Coverage For American Indian and Alaska Native Children

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Ensuring Coverage For American Indian and Alaska Native Children: An Assessment Of The Medicare Access and CHIP Reauthorization Act Outreach and Enrollment Round III Grantee Activities, July 2017–June 2018

Background

Children's access to health insurance in the United States has improved dramatically over the past two decades. Driven largely by the availability of public health insurance provided through Medicaid and the Children's Health Insurance Program (CHIP), the rate of uninsurance among children has dropped from about 15 percent in 1997 to 5 percent in 2017 (Bennefield 1998; U.S. Census Bureau 2018).

Despite this progress, as of 2017, nearly 4 million children were uninsured (U.S. Census Bureau 2018). In particular, more work is needed to find and enroll harder-to-reach populations, especially American Indian/Alaskan Native (AI/AN) children. Although they too have benefited from the expanded availability of public health coverage, 8 percent of AI/AN children were uninsured in 2016, nearly double the rate of uninsurance for all children in the United States that year (Haley et al. 2018). Better access to high-quality health insurance and health care could help address diabetes, chronic liver disease, heart disease, and other illnesses that are more common in AI/AN populations than other population groups in the United States (Center for Medicaid & CHIP Services 2016).

Connecting Kids to Coverage

To reach, enroll, and retain more children in Medicaid and CHIP, the Centers for Medicare & Medicaid Services (CMS) launched the Connecting Kids to Coverage (CKC) National Campaign and Grants Program in 2009. These initiatives have three primary goals: (1) raise awareness about Medicaid and CHIP; (2) motivate parents to enroll their eligible children and teens and renew their coverage; and (3) provide free materials to help states, community groups, and others conduct successful outreach activities (InsureKidsNow.gov not dated). Beginning in 2010, CMS launched a CKC grant program focused on enhancing outreach and enrollment support for AI/AN children. To date, CMS has awarded three rounds of Tribal outreach grants to AI/AN organizations and made available $10 million in the first round, $4 million in the second round, and $4 million in the third round (InsureKidsNow.gov 2017).

CMS contracted with Mathematica Policy Research to evaluate and report on grantees' performance, and to provide technical assistance to help support grantees. This evaluation summary describes the first-year experiences of the eight Round III cooperative agreements with AI/AN organizations (Figure 1). It is based on a review of grantees' progress reports covering the first year of their two-year grants, July 2017 through June 2018.

Key findings

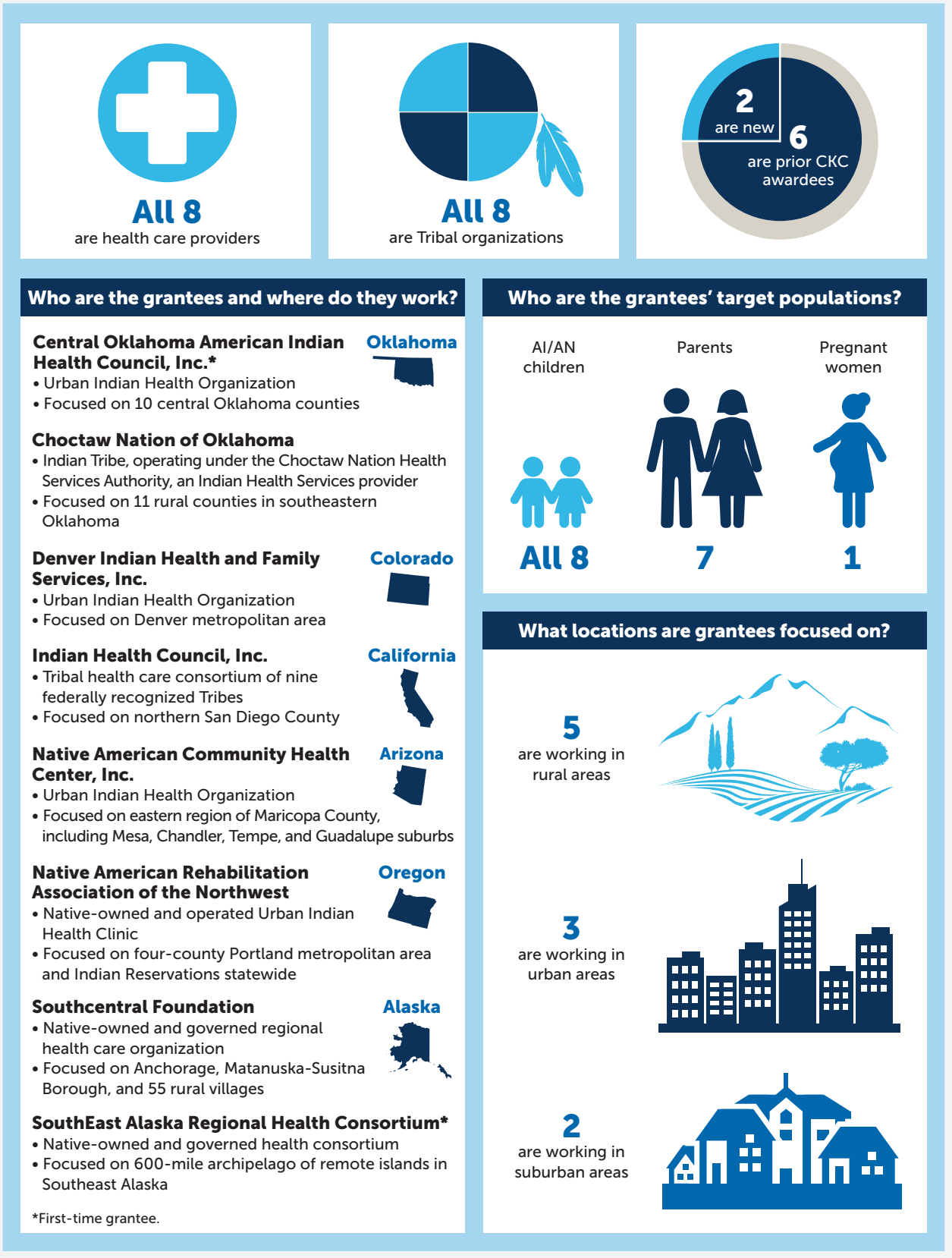
The Round III grantees helped more than 6,000 children gain or renew Medicaid or CHIP coverage between July 2017 and June 2018.

Outcomes. Many families benefited from grantees' efforts during the first year of Round III grants:

- The eight Round III grantees serving six states supported application and renewal form submissions for more than 7,000 children, helping 6,029 children gain or renew Medicaid or CHIP coverage from July 2017 to June 2018. Across all eight grantees, renewals outpaced new enrollments, with 3,589 renewals compared to 2,440 new enrollments, although this varied at the grantee level. About 80 percent of the children grantees helped to newly enroll or renew coverage were of AI/AN descent (six of the eight grantees tracked this data).

- Five grantees—Central Oklahoma American Indian Health Council, Inc. (Central Oklahoma), Denver Indian Health and Family Services (Denver Indian Health), Native American Community Health Center (Native Health), Native American Rehabilitation Association of the Northwest (NARA-NW), and Southcentral Foundation (SCF)—have already achieved 40 percent or more of their two-year child enrollment and renewal targets. To date, two of the three grantees that have not met their targets serve exclusively rural areas, and one of these is also a new CKC grantee. Several factors might have contributed to the challenges faced by these grantees, however, conducting outreach in very remote rural areas sometimes prevented the grantees from being able to contact or follow up with prospective applicants. Some of the barriers experienced by grantees included limited or no roads, poor road conditions, bad weather, challenging geographic terrain, and little or no internet or phone access.

Figure 1. Characteristics of Round III grantees



Source: Mathematica's analysis of grantees' semiannual reports for the period July 1, 2017, to June 30, 2018, as well as grant application materials.

Grantees reported that the most effective strategies for increasing coverage were: (1) forming partnerships with organizations that have access to AI/AN children and families; and (2) using available data on insurance coverage to identify uninsured children or parents, or those nearing their renewal date, and then offering to help them enroll or renew coverage.

Activities. Round III grantees engaged in a number of activities to help AI/AN children and families enroll or renew coverage:

- All Round III grantees regularly engaged in one-on-one enrollment and renewal assistance and conducted outreach and education activities at their own clinics, at partner locations, and at community events.
- Round III grantees also staffed outreach, education, and enrollment booths at events they thought AI/AN families would be likely to attend, such as parent–teacher meeting nights at local schools, community festivals, and powwows.
- Grantees reported two strategies as most effective for increasing coverage. First, grantees said that forming partnerships with groups that have access to the target populations was an effective outreach strategy. Second, as Indian health care providers, many of the grantees used insurance coverage data to identify uninsured children or parents (or those nearing their renewal date), and then offering help to enroll or renew coverage.
- Grantees reported inconsistent experiences with school-based activities, and most grantees said attending community events did not lead to new enrollments or renewals.

The long-standing misconception that AI/AN populations do not need insurance because the Indian Health Service will cover any health care needs was a barrier to this work.

Challenges. Grantees faced a number of challenges in the first year:

- Grantees noted that the long-standing misconception that AI/AN populations do not need insurance because the Indian Health Service (IHS) will cover any health care needs was a barrier to this work. The IHS does provide many services, but not all, and it is not insurance. Medicaid and CHIP cover a wider range of services than the IHS, and when AI/AN families and children enroll in Medicaid and CHIP, Indian health care providers can bill these programs for services provided.
- Distrust of government programs was also a commonly cited barrier.
- Staffing was the principal administrative challenge grantees identified, and likely affected progress for some grantees.

Discussion

The findings from the first year of the Round III AI/AN grants are promising. Although progress across the group was uneven, several grantees identified practices that worked well for these hard-to-reach populations, and grantees implemented the practices in a way that resulted in meaningful progress on coverage in the communities they serve. Such results can provide valuable direction about what activities other grantees might adopt, depending on circumstances in their state and community. The Round III grantees' first-year experiences can also help CMS set expectations and prioritize technical assistance activities for the second year of the grant, and for future grant cycles.

Factors related to stronger progress. Although there were exceptions, Round III grantees that consistently used data-driven approaches to guide activities tended to enroll and renew more children compared to grantees that did not use such strategies. Grantees that made more progress also tended to have prior CKC experience, and to affiliate with partners that had access to the target populations, including government agencies and community organizations such as food pantries, youth treatment centers, and Job Corps offices. Grantees that had success with school partnerships took an active role in seeking students to enroll, rather than just attending school events to share educational materials. Finding, hiring, and maintaining suitable staff—the success of which depends on recruiting and training strategies, as well as labor market conditions—also played a role: grantees that made stronger progress reported fewer staffing challenges.

Factors related to weaker progress. Whether new or experienced, groups that emphasized events and school-based outreach or education activities generally enrolled or renewed fewer children compared to grantees that focused on other kinds of activities. The grantees that made the least progress toward their goals in Year 1 each eventually identified a data-driven activity that might work. For example, SEARHC expected to identify uninsured children or parents by working with data from its associated health and dental clinics. However, SEARHC staff learned that the two data systems used by these clinics often had inaccurate information on insurance status: many children and parents marked as uninsured in the systems actually had coverage. SEARHC was contracting with a firm to correct these databases in the second year of the grant.

Promising practices to consider for wider adoption. Some of the Round III grantees highlighted activities that other groups should consider adopting:

Promising practices to consider for wider adoption include the use of data-based, proactive renewal strategies, and making grantee staff available to help families at partner sites, rather than relying on partner referrals.

Data-driven strategies. SCF and Central Oklahoma set the most ambitious targets and, in absolute terms, enrolled or renewed the most children. Both implemented data-based, proactive, renewal-focused strategies. For example, SCF receives a list of all current Medicaid beneficiaries and their expected renewal dates from the Medicaid agency twice a month. Staff use this information to call beneficiaries in SCF's service area to screen them for continued eligibility, help those who appear eligible to complete a renewal application, and then file it on the client's behalf. Central Oklahoma can access the state's Medicaid roster through an agreement with the Oklahoma Medicaid agency. Staff review the clinic's daily appointment list against this roster to check for coverage. When staff identify a child (or parent) nearing his or her renewal date, they print a prefilled renewal form and have it ready for review and signature at the next office visit. Central Oklahoma staff then submit the form to the state on the family's behalf. Both grantees have put those strategies into operation consistently, integrating them into the daily work of their clinics.

These strategies have worked in rural, suburban, and urban areas, and with beneficiaries of all ages. It does require access to state administrative data, one of the many reasons partnerships with state agencies are so crucial to this work. Some grantees noted they are taking a similar approach for new enrollments at their clinics, reviewing the daily visit schedule for uninsured patients and then targeting outreach and enrollment support to those patients. Before other grantees embark on renewal strategies, they should make sure they understand renewal processes in their state and devise processes that complement and support it.

Assigning grantee staff to partner sites, rather than relying on partners for referrals of uninsured children or parents. Some grantees that focused on new enrollments found success with another proactive strategy: providing regular on-site assistance at partner locations. Although it required staff to travel to other locations, it removed their dependence on partner referrals (processes that some grantees reported resulted in no referrals). Some grantees cautioned that this approach casts a wider net, and so children assisted might not all be of AI/AN descent, especially when schools are the partners.

Other lessons to consider. First-year experiences of the Round III group suggested some other lessons to consider:

- Tracking the sources of new applications or renewals is essential for grantees to understand what works and to redirect resources, if needed. Similarly, taking the time to strategize beforehand about potential substitute strategies could be useful; three grantees noted that they had trouble identifying where to redirect resources when a particular strategy they implemented did not work as expected.

- Several grantees cited the importance of partnerships with state agencies. For example, Choctaw Nation worked closely with its local Department of Health and Human Services agency, the state agency that could help families whose applications were pending approval or denied because the cases were incorrectly set up in the system. By building this relationship, Choctaw Nation staff could call agency staff for resolution when they encountered a problem, saving client families from taking time off from work to try to resolve the issue themselves. Similarly, staff from IHC, SCF and Central Oklahoma developed strong relationships with county- and state-level Medicaid staff that helped grantees solve problems with a particular application or renewal.

- The value of events seems to be the outreach and educational opportunities they provide, rather than as an enrollment or renewal venue. Many grantees stressed the need for repeated education with AI/AN families, given the long history of misinformation about the need for insurance coverage among families that use the IHS, so events might serve that purpose. At the same

time, it is not clear that events are the best venue for educating families. For example, several grantees said that events had many distractions, such as entertainment and giveaways. Moreover, some grantees highlighted success developing other partnerships to serve as educational vehicles, such as fostering relationships with Tribal leaders as an introduction to AI/AN families, as NARA-NW reported.

- Although Denver Indian Health and NARA-NW found success with school partnerships, more Round III grantees seemed frustrated that there was little to show from school-focused efforts. This echoes earlier findings from the first year experience of the Cycle IV grantees, for whom some school partnerships fell short, whether because no one at the school championed coverage or because parents did not want to engage on coverage within a school setting (as they might in a health care setting). In the future, CMS might encourage grantees to form partnerships with whatever organizations provide the best access to their target populations, cautioning them not to assume access through schools. Besides government agency partners, some Round III grantees found success with homeless shelters, Job Corps agencies, food pantries, and Tribal-focused organizations.

Common technical assistance needs. The challenges that grantees described in their first-year narrative reports suggest a need for technical assistance to be provided by CMS program officers, CMS Division of Tribal Affairs, the CKC National Campaign, Mathematica, and any future technical assistance contractors. Priority topics, several of which have been addressed before, could include developing and training staff, using data to identify clients without insurance or due for renewal, messaging about the relationship between IHS and Medicaid, and best practices in rural outreach. The Division of Tribal Affairs Outreach and Education website contains several fact sheets and brochures that could assist grantees in explaining the Medicaid and CHIP programs and understanding the relationship between IHS and Medicaid. For these and other resources, go to: https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Outreach-and-Education/medicaid-and-chip.html.

Continued learning opportunities. Mathematica's evaluation of the Round III grantee cohort will continue into Year 2, resulting in a second annual evaluation report and a final report covering both the Cycle IV and Round III cohorts. Technical assistance activities will also continue, and will include the production of a promising practices guide for connecting AI/AN children to coverage.

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