EXPANDING COVERAGE, DEVELOPING HIT INNOVATIONS, AND INCENTIVIZING QUALITY

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Practitioners' Essay

Early Implementation Lessons on the Patient Protection and Affordable Care Act Outreach and Enrollment Efforts in the Asian American and Pacific Islander Communities

Regina Lee, Jen Lee, David Aguilar,
Betty Cheng, Kevin Lee, and Thu Quach

Abstract

Enacted in 2010, the Patient Protection and Affordable Care Act (ACA) intended to make health insurance coverage more affordable and accessible for millions of Americans. However, achieving this goal requires significant targeted, culturally and linguistically appropriate outreach and education efforts for vulnerable communities, such as low-income, underserved Asian Americans and Pacific Islanders. This article describes multiple innovative strategies and approaches used by two well-established community health centers, Charles B. Wang Community Health Center in New York and Asian Health Services in California, as well as the early-stage impacts of outreach and enrollment assistance for the state exchange marketplaces promoting the ACA.

Introduction

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) is the most comprehensive health care reform legislation since the passage of Medicaid and Medicare in 1965 (Public Law 111-148, 2010). Since its promulgation, different parts of the law have already been implemented, allowing states to expand health coverage and improve affordability. The law's centerpiece established

federal and state health insurance marketplaces to give individuals greater ability to choose a health care plan that best suits their needs and preferences. Several states, including New York and California, have chosen to create their own state health insurance marketplace.

The ACA aims to improve patient care outcomes, control health care spending, and increase health insurance coverage. It also promotes health equity by increasing access to health care, the lack of which is a major underlying cause of health disparities. It is estimated that more than 1.9 million eligible, uninsured Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) will gain access to the new options for health care coverage (Wendt et al., 2014). Eight in ten, or 1.6 million, are eligible for tax credits to purchase insurance through the health insurance marketplace, or for Medicaid or the Child Health Insurance Program. California and New York are among the top states with high numbers of foreign-born residents and eligible uninsured AANHPIs at thirty-five percent and nine percent, respectively (Wendt et al., 2014). However, a majority of the U.S. population still does not know the full impact of the ACA (Grossman et al., 2013). On a published Health Tracking Poll by Kaiser, fifty-seven percent of the people surveyed reported that they do not have enough information about the ACA to understand how it will affect them. More importantly, this number increases to sixty-eight percent among some of the key groups the law was designed to help, such as the uninsured and those with incomes below $40,000 ("Kaiser Health," 2013). Health care access problems are also exacerbated in minority communities by immigration status, language barriers, cultural stigmas regarding public benefits, and low utilization of primary and preventive care ("Health Care Access," Asian and Pacific Islander American Health Forum, 2014).

Role of Community Health Centers in Promoting ACA Implementation

Since 1965, Federally Qualified Health Centers (FQHCs) have been a key component of the primary care safety net in the United States (Poppitt and Dacso, 2010). FQHCs have been the focus of the Obama Administration's health reform plan ("Report to Congress," 2011) because they provide the foundation for quality, accessible, and affordable primary care services (Adashi, Geiger, and Fine, 2010). Various studies have shown that FQHCs have been

effective in improving access to care for underserved populations (Starfield, Shi, and Macinko, 2005; Shi et al., 2009). FQHC patients have been shown to have a twenty-four percent lower total cost of care compared to those who do not receive most of their care from FQHCs (Richard et al., 2012). Additionally, a hallmark feature of a FQHC includes its location in underserved communities and its interdisciplinary teams, composed of primary care providers, nurses, social workers, health educators, patient navigators, nutritionists, interpreters, and outreach workers who provide a range of support services like translation and transportation (Calman, Golub, and Shuman, 2012). It is in this context that the vital role of the FQHC comes into play when reaching out to AANHPI communities to provide education and enrollment assistance for the ACA. Governed by consumer-majority boards, FQHCs have developed relationships with community leaders and organizations, placing them in the optimal position to connect to hard-to-reach pockets of the population. FQHCs are equipped with qualified professionals who can provide in-language services and are capable of lifting cultural barriers in many immigrant and migrant communities.

Two FQHCs serving Asian American and Pacific Islander (AAPI) communities in the New York metropolitan area and Alameda County in California have been actively involved in the implementation of the ACA. The Charles B. Wang Community Health Center (CBWCHC) and Asian Health Services (AHS) provide high quality and accessible primary care and support services to low-income, limited English proficient (LEP), and medically underserved Asian American and Pacific Islander populations.

CBWCHC is one of the leading primary health care providers in the New York metropolitan area for Asian Americans who face language, cultural, and financial barriers in accessing comprehensive health care. CBWCHC operates in four locations in Lower Manhattan and in Flushing, Queens, with services that include internal medicine, prenatal and postnatal care, pediatrics, dental care, mental health, social work, and health education, among others. In 2013, CBWCHC served more than 47,000 patients and provided 258,000 service visits.

AHS is a comprehensive community health center that provides medical care, health education, insurance counseling, and client advocacy. Specific services include adult medicine, pediatrics, prenatal and postnatal care, dental care, and behavioral health. In

2013, AHS provided more than 102,000 medical, dental, and behavioral health visits to 24,000 patients.

In 2013, CBWCHC and AHS received public and private funding to engage in outreach and enrollment assistance activities for the NY State of Health marketplace and the Covered California marketplace, respectively. According to the 2013 Urban Institute Report, an estimated 39,000 Chinese-speaking New York City residents will gain public or private health insurance coverage through the NY State of Health (Blavin, Bloomberg, and Buettgens, 2013). Similarly, Alameda County has approximately 44,870 Asian Americans and Pacific Islanders who are uninsured and could potentially benefit from the Covered California marketplace (U.S. Department of Commerce, 2011).

This article describes multiple strategies and approaches used by CBWCHC and AHS, and the early-stage impacts of outreach and enrollment assistance for the NY State of Health and Covered California. Early lessons learned can be beneficial to other FQHCs that are planning similar initiatives or are planning to expand existing programs. This article also provides policy recommendations and best practices to inform the ongoing implementation of the ACA.

Strategies

Preparatory Phase

In May 2013, CBWCHC and AHS started planning for the implementation of the ACA in their respective geographic areas. Both FQHCs focused their initial efforts on solidifying their organizational capacity to conduct multiple strategies around outreach, education, and enrollment. AHS expanded and redesigned its eligibility pathway by creating a new Certified Eligibility Center (CEC). The purpose of the CEC was to designate a separate location from the health center that would provide onsite, in-language enrollment assistance with a strong emphasis on customer service and consumer education. It was designed to provide assistance to nonpatients and to ensure that the AAPI community as a whole had access to health coverage, whereas AHS's existing membership services department continued to provide assistance to AHS patients who had to transition their health coverage to Expanded California Medical Assistance Program or commercial plans in Covered California. AHS used its funding to expand the capacity of existing community

health workers, sending 38 of them and membership services staff to complete state training as certified enrollment counselors. These enrollment counselors served as a critical team, assembled to conduct in-language (i.e., Cantonese, Mandarin, Vietnamese, Korean, Khmer, Tagalog, Burmese, and Karen) services for AHS patients and nonpatients.

CBWCHC also began its internal planning efforts. At the executive level, a planning committee chaired by the chief operating officer was established to map out outreach, education, and enrollment strategies. Executive team members began outreach to the local and ethnic media, elected officials, community organizations, private businesses, and health providers, among others. Nine experienced staff at CBWCHC as well as newly hired were trained by the NY State of Health to be navigators or certified application counselors.

Outreach and Education

There were multiple approaches used to promote outreach and education on the ACA in the diverse AAPI population. For example, the communications strategy adopted by CBWCHC focused on ACA benefits, such as gaining better coverage for individuals and families, providing for economic security, improving quality of health and quality of care, and reducing premium costs particularly for those who do not qualify for a tax credit. Information regarding penalties for failing to secure health coverage was made available but was not emphasized. This strategy was put into place to counter some of the misconceptions about the NY State of Health present in the community.

AHS took a different approach by conducting focus groups with frontline eligibility workers to identify and prioritize key questions from patients and community members seeking information about health coverage options. The input from these focus groups helped inform the development of an educational brochure and an animated video titled, "What You Need to Know about the Health Care Law." These resources served as an effective introduction to California's Medicaid expansion, Covered California, and the county's low-income health program option for the remaining uninsured. Working to understand key concerns and values coming directly from consumers and staff greatly informed the development of language- and literacy-appropriate education-

al tools. These tools addressed changes in Medicaid regulations, such as the elimination of the assets test for newly eligible, new income thresholds; qualifications for premium assistance; deadlines for open enrollment; and applicable ACA penalties. The video was then translated into various Asian languages and used in patient waiting areas and at outreach events.

The initial steps taken by CBWCHC and AHS highlight common features in relaying key messages to their respective communities. These messages focused on access to in-person assistance and informational workshops, the opportunity to qualify for "discounts" or premium assistance based on income, and the deadline dates for enrollment.

A major barrier CBWCHC and AHS encountered to implement enrollment services was the lack of culturally and linguistically appropriate consumer education materials about the ACA available in various Asian languages. In response, CBWCHC and AHS translated informational brochures and ACA documents from English into Asian languages, such as Chinese, Vietnamese, Khmer, Korean, Tagalog, Mien, Lao, Mongolian, Burmese, and Karen. The translations were subject to vigorous quality review to ensure fidelity to the source document and effectiveness in communicating key messages.

Similar approaches have been undertaken by CBWCHC and AHS in terms of community partnerships. Partnering with the local and ethnic media has proven to be a very effective way to reach the target population, ensuring accurate messaging and information about available in-language services. CBWCHC and AHS became leading sources of information by hosting multiple interviews and conversations with the local and ethnic media as well as participating in various community forums to speak about the ACA. AHS partnered with a local media source to provide accurate information and proposed terminology to best describe and explain access options through Covered California. Local and ethnic media has also been a proven ally in the promotion of onsite enrollment sites. For example, enrollment hours offered in partnership with a Vietnamese community-based organization were advertised in a weekly magazine. Similar efforts were taken by CBWCHC to educate and advise ethnic media on how to effectively communicate with the public on the rollout of the NY State of Health. After receiving technical assistance from CBWCHC, one

local Chinese-language daily newspaper ran a supplement about the NY State of Health for distribution to its readers. The purpose of the supplement was to provide guidance to consumers and to dissipate misleading information. CBWCHC also held consultation meetings with the Chinese language print and broadcast media to encourage the use of standardized, translated terms to avoid confusion for non-English-speaking consumers.

Building and nurturing existing partnerships with other agencies and organizations was an essential component of outreach strategies. These partnerships enabled CBWCHC and AHS to effectively identify and work with newly eligible populations and successfully help them navigate the enrollment process. Using the local YMCA, libraries, colleges, churches, temples, and local businesses as enrollment sites and places to disseminate information enabled CBWCHC and AHS to reach out to AAPI consumers, both young and adult. The use of Wi-Fi, laptops, portable printers, and scanners allowed enrollment counselors to provide onsite services in a variety of locations. Traditional venues such as town hall meetings and community forums were also used by CBWCHC and AHS to help promote awareness and education. For example, in September 2013, CBWCHC organized an Asian American community forum held at the Queens Library in Flushing, NY, to launch the official start of the NY State of Health marketplace enrollment. The forum was attended by more than 300 patients, community members, elected and appointed officials, and representatives from ethnic and mainstream media, community-based organizations and local business groups. Federal, state, and local officials conveyed the importance of the NY State of Health for all New York residents, highlighting the affordability of marketplace plans and impact of health insurance coverage on public health. During the forum, CBWCHC provided simultaneous interpretation in four Asian languages. Similarly, AHS also held a town hall meeting for more than 500 patients and community members offering simultaneous interpretation in nine Asian languages. During this meeting, AHS introduced its video and translated brochures and answered questions from patients about the ACA.

CBWCHC and AHS both partnered with a statewide network of AAPI organizations working on ACA outreach and enrollment efforts. The network allowed CBWCHC and AHS to advocate for the improvement of all access portals for LEP consumers in the NY State of Health and Covered California marketplaces. Advocacy

was crucial to help expedite the availability of enrollment certification trainings, which were delayed two to three months into the open enrollment period.

Enrollment Assistance

All outreach and education efforts were geared toward helping consumers sign up for health insurance through the marketplace. Some of the early major challenges that CBWCHC and AHS encountered during this phase include the following:

1) The state marketplace websites experienced sporadic system failures, technical difficulties, and delays in registering and enrolling consumers. These system issues created a backlog of consumers waiting for appointments or needing to be rescheduled. To address this issue, the enrollment counselors dedicated extra hours to meet the needs of consumers.

2) There were delays at the state level in certification training prior to and even after the October 2013 open enrollment that created significant time constraints on starting enrollment for CBWCHC and AHS.

3) Official responses to some complex questions asked by enrollment counselors about the state marketplaces took longer than expected. For example, CBWCHC enrollment counselors encountered delays in determining eligibility for Medicaid. AHS enrollment counselors had similar experiences with delays in determining eligibility for mixed-status families.

4) In the beginning, the requirement to use naturalization certificates instead of U.S. passports as proof of identity was difficult for consumers. CBWCHC and AHS maintained a proactive dialogue with the state marketplaces, and as a result, the state marketplaces allowed the use of U.S. passports as proof of identity. There was also confusion in the Covered California marketplace regarding the eligibility of legal permanent residents residing in the U.S. for five years or fewer. Historically, California had extended Medicaid coverage to such individuals from its own funds after federal funding was no longer available. In 2013, the Governor of California decided that these individuals would be placed into the marketplace but provided with Medicaid-like benefits. While the state required several more months to design this transition and policy, the early months of enrollment suffered from a lack of clear instruction and guidance.

Depending on the requirements from each state marketplace and the specific geographical circumstances, CBWCHC and AHS used a variety of enrollment methods unique to their target populations. At CBWCHC, enrolling a consumer initially took more than two hours, given the complexity of explaining the ACA law in a culturally competent way and navigating the various insurance policy options. During the enrollment period, CBWCHC staff provided four educational workshops per week in Cantonese, Mandarin, and Korean. Although this additional service was not supported by funding, CBWCHC believed it was crucial in order to provide quality care and help the consumers make informed decisions. During the two-hour workshop, attendees were provided with information about Medicaid and qualified health plan eligibility criteria, health insurance options and coverage, and documentation required for enrollment. The workshops helped cut down the actual enrollment time in half. Aside from the workshops, enrollment counselors dedicated extra time during the one-on-one enrollment assistance process to help their consumers understand the intricacies of the new health insurance program. In a conversation held in March 2014, the CBWCHC chief operating officer and ACA program director noted:

> We decided to spend a good amount of time with consumers to really help them understand in a culturally appropriate way what their insurance policy options are with the NY State of Health. Most consumers did not understand health insurance concepts, such as deductibles and co-pays, as well as their rights and responsibilities stated in their application in fine print. We want our consumers to make informed decisions. We want our success with the NY State of Health to be measured not just by the number of people we enroll, but also by the quality of services that we are known for in the community.

NY State of Health also requires consumers to have email accounts. The enrollment counselors provided a crash course on opening and managing email accounts for those who did not have them. To further boost enrollment efforts, CBWCHC sent out more than 6,000 letters to patients who might be eligible for ACA to inform them about the NY State of Health and available enrollment assistance.

At the CEC, AHS adopted a two-step enrollment process for consumers to help ease and streamline the enrollment process. The

first step involved a "shop and compare" appointment lasting fifteen to thirty minutes. During this process, a consumer would be screened using the cost calculator to predetermine eligibility. This appointment was effective as education, orientation, and preparation for full enrollment. Consumers were provided translated materials, including either an explanation of Medicaid services or a printout of their estimated marketplace options, followed by detailed instructions and a checklist of what forms of identification they need to bring to their full enrollment appointment in the next one to two weeks. Return rates for these consumers were extremely high, and the enrollment process — pending any website issues — averaged forty-five minutes to one hour. LEP enrollees benefited from learning insurance terminology, and this strategy significantly reduced time spent on the enrollment process. Consumers who directly called the state marketplace hotline and needed additional support were referred back to CBWCHC and AHS for further assistance. This additional support included helping consumers fax required documents to the state marketplace, providing in-depth understanding of health coverage options, or assisting the consumer in accessing data in the system. CBWCHC and AHS have also observed that some undocumented individuals have expressed their willingness to pay their own premiums for health coverage.

Some unique aspects of the ACA enrollment initiatives from CBWCHC and AHS merit special attention. CBWCHC provides ongoing education and updates regarding the NY State of Health to all administrative and clinical staff who also played a role in reaching out to the self-pay patients potentially eligible for coverage. The chief operating officer's (COO) involvement ensures that the health center's leadership is fully informed of any challenges within the enrollment program and takes immediate corrective action when needed. In addition, in order for the enrollment counselors to dedicate their time to enrollment and counseling, CBWCHC employed a collaborative team approach, using support staff to handle telephone inquiries, book appointments, facilitate workshops, and administer the database and reporting. Under the leadership and guidance of the seasoned COO, the enrollment counselors shared their experiences and lessons learned from each processed application at weekly case conferences. These measures resulted in increased productivity and efficiency of the enrollment

counselors and high numbers of successful applications and satisfied clients.

In addition to the efforts directed at diverse AAPI ethnic communities, AHS has outlined outreach and enrollment initiatives aimed at AAPI young adults, ages 18–34, or the so-called "young invincibles" (Levitt, Claxton, and Damico, 2014), a portion of the population whose enrollment was recognized as a key determinant and driver of success for the ACA. These initiatives included launching an education and support initiative for these transitional age young adults, starting an early intervention effort to orient the youth about the value of health and help them understand the health care system and how health insurance works, and launching a pilot program, *Health is in Your Hand*, using phone text messages to educate the youth, and a mobile application called *Got Coverage?* to help with assessing eligibility. This pilot program is offered through school-based partnerships and was carried out in the summer of 2014. Additionally, AHS is working with its patient leadership councils (i.e., Cantonese, Mandarin, Vietnamese, Korean, Khmer, and Tagalog speaking patient volunteers who meet monthly to promote patient engagement and community building) to train them to become ACA ambassadors who help disseminate information to the diverse communities (Liou et al., 2007). AHS is exploring plans to launch *Young Adults* patient leadership councils to train ACA ambassadors who are more representative of the targeted "young invincible" population. Moreover, AHS is committed to providing outreach and enrollment assistance to the different AAPI communities, including the emerging Burmese and Karen refugee communities in the local area.

Discussion

The efforts initiated at the federal, state, and local levels have provided individuals with information and opportunities to learn about and obtain health care coverage through the state marketplaces. Behind the challenges that CBWCHC and AHS encountered were the success stories of community members who benefitted from this program. Enrollment counselors take pride in the service they provide to hundreds of successful enrollees. According to an AHS enrollment counselor:

> Consumers were grateful that there are enrollment counselors who can help them with the whole application process.

> Some, even those who were computer-savvy needed confirmation and assurance that what they did was correct and the information they were getting was accurate.

Many individuals and families from the AAPI communities benefitted from the implementation of the ACA. In one case, a sixty-two-year-old Chinese female with a preexisting condition after a previous heart surgery had lost both her job and insurance coverage. CBWCHC assisted her with applying for coverage through the NY State of Health. She was overjoyed when she learned that she would be eligible for a government subsidy. Despite her preexisting health condition, her monthly premium was $236. Another case is a Korean male, fifty-two years old, with a family of three. He used to pay approximately $1200 as a monthly premium for himself and for his minor children. It was too expensive, and he was thinking about just getting his children covered but dropping coverage for himself. He applied for a Covered California plan with the assistance of AHS and was able to get coverage for the whole family with $314 in subsidies and a monthly premium of only $103.

The relative success of CBWCHC and AHS in implementing the ACA could be attributed to the following factors: 1) solid organizational infrastructure, 2) strong relationship with multiple public and private sectors in the area, 3) decades of experience providing culturally and linguistically competent care and services, 4) ability to provide support systems for the enrollment counselors, including close supervision and hands-on guidance, 5) dedicated, experienced, and knowledgeable enrollment counselors and supporting staff, and 6) a solid reputation and credibility in the AAPI community.

Recommendations

Based on these lessons learned, we recommend the following:

1. Previous technical difficulties in the state marketplace system affected the ACA's intended timeline, ultimately resulting in missed opportunities to maximize enrollment for consumers. Therefore, much effort was focused on enrollment target goal, which potentially compromised the rights of consumers to make informed decisions. Many of the newly enrolled have been uninsured for years. For some, it was their first time having health insurance coverage. Dealing with a new system

and new terminology, such as "deductibles," "out-of-pocket expenses," "copayments," "premiums and tax subsidies," and "liens," to mention a few, was overwhelming for them. We recommend that the state marketplace prioritize and provide additional funding to FQHCs and other community-based certified enrollment programs to expand their language-specific, in-person assistance. Effective insurance counseling and education models that can be applied consistently in the enrollment setting will have substantial long-term effects to help improve consumers' understanding and ability to maintain health insurance coverage.

2. From a programmatic standpoint, the success of outreach, education, and enrollment for the ACA is not the work of the enrollment counselors alone. To ensure successful enrollment, FQHCs' infrastructure includes bringing together a close-knit and crosscutting team, including representatives from IT, finance, operations, clinical, outreach, social work, and administrative departments. Additional federal funding is needed to support the infrastructure within FQHCs to not only accomplish but also sustain a seamless enrollment-to-care experience in which the consumer is supported, informed, and empowered to access preventive and primary care services over his or her lifetime.

3. The process and policy requirements for identity verification should be streamlined. Delays in verification led to confusion and frustration for enrollment staff and may potentially discourage consumers from the enrollment process.

4. It is unfortunate that the state marketplace is not accessible to undocumented immigrants, even to purchase with their own funds. One related concern is for the growing numbers of mixed-status families made up of individuals with different citizenship or immigration status. As of 2010, nearly one in four children younger than eight had at least one immigrant parent (Chaudry and Fortuny, 2010). While the policies regarding immigrant eligibility for health insurance are complex, it is important to remember that a person who is not eligible, such as an undocumented parent, may apply on behalf of eligible household members. Immigrants in general, and mixed-status families in particular, often do not know what they may be eligible for and are worried about applying. They may not be aware that the ACA protects "non-applicants" who are seeking

benefits for eligible household members from disclosing their immigration status or needing a social security number. The lack of awareness and concerns about immigration consequences could result in children who are U.S. citizens going without health insurance coverage. Minimally, more outreach efforts need to focus on addressing the fears of mixed-status families about enrolling.

5. FQHCs are key providers of comprehensive, efficient, high-quality primary care services to low income, especially Medicaid and uninsured patients. As a safety net provider that serves all patients regardless of their ability to pay, FQHCs face higher operational costs as well as funding challenges (Katz et al., 2011). It is our recommendation that FQHCs be paid by the qualified health plans in the marketplace exchange according to the Prospective Payment System (PPS) rates for Medicaid and Medicare patients. PPS rates more adequately account for the type, intensity, and duration of services furnished by FQHCs. (79 Fed. Reg. 25436, May 2, 2014).

Next Steps

In our effort to accomplish the aims of the ACA and promote health equity beyond the March 31, 2014 enrollment deadline, CBWCHC and AHS will conduct a full inventory of lessons learned, challenges, unaddressed issues, and assets to make further improvement. Corrective measures will be put in place and the necessary adjustments will be implemented. We will continue to raise the awareness of our community members through outreach events, education, and policy recommendations.

The first year of intense planning and implementation provided critical experience to the FQHCs and informed future efforts for sustained outreach and enrollment. Importantly, it also highlighted the major role that FQHCs play in implementing crucial health policies, especially with medically underserved populations. As the nation moves forward to carrying out this historic health policy, FQHCs continue to be at the helm of the transformation.

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Regina F. Lee, J.D., is a cofounder of the Charles B. Wang Community Health Center (CBWCHC). As the center's chief development officer, she directs its fundraising, resource development, communications, internships, outreach, and health education programs and functions. Ms. Lee was deputy director for the Office of Refugee Resettlement, and senior advisor to the Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services. Ms. Lee received her law degree from New York University Law School and completed a postgraduate fellowship in community development in the Department of Urban Studies and Planning, Massachusetts Institute of Technology.

Jen Lee, M.P.H., has worked in health education and prevention for seventeen years, focusing on areas such as HIV/AIDS, rural communities outreach, reproductive health, clinical access, and workforce development. At Asian Health Services (AHS) in Oakland, California, Ms. Lee provided oversight of AHS's prevention programs, translation and medical interpreter certification, and the Patient Leadership Council Initiative. In 2014, she became director of Community Services and Partnerships at the Association of Asian Pacific Community Health Organizations. She received her Masters of Public Health from San Francisco State University and is a graduate of the Blue Shield of California's Clinic Leadership Institute.

David Aguilar, M.A., was an assistant administrator at CBWCHC. He was also a program manager at the New York University Center for the Study of Asian American Health, where he led the Filipino Community Health Worker Health Disparities training program. He has extensive experience in conducting community-based participatory research, focusing on cardiovascular disease, hypertension, and diabetes. Fluent in Filipino and Spanish, Mr. Aguilar holds a master's degree in law from the Universidad de Navarra, Spain, and a certificate in management of nonprofit organizations from Seton Hall University, New Jersey.

Betty Cheng, L.C.S.W., is the chief operating officer of the CBWCHC and oversees the center's operations, focusing on managing the Flushing site, and directing the social work, managed care, marketing, and corporate compliance programs. A medical social worker for more than thirty-five years, Ms. Cheng currently leads the CBWCHC's Affordable Care Act outreach and enrollment program. Fluent in Cantonese and Mandarin, Mrs. Cheng earned a Masters in Social Work and a Postgraduate Certificate in Social Work Administration from the Hunter College School of Social Work.

Kevin Lee is a graduate student pursuing his Master of Public Health at the University of California, Berkeley, and is interested in examining the intersections of the social, structural, and racial determinants that impact the health of marginalized Asian immigrants. Prior to returning to school, he worked at AHS as a health educator focusing on implementing interventions aimed to reduce HIV transmission among at-risk populations. He remains a part-time research assistant working on sexual exploitation of minors, and ACA implementation. Following his graduate studies, he is interested in planning and evaluating interventions and policies that achieve greater health equity.

Thu Quach, Ph.D., M.P.H., is an epidemiologist and a research scientist whose primary research interest has focused on the influence of environmental and sociocultural factors on immigrant population health. At the Cancer Prevention Institute of California, she leads research studies on environmental health issues affecting disadvantaged populations. In 2010, Dr. Quach became the inaugural research director at AHS where she works on multiple clinic-based and health care research projects. She serves on the National Institute of Occupational Safety and Health Service Sector Council, and National Quality Forum's expert panel for the "Risk Adjustment and SES" project.