FINDINGS: SUGGESTED STRATEGIES TO FACILITATE AI/AN ENROLLMENT IN MEDICAID, SCHIP AND MEDICARE

Introduction

During each set of interviews conducted for this study, interviewees were asked to suggest strategies that, in their view, would be effective in reducing barriers to AI/AN enrollment in Medicaid, SCHIP, and Medicare. They were also asked to comment on the entities that they believed should have the responsibility for implementing and financially supporting each identified strategy. The strategies suggested were then categorized by the entities that interviewees suggested should be responsible for implementing and paying for the activity or program proposed by the strategy. These entities include:

- *All Involved Entities: Tribes, IHS, States, and Federal Government*. There were a number of strategies that interviewees said should be carried out, either independently or jointly, by all of the entities that are involved in AI/AN health care and program enrollment.
- *States*. Some strategies were indicated as a specific responsibility of State governments.
- *Federal*. Some strategies were indicated as a specific responsibility of the Federal government.

This information was organized in the same manner as in the preceding section on barriers to enrollment. First, the information collected was organized by State in order to examine the extent to which individual strategies were suggested across States. Table 5 below presents information on whether a specific strategy was suggested by any respondent group in the State. The information in Table 5 does not reflect the frequency with which a specific strategy was suggested, but rather shows that the strategy was mentioned in interviews conducted in the State. We also compared the frequencies with which specific strategies were suggested by Tribal, State, Urban Indian Clinic, and other organizations' respondents, and are reported and summarized in the separate Cross-Cutting Case Study Report submitted to CMS

Again, as is the case with the discussion of barriers to enrollment, it is important to bear in mind that the suggested strategies are based on interviewees' perceptions of the problem and possible solutions. There is little or no information available to determine whether specific strategies would be effective or whether they would be feasible based on costs or political considerations. However, the strategies listed in this section should be viewed as those that knowledgeable people who are involved in AI/AN health care and public program enrollment issues believe would be effective.

Suggested Strategies for Reducing Barriers and Facilitating Enrollment by State

States in which interviewees mentioned a specific strategy to reduce barriers and facilitate AI/AN enrollment are presented in Table 5.

Table 5: Suggested Strategies to Increase Enrollment in Medicaid, SCHIP, Medicare, and Medicare Savings Programs, by State

Suggested Strategies (Percent of States Reporting Strategy)	AK	AZ	MI	MN	MT	ND	OK	SD	UT	WA
Strategies Related to Tribes/IHS/State Governments/Federal Government										
Funding for AI/AN-specific outreach/ enrollment assistance (100%)	●	●	●	●	●	●	●	●	●	●
Targeted outreach/enrollment assistance funding directed to Tribes/Urban Indian Health Clinics (100%)	●	●	●	●	●	●	●	●	●	●
Educational/marketing activities on program benefits to individuals and Tribes (100%)	●	●	●	●	●	●	●	●	●	●
Develop Tribal-specific outreach and enrollment materials (90%)	●	●		●	●	●	●	●	●	●
Strengthen Tribal/IHS incentives for enrollment (70%)	●	●	●	●		●			●	●
Focused outreach and education to elders for Medicare Savings Programs (60%)	●					●	●	●	●	●
Strategies Related to State Governments										
Develop collaborative working relationships among State-Tribes-IHS (100%)	●	●	●	●	●	●	●	●	●	●
Simplify application/redetermination processes (80%)		●	●	●	●	●	●	●		●
Improve Medicaid/SCHIP training for Tribal/IHS/Urban staff (80%)	●	●	●	●	●		●	●		●
Improve eligibility worker program knowledge, focused on AI/AN issues (70%)	●	●			●	●	●	●	●	
Limit redetermination to annual or less frequent (70%)	●	●	●		●	●	●	●		
Out-station eligibility workers on Reservations (70%)		●		●	●		●	●	●	●
Develop AI/AN cultural competency programs for State staff (50%)		●			●		●	●	●	
Educate eligibility workers on AI/AN history, Federal Trust Responsibility, and legal issues (40%)		●		●	●	●				
Exempt AI/AN enrollees from managed care enrollment/program fees/cost-sharing (40%)	●		●			●			●	
Recruit and hire AI/AN eligibility workers (30%)				●	●				●	

Table 5: Suggested Strategies to Increase Enrollment in Medicaid, SCHIP and Medicare Programs, by State (continued)

Suggested Strategies (Percent of States Reporting Strategy)	AK	AZ	MI	MN	MT	ND	OK	SD	UT	WA
Strategies Related to Federal Government										
Improve Medicare program training for Tribal/IHS/Urban staff (80%)		●		●	●	●	●	●	●	●
Improve Federal-State-Tribal government-to-government relationships (80%)	●	●		●	●	●		●	●	●
Develop Tribal Medicaid option (70%)		●	●	●		●		●	●	●
Targeted outreach/enrollment assistance funding directed to Tribes/Urban Indian Health Clinics (70%)	●			●	●	●		●	●	●
Exempt AI/AN Medicaid and Medicare enrollees from premium/cost-sharing (30%)	●					●			●	
Require States to share administrative match funds with Tribes (20%)					●			●		
Develop strategy to assist people to apply to SSDI (20%)			●				●			
Improve AI/AN cultural competency awareness of Federal staff (20%)		●			●					
Make program application information inaccessible to other State agencies (10%)							●			

<u>Suggested Strategies Directed to All Involved Entities</u>

The first category of suggested strategies are those that interviewees believed should be the responsibility, individually and jointly, of all of the entities that have responsibilities for AI/AN health care and program enrollment. Key strategies suggested encompass the following:

- *<u>Increase Funding for AI/AN-Specific Outreach and Enrollment Assistance</u>*. In all of the 10 case study States, interviewees said that funding should be provided or increased for AI/AN-specific outreach and enrollment assistance. In nine of the 10 case study States, this strategy included the development of Tribal-specific outreach and enrollment materials that are culturally appropriate, with messages, language, and design (e.g., use of visuals and familiar faces) that resonate among the specific Tribal members, and that are perhaps translated into the appropriate AI/AN language(s).
- *<u>Provide Increased Outreach and Enrollment Assistance Funds Directly to Tribes and to Urban Indian Health Clinics</u>*. Furthermore, interviewees in all 10 States suggested that the majority of funding for outreach and enrollment assistance should be provided directly to Tribes and to Urban Indian Health Clinics so that Tribes and clinics themselves could design and implement Tribal- or community-specific outreach and enrollment assistance activities with these funds.

- *Develop Educational/Marketing Program for Tribal Leaders and Tribal Members*. Interviewees in all 10 States said that an educational/marketing program should be developed and implemented to increase awareness of Tribal leaders and Tribal members of the benefits to Tribal members individually and to the Tribe as a whole of increasing Tribal members' enrollment in Medicaid, SCHIP, and Medicare.
- *Develop Outreach and Enrollment Assistance Strategies Targeted to AI/AN Elders*. Interviewees in six of the 10 States stated that focused outreach and enrollment assistance strategies would be important to assist AI/AN elders to understand and enroll in the Medicare Savings Programs.
- *Strengthen Tribal/IHS Incentives to Promote AI/AN Program Enrollment*. Interviewees in seven of the 10 states suggested strengthening Tribal/IHS facility incentives to promote AI/AN program enrollment. This included increasing the facility's ability to successfully bill third-party insurance through improved infrastructure for coding, billing, auditing, and follow-up billing and enrollment systems (e.g., improved computer billing systems and improved training for coding and billing clerks).

The major theme, clearly, of suggested strategies that encompass all of the involved entities is that more outreach, education, and enrollment assistance specifically directed to AI/AN people is needed, and that the majority of this outreach, education, and enrollment assistance should be developed either by individual Tribes or with extensive input from Tribes.

Suggested Strategies Directed to States

Suggested strategies that are directed to the States fall into five categories:

- *Improve Collaborative Working Relationships Among the States, Tribes, and IHS*. This suggestion was mentioned by interviewees in all 10 case study States and reflects the reported lack of coordination and cooperation among these entities on Medicaid and SCHIP enrollment issues. While the problem was noted in all States, interviewees were not specific about the best approach to achieve this goal, although some suggested that efforts should be made to bring together the State agency staff, Tribal leaders and staff, and IHS staff on a regular basis to discuss Medicaid and SCHIP issues. Others suggested that States should commit to a formal consultation process with the Tribes on Medicaid and SCHIP policy changes that affect Tribal members. Interviewees in several States noted the importance of a Medicaid/SCHIP AI/AN liaison who is American Indian or Alaska Native in improving relationships in their State.
- *Increase Training for State/County Eligibility Workers and Others Who Assist AI/AN Enrollment Processes*. Interviewees in eight of the 10 case study States suggested that the State should provide and improve Medicaid/SCHIP program training for Tribal, IHS, and Urban Indian Health Clinic staff. There was considerable concern that staff at these organizations have inadequate knowledge and understanding of program eligibility rules and application procedures and, as a result, are not able to effectively assist AI/AN people with

enrollment. There was also considerable concern that gaining such knowledge is extremely time-consuming for staff, particularly for patient benefit advocates who are often responsible for enrollment assistance. In seven of the 10 States, interviewees also mentioned that eligibility workers should be provided training on programmatic issues specific to AI/AN eligibility. This suggestion particularly related to issues of asset determination and Trust lands, Medicaid estate recovery, cost-sharing exemptions, and ability of AI/AN enrollees to continue to use IHS providers after enrollment in Medicaid/SCHIP. In five States, interviewees also suggested that training of eligibility workers should include cultural issues that are important to working effectively with AI/AN clients. In four States, interviewees suggested that training be provided to eligibility workers to increase their knowledge of AI/AN history, the Federal Trust Responsibility, and legal issues affecting AI/AN eligibility and enrollment in Medicaid and SCHIP.

- *Implement Additional Strategies for Eligibility Workers*. In addition to increased training for eligibility workers and others, interviewees in seven States said that it would be helpful if States would place eligibility workers on Reservations or in Urban Indian Health Clinics. This would address two major barriers: 1) transportation difficulties would be reduced; and 2) eligibility workers assigned to work on Reservations and in Urban Indian Clinics would have the opportunity to develop in-depth relationships and understanding of AI/AN culture, history, and eligibility issues that are unique to this population. Interviewees in three States put forth a related suggestion that States should make greater efforts to recruit and hire eligibility workers who are American Indians or Alaska Natives.

- *Simplify Application and Redetermination Processes*. In eight of the 10 States, interviewees recommended that the application and redetermination processes for Medicaid, particularly, and SCHIP should be simplified and made less burdensome. In seven of the 10 States, interviewees suggested that redetermination should be required annually or even less frequently. These suggestions were consistent with the substantial majority of interviewees' perceptions that the complexity of the application/redetermination process, including attainment of supporting documentations, is a deterrent to enrollment in Medicaid and SCHIP.

- *Exempt AI/AN Enrollees from Managed Care Programs and from Program Fees/Cost-Sharing*. Interviewees in four of the 10 case study States suggested that special provisions to exempt all AI/AN enrollees from participation in managed care and waiving Medicaid program fees and cost-sharing requirements (as is the case for SCHIP) for AI/AN enrollees would encourage higher enrollment.

With the exception of the first strategy above – improving collaborative working relationships among the States, Tribes, and IHS – the suggestions made by interviewees are ones that would also be likely to reduce barriers to enrollment for the general population eligible for Medicaid/SCHIP programs and for other racial/ethnic minority groups within the general population.

Suggested Strategies Directed to the Federal Government

Suggested strategies that would be the responsibility of the Federal government and its agencies include:

- *Improve Federal-Tribal-State Relationships*. Interviewees eight of the 10 case study States said that improving the Federal-Tribal-State government-to-government relationships would reduce barriers and facilitate enrollment of AI/AN people in public programs. This issue was related to interviewees' perceptions that Medicaid and SCHIP, particularly, place States in the middle of the Federal-Tribal relationship with respect to the Federal Trust Responsibility to provide health care to members of Federally-recognized Tribes. In seven of the 10 States, interviewees suggested that one way to address this problem was for the Federal government to make a Tribal Medicaid program option available. Since the Federal government pays 100 percent of the cost of Medicaid services provided within IHS/Tribal facilities, a Tribal Medicaid program would permit Tribes to have responsibility for program management, eligibility determination, and the provision of outreach and enrollment assistance to Tribal members. Interviewees in two States suggested that the Federal government should require States to share administrative match funds with Tribes, which would then assume responsibility for outreach and enrollment assistance to Tribal members.

- *Fund Tribal and Urban Indian Health Clinic Outreach and Enrollment Assistance Programs*. In seven of the 10 States, interviewees suggested that the Federal government should provide funds to Tribes and Urban Indian Health Clinics to conduct Tribal- or community-specific outreach and enrollment assistance activities for Medicaid, SCHIP, Medicare, and the Medicare Savings Programs. If such funding were available, Tribes and clinics could design and carry out culturally-effective outreach and would be able to hire Tribal or local community members with knowledge of cultural and other issues that are important to developing trusting and effective one-to-one relationships with AI/ANs eligible for public program enrollment.

- *Develop and Provide Medicare and SSDI Program Training to Tribal, IHS, and Urban Indian Health Clinic Staff*. Interviewees in eight of the 10 case study States suggested that the Federal government should design and conduct training programs on the Medicare program and its benefits. In two of the 10 States, it was recommended that the Federal government develop programs to assist AI/AN people to understand and apply for SSDI as a means of obtaining Medicare enrollment. Interviewees generally stated that most Tribes, IHS, and Urban Indian Clinic staff lack sufficient knowledge of Medicare and SSDI to be able to provide useful assistance to AI/AN clients eligible for these programs.

- *Exempt AI/AN Enrollees from Premiums and Cost-Sharing Requirements*. Interviewees in three of the 10 States suggested that the Federal government exempt all members of Federally-recognized Tribes from paying premiums and cost-sharing when they are enrolled in Medicaid or Medicare. This exemption would be consistent with the Federal rule that exempts AI/AN SCHIP enrollees from cost-sharing, and would address the concerns that

many AI/AN eligibles have about additional costs that may be associated with enrolling in Medicaid or Part B of Medicare.

- *Provide Cultural Competency Training to Federal Program Customer Service Staff*. In two of the 10 States, interviewees suggested that Federal customer service staff be provided cultural training so as to provide more effective service to AI/AN people who contact them for assistance.
- *Prohibit States from Internal Sharing of Medicaid/SCHIP Program Application Information*. In one State, interviewees specifically requested that Federal policy be changed to prohibit States from sharing Medicaid/SCHIP program application information with other State agency staff. This would help to increase enrollment by reducing the fear that the State will pursue child support from absent parents, place children supported by grandparents in the foster care system, identify illegal aliens, or other types of information sharing that increase mistrust of governments.

The suggested strategies that focus on improvements or changes in Federal-Tribal-State relationships are unique to the AI/AN population and reflect the special status of Tribes relative to Federal and State governments. The other strategies directed to the Federal government, though, address barriers to enrollment that are likely to affect all persons who may be eligible for enrollment in Medicaid, SCHIP, and Medicare. These include community-based and culturally-tailored outreach, reduction in program costs to enrollees, and increased cultural competency training for Medicaid and SCHIP customer service workers. (Medicare does not have customer service workers, and, unlike Medicaid and SCHIP, has regional, rather than local, intake offices.)

The greatest agreement among Tribal, State, and Urban Indian Health Clinic interviewees was that more outreach and application assistance tailored to the AI/AN population would be a useful strategy to reduce barriers and facilitate enrollment in Medicaid, SCHIP, and Medicare. There was considerably less agreement about the need for more training for State/county eligibility workers and for the simplification of Medicaid/SCHIP application processes. State interviewees were also less likely than Tribal and Urban interviewees to make suggestions about strategies that the Federal government might undertake to increase enrollment in these programs.

Discussion

The information and findings presented in this report provide interesting and useful insights into the perceptions of Tribal, State, IHS, Urban Indian Health Clinic, and other organizational interviewees in the 10 States that have the largest populations of AI/ANs. More than 300 people participated in the interviews conducted with 10 States with staff from Medicaid, SCHIP, and Tribal liaison agencies, 22 Tribes/Reservations, nine Urban Indian Health Clinics, and 10 other organizations involved in AI/AN health and public program enrollment.

Interviewees identified a number of issues that are unique to AI/ANs that create barriers to enrollment in public programs. These include the relationship between the Federal government

and Federally-recognized Tribes that includes Federal provision of health care and other services to members of these Tribes, and Tribal sovereignty issues that affects Federal-Tribal-State government-to-government relationships. The historical experiences of Tribes with Federal and State governments results in a degree of mistrust of governmental programs that may affect the willingness of AI/AN people to apply for Federal and State health programs. In addition, Tribal leaders and Tribal members may perceive that the Federal Trust Responsibility to provide health care to the Tribes means that Tribal members should not have to apply for assistance through Medicaid, SCHIP, and Medicare. As well, the fact that IHS services are available to provide routine primary and preventive care and some degree of specialty care for serious illnesses may cause some AI/AN people to question the need to enroll in public programs. A number of interviewees suggested that there is a lack of awareness among Tribal leaders and Tribal members of the benefits to the entire Tribe that are associated with enrollment in these programs, which can provide additional revenues to I/T/U facilities that permit more services to be available to all Tribal members.

The majority of the barriers to enrollment in public programs identified by interviewees are common to barriers faced by the general U.S. population and by other racial/ethnic minority groups. The most frequently mentioned barriers to enrollment include: lack of awareness and knowledge of Medicaid, SCHIP, and Medicare programs and benefits and of eligibility criteria; transportation barriers; language and literacy barriers; complexity of application and redetermination processes; and cultural barriers.

Because a high proportion of AI/ANs reside in rural areas on Reservations with high poverty rates and low educational levels, these barriers may be a greater deterrent to enrollment than is the case for the general program eligible population. However, this study was not able to quantify the magnitude of the impact of specific barriers on enrollment rates. As a result, it is only possible to speculate that this might be the case. The concentration of the AI/AN population in rural areas does, though, suggest that transportation barriers may be substantial given long travel distances and lack of public transportation to eligibility offices. In addition, outreach, education, and enrollment assistance has been found to be a greater challenge in remote areas that require outreach/enrollment workers to travel long distances between clients and where television, radio, and newspaper availability is lower than in urban areas. It is also possible that the large number of different languages spoken by AI/AN people is a greater barrier to providing outreach and educational materials in translation than is the case for other racial/ethnic minority groups that speak common languages.

Strategies suggested by interviewees to reduce barriers and to facilitate AI/AN enrollment in Medicaid, SCHIP, and Medicare were strongly focused on increased culturally-appropriate outreach and education materials and activities, and providing one-to-one assistance with application and redetermination processes. Many interviewees recommended that State governments and/or Federal government provide training to Tribal, IHS, and Urban Indian Clinic staff on Medicaid, SCHIP, and Medicare benefits, eligibility requirements, and application processes so they can better provide the one-to-one assistance needed. In addition, many

interviewees suggested that simplifying the application process and making redetermination less frequent would be useful strategies. A number of interviewees also suggested that State/county eligibility workers – and Social Security Administration employees who work with Medicare and Social Security Retirement and Survivor's Benefits, SSDI, and, SSI application processes – be given more training on program and eligibility determination issues and on AI/AN history and legal issues that affect eligibility determination. Cross-training of these eligibility workers is also important because most AI/ANs do not consider CMS programs separately from Social Security Administration (SSA) programs; eligibility workers need to be knowledgeable about both agencies' programs. In addition, some interviewees also suggested training for eligibility workers to increase cultural awareness.

Several interviewees proposed additional strategies that address unique issues for the AI/AN population. A number of interviewees suggested that the Federal government provide funding to Tribes and Urban Indian Health Clinics to develop and implement locally-directed and AI/AN-specific outreach and enrollment assistance programs, either directly or through requiring that States provide a share of Medicaid/SCHIP administrative match funds to Tribes for this purpose. Some interviewees suggested that the Federal government establish a Tribal Medicaid option that would permit Tribes to manage their own Medicaid programs and determine eligibility for Tribal members. Several interviewees from Tribal, State, and Urban Indian Clinics also suggested that developing processes to improve Federal-Tribal-State government-to-government relationships would be useful for reducing barriers and facilitating enrollment in these programs.

The specific strategies that have been suggested by participants in this study are wide-ranging, from relatively narrow, targeted strategies (e.g., provide more training on program eligibility criteria to State/county eligibility workers) to strategies that would require substantial changes in Federal and State policy (e.g., develop a Tribal Medicaid option). The feasibility of specific strategies has not been assessed in this study. However, it will be necessary to consider feasibility in considering and choosing specific strategies that might be implemented. Two of the most important feasibility considerations are: 1) the cost of the strategy, if extended to all AI/AN populations; and 2) the political issues that would need to be addressed to implement the strategy.

With current Federal, State, and Tribal budget constraints, some strategies might require more resources relative to the benefits obtained than are considered reasonable. As an example, a strategy that would require translation of all program outreach and educational materials into every AI/AN language in order to make these materials accessible to all AI/ANs with limited fluency in English might require considerable costs to meet the needs of a relatively small number of people. Similarly, strategies that would require Congress to act before they could be implemented and/or that would require negotiations between the Federal government, States, and Tribes (such as a Tribal Medicaid option) could take many years to develop and carry out. These considerations will need to be assessed in order to determine whether the strategies identified in this study might be developed and implemented to reduce barriers and increase AI/AN enrollment in the Medicaid, SCHIP, and Medicare programs.