NATIONAL ASSOCIATION OF Community Health Centers

Outreach and Enrollment Case Study: Mountain Comprehensive Health Corporation

Health Center:	Mountain Comprehensive Health Corporation (MCHC), Whitesburg, KY	Medicaid Expanded State	
2013 Patients Served:	25,699	State-Based Exchange:	kynect
Uninsured Patients:	3,959 (2013)	Number of HRSA-funded assisters:	3
Total Sites:	21 rural clinics, including 16 school-based clinics	Total # of staff trained as assisters:	27 (All sites)

The Impact of Insurance Enrollment on a Federally Qualified Health Center

Paper Objective

This case study highlights how the use of federal funding for outreach and enrollment activities impacted a federally qualified health center in a state that expanded Medicaid and created its own exchange.

Background

In May 2013, Kentucky Governor Steve Beshear announced that the Commonwealth of Kentucky would expand Medicaid and launch its own state-based health insurance exchange called *kynect*.

In the summer of 2013, the Health Resources Services Administration's (HRSA) Bureau of Primary Health Care awarded $150 million in funds specifically for outreach and enrollment (O&E) activities to nearly 1,160 health centers nationwide. Mountain Comprehensive Health Corporation (MCHC), a federally qualified health center located in rural, southeastern Kentucky, received approximately $108,075 in funding for O&E activities. MCHC received and used its funds to hire three certified enrollment assisters, referred to as *kynectors*.

Building an Enrollment-Centered Culture

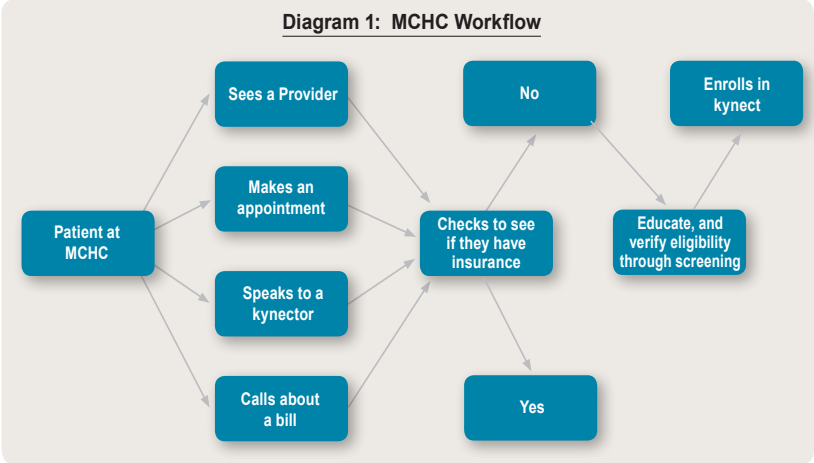
Prior to the First Open Enrollment Period (OE1) under the Affordable Care Act (ACA), which began on October 1, 2013, MCHC's senior leadership, led by CEO L.M. Mike Caudill, recognized the potential impact of increasing the number of insured patients with reimbursable visits on the organization's overall finances and operations.

Leading up to OE1, MCHC was proactive in marketing and contacting patients who qualified for either Medicaid or subsidized insurance through the exchange. As a result of these early outreach efforts, it quickly became clear that the three *kynectors* would not be able to meet the demand for services. To accommodate this demand, MCHC overhauled its operational workflow and began developing a workforce of highly-skilled, dedicated paraprofessional staff.

This restructuring process led MCHC to train 27 staff members as *kynectors*. Trained staff included billing staff, receptionists, financial counselors, and administrators at all locations. *(See Diagram 1: MCHC Workflow)*.

MCHC focused their outreach on three key consumer types: 1) existing uninsured patients, 2) existing patients with out-of-date income information, and 3) uninsured community members.

Diagram 1: MCHC Workflow



Training billing staff as assisters allowed the clinic to capture revenue that would have been otherwise been lost. Through training front-line and clinical staff to be assisters, MCHC's internal processes, policies, and procedures became streamlined and more efficient. Staff spent less time and money tracking down the uninsured and more time managing care. These efficiencies led to more staff – MCHC's total staff grew 13% between 2013 and 2014 – a 10% increase in total revenue, and the subsequent creation of new health care programs (see next section).

Impact on Finances and Operations

Converting self-paying patients into insured patients and retaining newly insured community members as patients led to improvements on several key financial metrics (changes correspond to the 2013 and 2014 fiscal years):

- 5% Increase in Total Patients
- 56% Decrease in Self-Pay/Uninsured Patients
- 3% Reduction in Total Uncompensated Care as a Percent of Net Service Revenue
- 10% Increase in Total Revenues

See Table 1: Key Metrics for MCHC

Impact on Patient, Community Health

Given that newly enrolled patients are encouraged by their insurance companies to receive preventive visits and screenings, the assisters played a critical role in connecting patients to care.

The increase in revenue allowed MCHC to form a Quality Services Care Team (QSCT). This team became responsible for the quality outcomes of MCHC patients. Also, all staff are made aware of the importance of quality in day to day operations. MCHC says all staff are part of the QSCT, because it takes teamwork to manage patients well. Assisters were also trained on quality improvement.

As of a result of early QSCT efforts, there has been significant improvement on most of MCHC's Uniform Data System (UDS) clinical measures for health center patients (changes correspond to the 2013 and 2014 fiscal years):

- 21% increase in preventive/wellness visits between 2013 and 2014
- 13.5% increase in patients (18+) with BMI charted
- 11.2% increase in female patients with Pap test (last 2 years)

See Table 2: Selected UDS Measures

MCHC also focuses on other Healthcare Effectiveness Data and Information Set measures such as cancer screenings and chronic illness follow-up. The QSCT contacts patients after hospital or Emergency Department (ED) visits to ensure that the necessary follow-up care is given. Through establishing direct relationships with patients, the QSCT helps patients come to the clinic for non-emergency reasons to avoid unnecessary visits to ED. This personal contact with patients has led to reductions in the no-show rate and canceled appointments at the clinics.

Conclusion

The net impact of Kentucky's Medicaid expansion and the creation of Kynect has been significant not just in terms of financial and operational metrics, but also in terms of patient and community health. Many people now receive care that otherwise would have been unattainable and their lives are forever transformed.

Data for health centers in Kentucky during this time period will be more favorable than in states that did not expand Medicaid. Early success with Kentucky's exchange also translated into gains in access to coverage for consumers. HRSA's ongoing outreach and enrollment funding is ultimately an opportunity to innovate, collaborate, and ultimately better serve health center patients and communities.

Table 1: Key Metrics for MCHC

Data Point	2013	2014	% Change
Total Patients	25,699	27,082	5%
Total Uninsured Patients	3,959	1,744	56%
Payer Mix:			
Medicaid	7,989	11,446	43%
Medicare	5,491	5,661	3%
Private Insurance	8,260	8,231	-.4%*
Self-Pay/Uninsured	3,959	1,744	-56%
Total Revenues	$15,166,063	$16,942,438	10%
Total Uncompensated Care as a Percent of Net Service Revenue	17%	14%	-3%
Total FTE Staff	193.81	223.80	13%
Total # of Staff Dedicated Solely to Providing Enrollment Assistance	3.28	6.68	51%
Total # of Trained Enrollment Assisters	27	27	0%
Total # of Insurance Enrollment Assists	3,177	7,889	60%
Total # of Applications Completed	2,541	5,254	52%

*This decrease was due to multiple factors: The largest factor is that patients were losing private commercial insurance due to large loss of employment in the coal fields of Eastern KY where MCHC is located. Other privately insured patients were eligible for Medicaid after the state expanded Medicaid.

Table 2: Selected UDS Measures*

Measure	MCHC-2013 UDS	MCHC-2014 UDS	MCHC-Jan.-Sept., 2015	Ky Average-(2014 UDS)	National Avg.-(2014 UDS)
Number Female Pts. with Pap test last 2 years	38%	42.63%	50%	52.12%	56.34%
Patients aged 2-17 with BMI percentile and counseling	56%	63.56%	84%	51.77%	56.64%
Patients >= 18 with BMI Charted, and follow up plan if overweight	69%	77.08%	93%	63.86%	56.14%
Patients between 51-74 having colonoscopies	19%	44.73%	60%	34.45%	34.53%

*As illustrated, MCHC is making strides in improving quality measures. The shift truly began in 2014, with the expansion of Medicaid.

Preventive/Wellness Visits*

Year	# Visits
2013	4,336
2014	5,248
2015 (Jan-Sept)	6,119

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