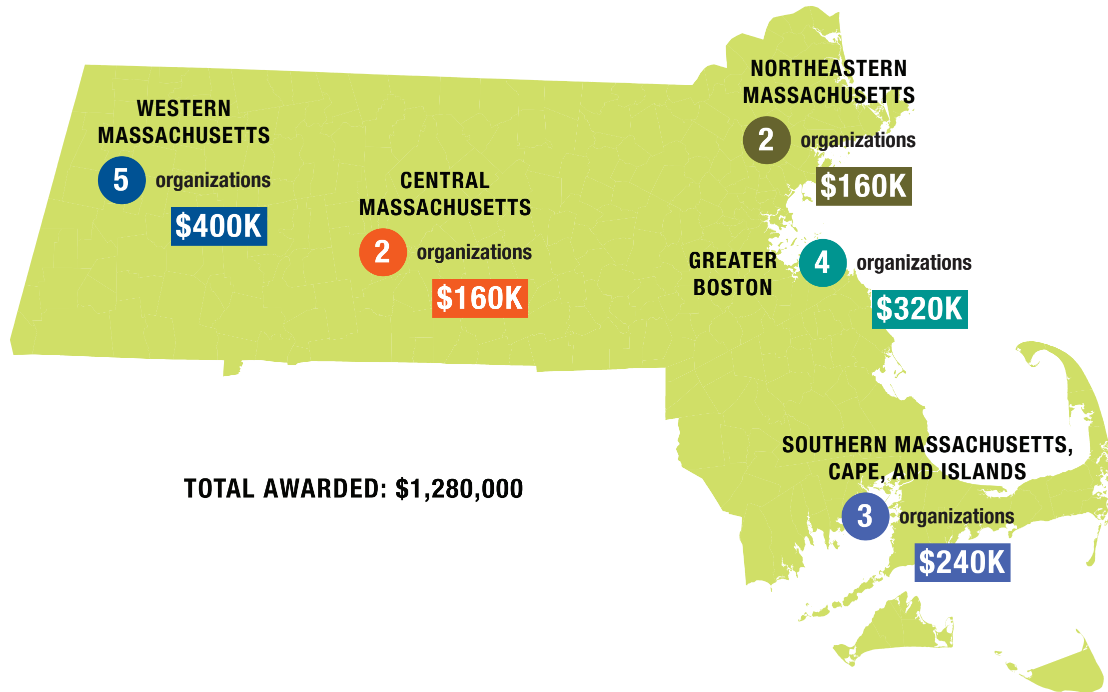
In 2014, the Foundation provided seed funding to Health Care For All to help launch In the Loop—Massachusetts.

In the Loop is a private online community where enrollment specialists share successes, challenges, and lessons learned. Input from enrollment specialists is shared regularly with state policy makers.

To support this initiative, the Foundation secured the University of Massachusetts (UMass) Medical School Center for Health Policy and Research (CHPR) to conduct a summative evaluation, as well as the Massachusetts Area Health Education Center (MassAHEC) Network of UMass to coordinate and facilitate Learning Community convenings and provide individualized technical assistance to grantee organizations. The Foundation additionally hosted an online forum to promote peer-to-peer learning and the sharing of resources and best practices.

This report captures the lessons learned, best practices, and overall impact of the *Connecting Consumers with Care* grant program from October 2013 through September 2015. The goals of the evaluation were to assess progress made on select outreach and enrollment measures and to characterize efforts and challenges in defining, promoting, and evaluating consumer self-sufficiency activities. To address these aims, the evaluators used a mixed-methods study design, utilizing data from quarterly and semi-annual reports submitted by grantees to the Foundation, as well as qualitative data collected during site visits to a select group of five organizations. See the Appendix for additional information on study methodology.

CONNECTING CONSUMERS WITH CARE 2013–2015 FUNDING DISTRIBUTION



SECTION 2: OUTREACH AND ENROLLMENT EFFORTS

This grant period coincided with the unique challenges associated with the 2013–2014 open enrollment period, as consumers were initially unable to use the online health insurance exchange to enroll in health insurance coverage, and the integrated eligibility system was unable to determine a person's eligibility for programs or subsidies. During this time, the state extended subsidized plans and enrolled people in temporary Medicaid coverage while it developed workarounds and resolved the technical issues. Within this context, grantees adopted a range of practices to reach out to and engage uninsured individuals and enroll them in health coverage.

OUTREACH AND CONSUMER EDUCATION

> "We … conduct[ed] outreach in places where and when we knew residents otherwise had to be, such as Saturdays at town transfer and recycling stations…. In our area, being familiar and visible as community members is key to our success."

Grantees employed outreach workers to actively locate, engage, and educate consumers about health insurance coverage and where to get assistance with the application process. Across grantees, outreach workers targeted a range of community settings including recycling centers, bus stops, grocery stores, and community events such as healthy living expositions and cultural festivals. Grantees also used media—including local television, print, and social media—to reach consumers and educate them about insurance, upcoming deadlines, and available enrollment assistance. Some grantees also developed print materials (e.g., insurance information packets, flyers), which they distributed at outreach events. A central aim of all these efforts was to inform consumers about the different eligibility guidelines for temporary, subsidized, and unsubsidized insurance and, importantly, to explain that those eligible for subsidized coverage could apply outside of open enrollment periods. Additionally, in some cases, these efforts were critical to increase trust among consumers who had grown wary from misinformation and changing information about open enrollment dates and eligibility during the ACA rollout.

PARTNERING WITH LOCAL ORGANIZATIONS AND OTHER KEY GROUPS

> "One of our health benefit advisors [HBAs] … collaborated with [the] public library to post an announcement in their monthly newsletter, which reaches hundreds, about open enrollment and how our HBAs … can be of assistance."

Many grantees collaborated with other local organizations to expand their reach into the community. In this capacity, grantees worked with homeless shelters, community colleges, food pantries, faith-based organizations, correctional facilities, and unemployment offices, to name a few types of partners. These partnerships not only helped to spread the word about insurance and available assistance but also provided venues for outreach workers to offer workshops and disseminate information about insurance and

> One grantee partnered with a community college to target and engage college students, who now have more insurance options under the ACA.

One community health center embedded benefits advisors in its primary care teams.

enrollment. Some grantees additionally collaborated with staff in other departments or divisions of their own organizations to help identify uninsured consumers and refer them to enrollment assisters; in this way, grantees expanded their "in-reach" capacity as well.

IN-PERSON ASSISTANCE WITH ENROLLMENT

All sites provided individualized in-person assistance with the application process. Most provided this assistance on-site through scheduled or walk-in appointments. Several also provided enrollment assistance at off-site locations in the community. For example, two grantees spent regularly scheduled time at the county jail to complete enrollment applications with prisoners before their release; another provided enrollment services at a local YMCA on a weekly basis.

During the first open enrollment period, grantees assisted consumers with completing paper applications, which often required several appointments to complete. Sometimes it meant having to fax applications more than once because the original information got lost, and often it required calling MassHealth or the Connector to get information that was not accessible online. Grantees also followed up to check on the status of and troubleshoot problems with an application, and advocated for consumers when delays in determining eligibility for insurance made this necessary. Some grantees extended appointment times or increased staffing and office hours to accommodate the extra demand and time needed to assist consumers.

ONGOING SUPPORT WITH MAINTAINING COVERAGE AND CARE

Hand in hand with assisting uninsured consumers with enrollment were grantees' efforts to assist consumers in maintaining health coverage and minimizing gaps in care. Consumers might have lost coverage because they failed to submit the redetermination form on time or did not submit missing documentation or share updated information about a change of address or employment. Renewal support became a particularly high priority for grantees during the second year of the grant, after MassHealth lifted the suspension on redeterminations once its system issues had been resolved from the previous year.

Grantees' strategies in this area included conducting reminder phone calls and mailings to consumers whose renewal dates were approaching, providing one-to-one assistance with completing renewal applications, and educating consumers about letters from MassHealth and the need to respond. Grantees also adopted specific strategies for consumers who were enrolled in temporary MassHealth coverage. MassHealth had sent all individuals on temporary coverage a packet of information to explain their status and next steps. Grantee strategies included reaching

One health center used its electronic medical record to track patients' enrollment status and sent letters to patients when their insurance was up for renewal or no longer active.

One grantee held workshops throughout the community to inform consumers with temporary coverage that they needed to reapply; another grantee contacted consumers with temporary coverage by phone, urging them to re-enroll.

out to these consumers to explain this provisional type of coverage and how to find a provider who accepted it, and facilitating re-enrollment for this population by helping individuals respond to letters and requests from MassHealth.

QUANTITATIVE DATA: SELECT OUTREACH AND ENROLLMENT MEASURES

Grantees reported progress against select outreach and enrollment measures on a quarterly basis. These measures included 1) the number of consumers who completed insurance applications, 2) the number of consumers assisted with any part of the application process (e.g., creating an account, selecting a plan), and 3) the number of encounters overall. For the first measure, over the 15-month period of January 2014 through March 2015, grantees collectively reported completing insurance applications for 89,311 consumers. This number includes individuals whose applications were completed with one-to-one assistance from grantee staff both supported and not supported by this grant. Grantees reported on consumers included in both new and renewal applications, as well as those included in both paper and electronic applications.

Grantees assisted almost 90,000 consumers in submitting applications for publicly subsidized health insurance coverage.

Submitting applications was just one way that grantees supported consumers. For the second measure, grantees counted consumers who received one-to-one assistance with any aspect of the enrollment process, including education about basic insurance topics, creating an account, updating an account profile, selecting a plan, and making an appointment with a primary care physician. Mass mailings, participation in health fairs, and other activities that did not include messages tailored to individual client needs were excluded from these counts. Grantees collectively reported serving an average of 35,675 consumers each quarter with some part of the enrollment process. They also reported serving consumers in a range of languages other than English.

Beyond English, grantees were most likely to assist consumers in Spanish, Haitian Creole, and Portuguese.

For the third measure, grantees tracked encounters as another way to quantitatively assess their outreach and enrollment activities. One consumer might have multiple encounters, depending upon the intensity of services required. Again, grantees documented encounters only where individuals received one-to-one assistance with some part of the enrollment process, and documented encounters attributable to staff time supported and not supported by this grant. Grantees collectively reported providing 292,242 encounters over the 15-month reporting period.

Grantees reported over 290,000 encounters with consumers related to any part of the health insurance enrollment process.

Across the 16 grantee organizations, there was wide variation in the data reported for these three measures, which likely existed for many reasons. First, resource capacity—specifically, staff size and funding secured for outreach and enrollment activities—differed across the grantee organizations. For instance, some but not all grantees secured additional dollars for outreach and enrollment activities from the Health Resources and Services Administration and/or the Connector's Navigator Program. Geography and consumer characteristics also likely influenced

the quantitative data reported. Grantees that served rural areas often reported smaller numbers, possibly related to lower population density, and those serving consumers with complex needs (e.g., homeless, immigrant, and refugee) often reported smaller numbers owing to the time and intensity of services required per consumer. Finally, variation also existed related to grantees' capacity to collect and report on data. While the Foundation and the MassAHEC Network made efforts to clearly define measures and provide technical assistance around reporting, some differences persisted in grantees' interpretations of the measures. Similarly, a few grantees struggled to provide actual counts of consumers served and provided estimated numbers instead; still others experienced difficulty collecting data consistently across their outreach and enrollment staff members.

Variation finally might be attributable to differences in grantee organizational type. For instance, FQHC grantee sites served on average 3,159 consumers each quarter, while their counterpart CBO grantee sites served on average 633 consumers each quarter. At the same time, CBOs on average had higher rates of encounters per individual each quarter than did FQHCs (2.5 vs. 1.5 respectively).[1] This is suggestive of variation in volume of consumers served, as well as different models of outreach and enrollment service delivery.

1 Average encounter rates for each grantee were calculated as the average number of encounters each quarter divided by the average number of individuals assisted each quarter.

SECTION 3: ADVANCING SELF-SUFFICIENCY

In this grant cycle, the Foundation emphasized the concept of consumer self-sufficiency, broadly defined as consumers assuming a more active role in their own health coverage and care, and navigating systems with increasing independence. The idea of advancing consumer self-sufficiency was introduced to the Foundation by a handful of grantee organizations, which articulated the need to cultivate a more educated and informed consumer population. Just as important to consumers as securing health insurance was their ability to maintain and use their coverage. Furthermore, a consumer population that was better equipped to manage their own health coverage and care would, in theory, free up enrollment specialists to spend more time on particularly complex cases and troubleshooting. Given the challenges associated with the ACA rollout, it wasn't until halfway through the grant cycle that the Foundation and the grantees began to prioritize activities related to consumer self-sufficiency.

A. DEFINING CONSUMER SELF-SUFFICIENCY

Within the broader context described above, grantees were asked to define consumer self-sufficiency specific to their client populations. For instance, a grantee that served a large immigrant population defined consumer self-sufficiency as knowing where and how to seek assistance with questions related to coverage and care. A grantee assisting consumers with more experience in accessing public health insurance programs defined self-sufficiency as being able to independently select a health plan. In this sense, consumer self-sufficiency varied on a continuum or a spectrum. The overall goal of grantees' efforts was to move consumers along the continuum—from less to more knowledgeable, confident, and/or prepared to navigate systems of coverage and care—while being responsive to the characteristics and needs of distinct client populations.

B. STRATEGIES FOR ADVANCING CONSUMER SELF-SUFFICIENCY

Strategies to advance consumer self-sufficiency included providing education, developing written materials, encouraging consumers to stretch their capacities, and offering computer access and support.

Providing consumer education: All grantees provided one-to-one education to consumers, often as part of an enrollment session. These sessions were used to assist and educate consumers about key tasks related to applying for insurance including creating an online account, navigating the Connector website, and securing the documentation needed for the application process. Several grantees described using sessions to model enrollment activities, showing consumers how to complete the enrollment process, including how to interact by phone with MassHealth and the Connector. Some grantees also used these sessions to assist and educate consumers about insurance and health care

services more generally including why it is important to have health insurance, how to identify a primary care physician, and how to use insurance to access primary and urgent care.

Grantees also leveraged group settings to promote education about insurance and the enrollment process. For example, one grantee included a presentation on available insurance services as part of its new patient orientation sessions. Other grantees partnered with off-site local organizations to extend the reach of their activities. For example, one grantee partnered with students at Boston University School of Medicine to develop a health literacy workshop to be delivered at community health centers; another partnered with a career center to educate recently unemployed individuals about insurance options; two grantees targeted food pantries to educate patrons interested in health insurance information; and another two grantees partnered with schools for the same purpose.

Developing written guides/resources: Along with education sessions, most grantees developed some form of written materials intended to educate consumers about insurance coverage and enable consumers to navigate the enrollment process more independently. These materials came in the form of how-to guides, checklists, and resource sheets. Information included in these materials varied across grantees, but common features included the following: tools that helped consumers keep track of their user names and passwords for online accounts, documents that explained the enrollment process, glossaries that included health insurance terms and definitions, forms that listed all the documents needed to complete the enrollment process, and lists of phone numbers for relevant state agencies. The Foundation and the MassAHEC Network encouraged grantees to share these materials with one another via an online forum, to promote sharing of best practices and to minimize duplication of effort.

Encouraging consumers to stretch: Another strategy that grantees adopted to promote consumer self-sufficiency was to encourage consumers to take on increasing levels of responsibility. Some grantees assigned homework to clients in advance of an enrollment appointment, usually a task associated with completing some part of the application process. This included encouraging consumers to access the Connector website and create an account or download an application. Other grantees assigned follow-up homework at the close of an enrollment session, such as selecting a MassHealth managed care plan or selecting a primary care provider.

Offering access to computers and other technology: Many of the consumers served by grantees lacked computer skills and/or access to computers or the Internet, and these lacks are significant barriers given the emphasis on online platforms for health insurance enrollment. In response, several grantees provided access to computers and the Internet, which consumers used for a range of tasks including setting up an online account, paying insurance premiums, and finding primary care providers. Some grantees additionally had staff stationed nearby to assist consumers with these and related tasks if needed. Some grantees also offered access to telephones, mainly for calling MassHealth and the Connector. For some consumers, this alleviated a concern about using their limited cell phone minutes while waiting on hold. At one site, grantees used a conference line function for calls with MassHealth; the consumers led the calls but grantee staff were able to offer assistance as needed.

C. CRITICAL ORGANIZATIONAL CAPACITIES FOR PROMOTING CONSUMER SELF-SUFFICIENCY

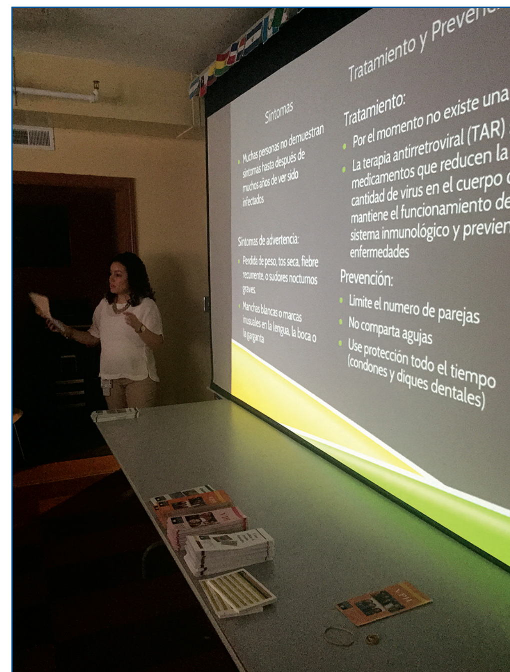
A close look at grantees' practices for promoting consumer self-sufficiency reveals a diversity of approaches. Yet, within this diversity it is possible to identify common themes as well as critical organizational capacities related to the implementation of consumer self-sufficiency strategies.

Culturally competent staff: Having staff that reflected the linguistic and cultural background of the consumers being served was a critical ingredient. Many grantees reported having staff who were bilingual/bicultural and from the community being served. One site reported being able to serve clients in 32 languages. Having culturally competent staff was critical to building trust with consumers. It was also critical for communicating with non-English speakers in terms of assessing both the type of assistance a consumer needed and whether she understood the information being shared.

> "About 43 percent of our patients are best served in a language other than English, so … we've pulled together new patient orientations that involve staff from all of our major program areas to provide in-depth information … in multiple languages."

Knowledgeable, engaged staff: Having staff who were knowledgeable about insurance and the enrollment process was also critical to promoting consumer self-sufficiency. This was especially critical given challenges related to the 2013–2014 open enrollment period. Deadlines and processes changed frequently, and grantee staff invested considerable time to stay current with the changing landscape and therefore serve as effective resources for consumers. Grantee staff attended Massachusetts Health Care Training Forums, stayed in frequent communication with MassHealth and the Connector, and shared information within and across grantee sites. Grantees also used resources like Health Care For All's "In the Loop," which helped facilitate information sharing and troubleshooting in real time.

Collaborations and presence in community: While many consumer self-sufficiency activities took place on-site at grantees' main operating sites, many grantees said it was critically important to have staff out in the community. Making this happen often depended on developing links with other local organizations and events. Being out in the community enabled grantee staff to reach more consumers who could benefit from information, offered more locations in which to provide insurance education, and helped to build trust among consumers by showing grantees' commitment to the needs of the community.



D. BARRIERS TO ADVANCING CONSUMER SELF-SUFFICIENCY

Grantees identified three main barriers that impeded efforts to advance consumer self-sufficiency. One barrier was that consumer demand for application support exceeded the capacity of many grantee sites. This was particularly true during the initial open enrollment period when grantees needed to focus their resources on outreach and enrollment, rather than initiating efforts to advance self-sufficiency.

> "The volume of people that we were assisting with applications was another factor that impacted our patient self-sufficiency work, because that was so intensive."

Another kind of barrier related to the complexity of the enrollment process itself. Again, this was especially problematic during the first open enrollment period, when processes and deadlines were repeatedly adjusted. Keeping abreast of the changes was daunting at times even for sophisticated consumers. Further, when the online eligibility and enrollment systems became operational, some computer-savvy consumers were still confused when trying to complete the process. Another component of the generally complex enrollment process was the long telephone wait times to speak with someone at state agencies, which thwarted some consumers' efforts to navigate systems more independently.

A third barrier related to the diverse language needs of consumers. The Connector website is only available in English, with phone assistance available for non-English speakers. Most written correspondence and written forms are available in both English and Spanish but lacking for other languages. Thus, for consumers who speak languages other than English and Spanish, the challenge of independently navigating the health care insurance enrollment process is especially steep.

Consumers experienced other barriers that undermined their ability to navigate the health coverage system independently. These included cultural barriers (some new immigrants are less familiar with the concept of health insurance, why it is important, and what to do once they are enrolled) and transportation barriers (challenges getting to enrollment appointments).

E. EVALUATING ADVANCES IN CONSUMER SELF-SUFFICIENCY

Each grantee developed an evaluation plan to assess its work in promoting consumer self-sufficiency. Evaluation plans varied, but all included process measures, typically in the form of counting consumer self-sufficiency practices (e.g., number of workshops held, number of individuals contacted for follow-up). The Foundation also encouraged grantees to develop measures and collect data on outcomes, which it defined as changes in consumer knowledge, preparedness, or behavior related to grantees' self-sufficiency efforts. While the grantees' evaluation plans were not scientifically rigorous, 10 of the 16 grantees were successful in developing their capacity to collect data on outcomes to begin to understand the effects of their efforts. Grantees developed

surveys and questionnaires, which were administered both on paper and by phone, typically aimed at assessing changes in consumer knowledge.

This was the first grant cycle in which grantees were required to design and implement evaluation plans, and as such, this component of the program was not without challenges. Some grantees struggled with defining evaluation measures, especially outcome measures; others defined measures but had difficulty consistently collecting and reporting on their measures. In general, grantees were eager for more guidance in this area. The Foundation and the MassAHEC Network responded by including evaluation, specifically outcomes measurement, on the agendas of Learning Community meetings and providing individualized technical support to grantees. In almost all cases, the Foundation and MassAHEC were able to help grantees enhance their evaluation capacity over the course of the grant period.

Given the diversity of consumer self-sufficiency strategies, given that this was the first grant cycle in which grantees were required to evaluate their strategies, and given the diversity of evaluation plans and challenges associated with these plans, there are limitations to rigorously assessing how well grantees performed with respect to advancing consumer self-sufficiency. However, it is possible to point to some select preliminary indicators of performance that suggest grantees are playing a key role in assisting consumers to navigate coverage and care with increasing independence. For this purpose, here are brief descriptions of how two grantees approached elements of their evaluation:

- Consumer self-sufficiency strategies at Site A included education on coverage and care as part of one-to-one enrollment sessions. Site A also developed a comprehensive packet of information that was given to applicants at the time of their appointments. Included in the packet was online account information so applicants could access their accounts on their own, a reminder sheet of changes in circumstance that needed to be reported to MassHealth and/or the Connector, contact information for each program, a glossary of terms to help consumers understand their coverage, and a "next steps" guide featuring tips on plan selection and reminders about important due dates. Between November 2014 and June 2015, Site A conducted 1,254 one-to-one educational sessions. A brief exit survey was conducted with 88 individuals to better understand the sessions' impact. Among other findings, 67 percent reported feeling "very confident" and 33 percent reported feeling "somewhat confident" in their ability to select a health plan after their session.
- Site B also provided individualized education. Enrollment specialists helped consumers set up online accounts and modeled appropriate information-seeking skills when calling state agencies. They also explained plan options, co-pays, and premiums, and connected consumers to additional services like fuel assistance. From October 2014 through June 2015, Site B provided support to 391 households. During the spring of 2015, Site B tracked 57 individuals who had at least two visits with an enrollment specialist. At the beginning of each appointment, enrollment specialists assessed individuals' knowledge and behaviors against a list of predetermined self-sufficiency indicators, which they then documented in a matrix to track changes over time. Over the course of three months, there was a 76 percent increase in the number of individuals who knew their health plan and how to contact it, and a 124 percent increase in the number of individuals who knew how to use their Connector account.

SECTION 4: CONCLUSION

In sum, the 2013–2015 *Connecting Consumers with Care* grantees played a critical role in reaching and enrolling the remaining uninsured in the Commonwealth. They also implemented key program adjustments to promote consumer self-sufficiency. Importantly, in addition to the routine tracking and reporting of their outreach and enrollment work, grantees developed and implemented evaluation plans to assess their efforts to advance consumer self-sufficiency. Lessons learned across these aspects of the program can serve as a guide for other organizations doing or considering similar work, state and federal policy makers as they continue to implement components of the ACA, and other funders.

The Foundation has extended the *Connecting Consumers with Care* grant program through September 2017. In response to the evolving health reform environment, as well as to lessons learned from the 2013–2015 funding cycle, the grant program now emphasizes enrollment in public health insurance coverage, reducing rates of churn, and addressing health insurance literacy needs. Because MassHealth reinstated its redetermination process in early 2015, grantees are charged to develop and implement strategies to maintain continuity of coverage. Related is grantees' work to further health insurance literacy so that their client populations report enhanced knowledge, confidence, and/or preparedness in navigating health coverage and care. These education and engagement strategies are designed to further access to care and maintenance of coverage for the Commonwealth's low-income and vulnerable residents.

APPENDIX: METHODS

GENERAL APPROACH AND DATA SOURCES

The evaluation used a descriptive study design and relied on two main data sources: 1) each grantee's quarterly and semi-annual reports to the Foundation, and 2) key informant interviews with representatives of select grantee sites. For the first data source, the Foundation, in collaboration with the evaluation team, developed the data collection protocols. The Foundation was responsible for collecting reports from sites and in turn made them available to the evaluation team. For the site visits, the evaluation team, in collaboration with the Foundation, selected a sample of five sites to study in depth, and the evaluation team conducted the interviews.

Quarterly and Semi-Annual Reports: Each grantee submitted a report to the Foundation for each quarter of the funding cycle staring with the second quarter (for a total of five quarterly reports per grantee). Each grantee also submitted a semi-annual report to the Foundation for each half-year of the funding cycle (for a total of four semi-annual reports). The evaluation used all five of the quarterly reports and three of the four semi-annual reports; the last round of reports was eliminated because it was submitted after the evaluation team's cut-off date for data collection. The quarterly reports focused specifically on grantees' work related to outreach and enrollment, while the semi-annual reports focused on grantees' work related to consumer self-sufficiency. For the quarter and half-year being reported, grantees submitted the information detailed in Table A.

TABLE A: QUARTERLY AND SEMI-ANNUAL REPORT VARIABLES

QUARTERLY REPORT: OUTREACH AND ENROLLMENT	SEMI-ANNUAL REPORT: CONSUMER SELF-SUFFICIENCY
• Number of unduplicated individuals served • Number of encounters • Number of individuals represented in completed applications • Estimated number of individuals that completed enrollment • Number of individuals assisted with applications in languages other than English • Challenges faced in helping consumers enroll • Examples of especially effective outreach and enrollment strategies • Strategies used to help consumers retain the coverage they have	• Definition of consumer self-sufficiency • Target population for consumer self-sufficiency efforts • Consumer self-sufficiency strategies adopted • Process and outcome measures used to evaluate strategies • Collected data on process measures • Collected data on outcome measures • Any changes made to consumer self-sufficiency strategies • Especially effective consumer self-sufficiency strategies

Key Informant Interviews: Five grantees were selected for more in-depth analysis of consumer self-sufficiency strategies. In contrast to the semi-annual reports, which focused primarily on

what grantees were doing with respect advancing consumer self-sufficiency, key informant interviews were used to understand *how* grantees implemented their respective consumer self-sufficiency strategies and key lessons about implementation. The five grantees represented a diversity of locations across the state as well as a mix of community health centers and community-based organizations. Two members of the evaluation team visited each site and conducted in-person interviews with two to three staff members who worked directly with the grant program. In total, 13 staff members were interviewed across the five sites. To ensure data comparability within and across sites, a semi-structured interview guide was developed specifically for this study. Key domains of inquiry included grantee decision making about which strategies to pursue, critical ingredients to effectively implement strategies, barriers encountered and how they were overcome or minimized, and lessons learned. Each interview was audio-recorded and transcribed into Word files following the site visit.

DATA ANALYSIS

Using descriptive statistics, the evaluation team examined the quantitative metrics from the grantee quarterly reports. All quantitative data were entered into Excel spreadsheets and analyzed to determine the scope and scale of the entire grant program and variation across grantee sites. Using qualitative methods, the evaluation team coded all qualitative data from the grantee reports as well as the key informant interview data. An initial coding framework was developed with codes representing core domains of interest: 1) adopted practices; 2) facilitators; and 3) barriers, which were further refined as the data were analyzed. The evaluation team then developed initial concepts and categories that reflected salient and recurring themes in the data. Site memos were developed to facilitate cross-grantee comparisons in terms of grantee outreach and enrollment and consumer self-sufficiency strategies, experiences, and lessons learned.

LIMITATIONS

As with any evaluation, a few limitations should be noted. First, the evaluation team did not have access to a consistent set of program outcomes across sites and therefore was not able to assess the relative success of different approaches to outreach and enrollment and consumer self-sufficiency. Grantees did provide data on select outreach and enrollment performance measures, but these measures were likely mediated by factors that the evaluation could not control for (e.g., grantee size and staffing, additional outreach and enrollment resources). Grantees also reported select consumer self-sufficiency process and outcome measures, but in contrast to the pre-defined outreach and enrollment measures, consumer self-sufficiency measures differed across sites and so could not be compared. Finally, in the qualitative analysis, it was not the intent to detail every practice and every challenge but rather to identify and describe the general patterns observed across sites. As a result, some examples of grantee activities were inevitably omitted.

15 years

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