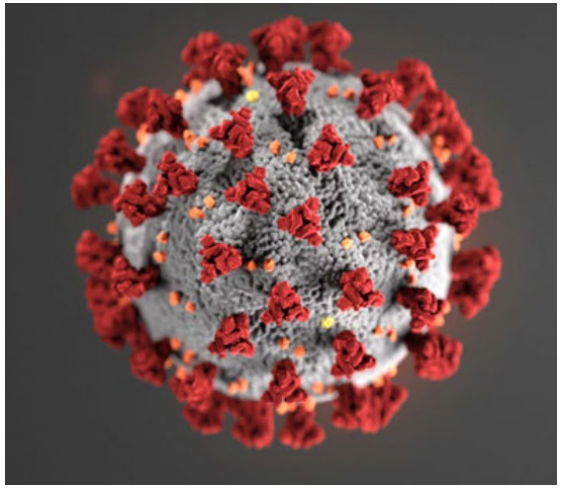
Indian Health Service

Medicaid Unwinding

SARAH FORREST
MANAGEMENT ANALYST
INDIAN HEALTH SERVICE, HEADQUARTERS
DIVISION OF BUSINESS OFFICE ENHANCEMENT

PHE Background

- Public Health Emergency (PHE) for COVID-19 was declared on January 31, 2020 and ended on May 11, 2023.
- CMS waived certain Medicaid and CHIP requirements related to verifying eligibility in order to prevent people with Medicaid and CHIP from losing their health coverage during the pandemic.
- Medicaid has now resumed verifying eligibility and is terminating coverage for those no longer eligible or for those who do not respond to the notice to renew coverage.
- To see state timelines and data, use this tracker: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/



Outreach Efforts

Over the last year, IHS has been preparing for the end of the Public Health Emergency and Medicaid Unwinding. Planning has focused on strategies to minimize coverage loss for the patients we serve.

IHS has worked in partnership with CMS and the NIHB to develop guidance, toolkits, and strategies to inform AI/AN about renewing their coverage and exploring other available health insurance options if they no longer qualify for Medicaid or CHIP.

IHS has communicated with the Areas, and emphasized repeatedly, how important it is for our staff to make every effort to educate and inform so that patients will take action to respond to mail and seek help to protect their coverage.

IHS Unwinding Webpage

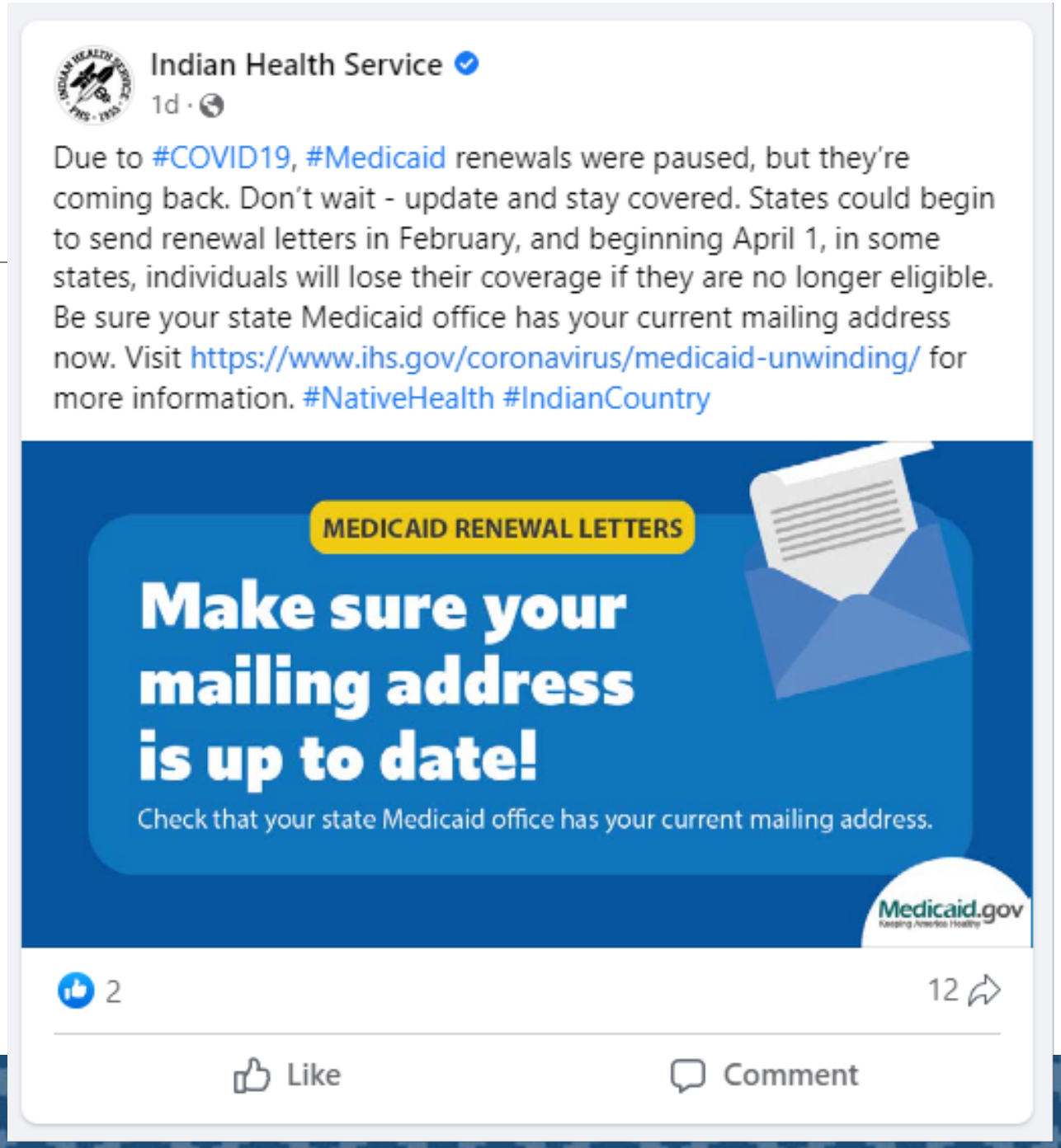
- IHS published a Medicaid Unwinding webpage in January 2023

- Contains the essential information on Medicaid Unwinding, FAQs and links to many helpful resources.

- https://www.ihs.gov/businessoffice/medicaid-unwinding/

IHS Facebook Page

- IHS has a Facebook page for Headquarters and has shared information on Medicaid Unwinding
- Areas, Service Units and others are sharing the posts and are also posting their own messages on social media



Indian Health Service

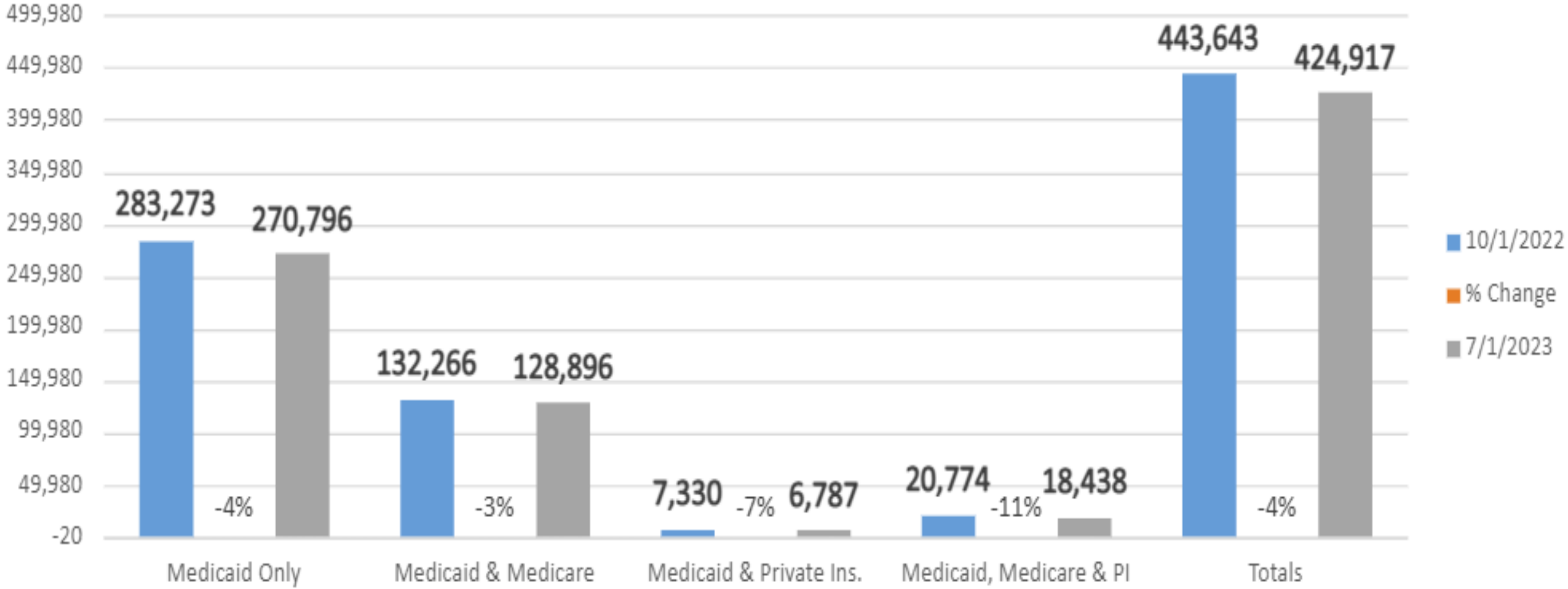
Medicaid Unwinding

K DEMPSEY
MANAGEMENT ANALYST
INDIAN HEALTH SERVICE, HEADQUARTERS
DIVISION OF BUSINESS OFFICE ENHANCEMENT

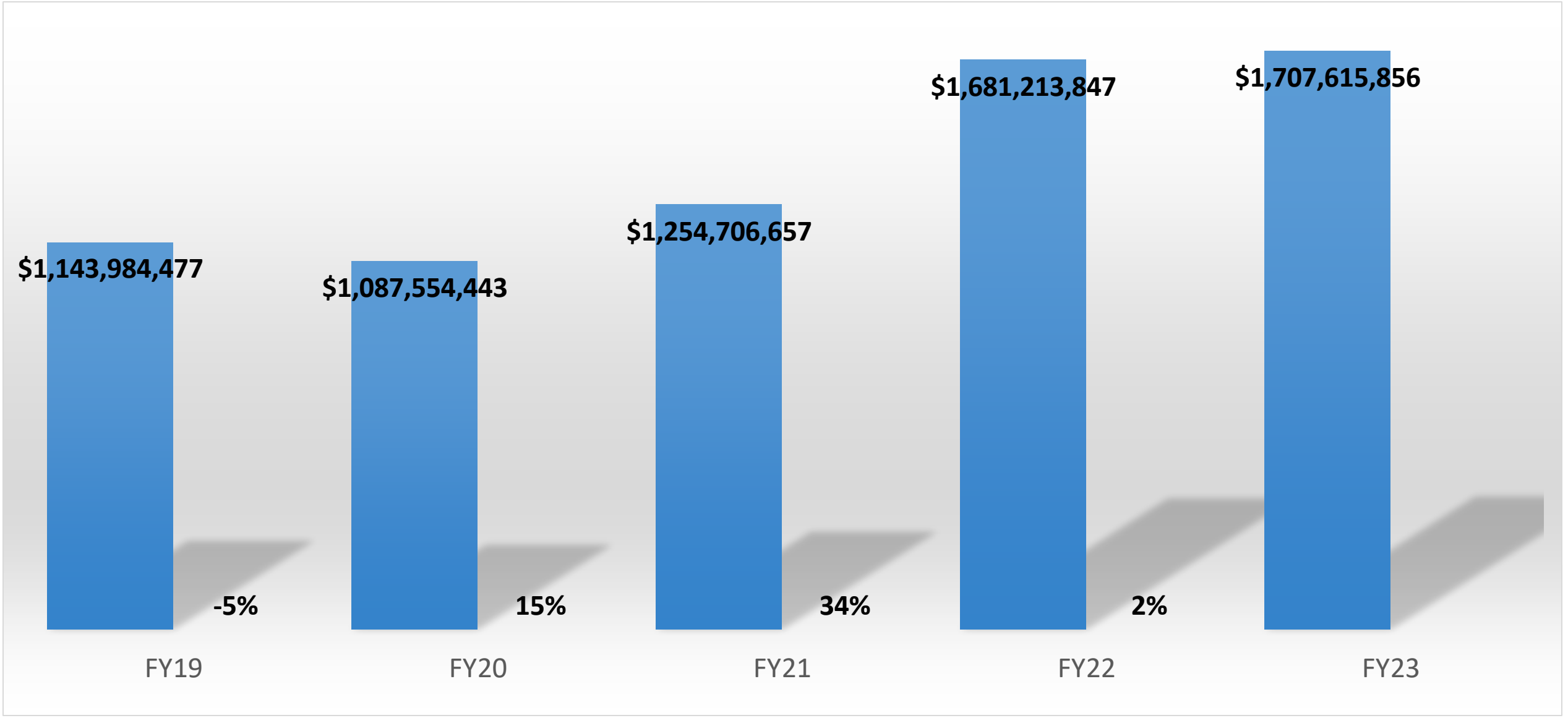
IHS AGSM-Medicaid Category Only

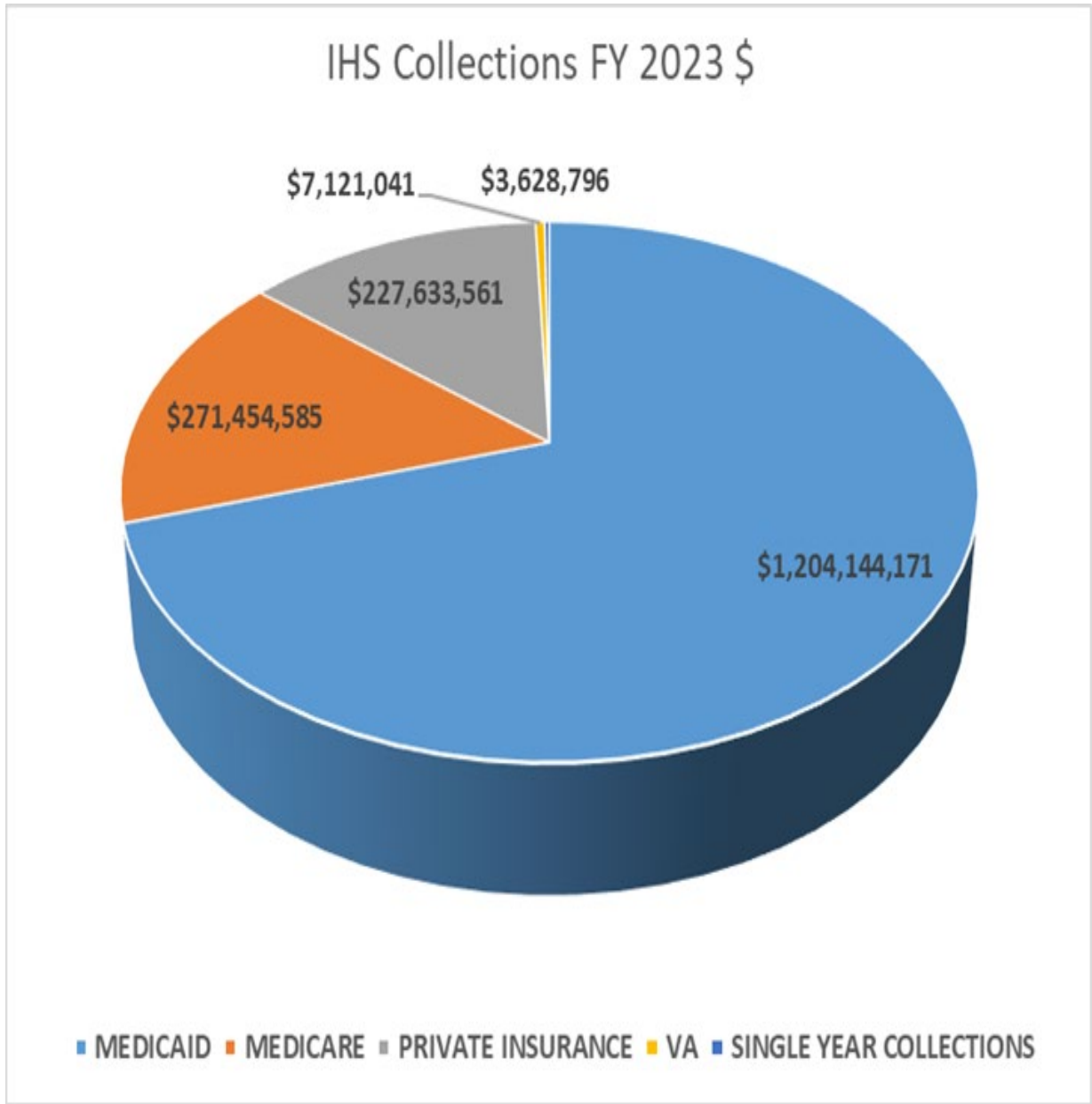
	10/1/2022	7/1/2023	% Change	Difference
Medicaid Only	283,273	270,796	-4%	-12,477
Medicaid & Medicare	132,266	128,896	-3%	-3,370
Medicaid & Private Ins.	7,330	6,787	-7%	-543
Medicaid, Medicare & PI	20,774	18,438	-11%	-2,336
Totals	443,643	424,917	-4%	-18,726

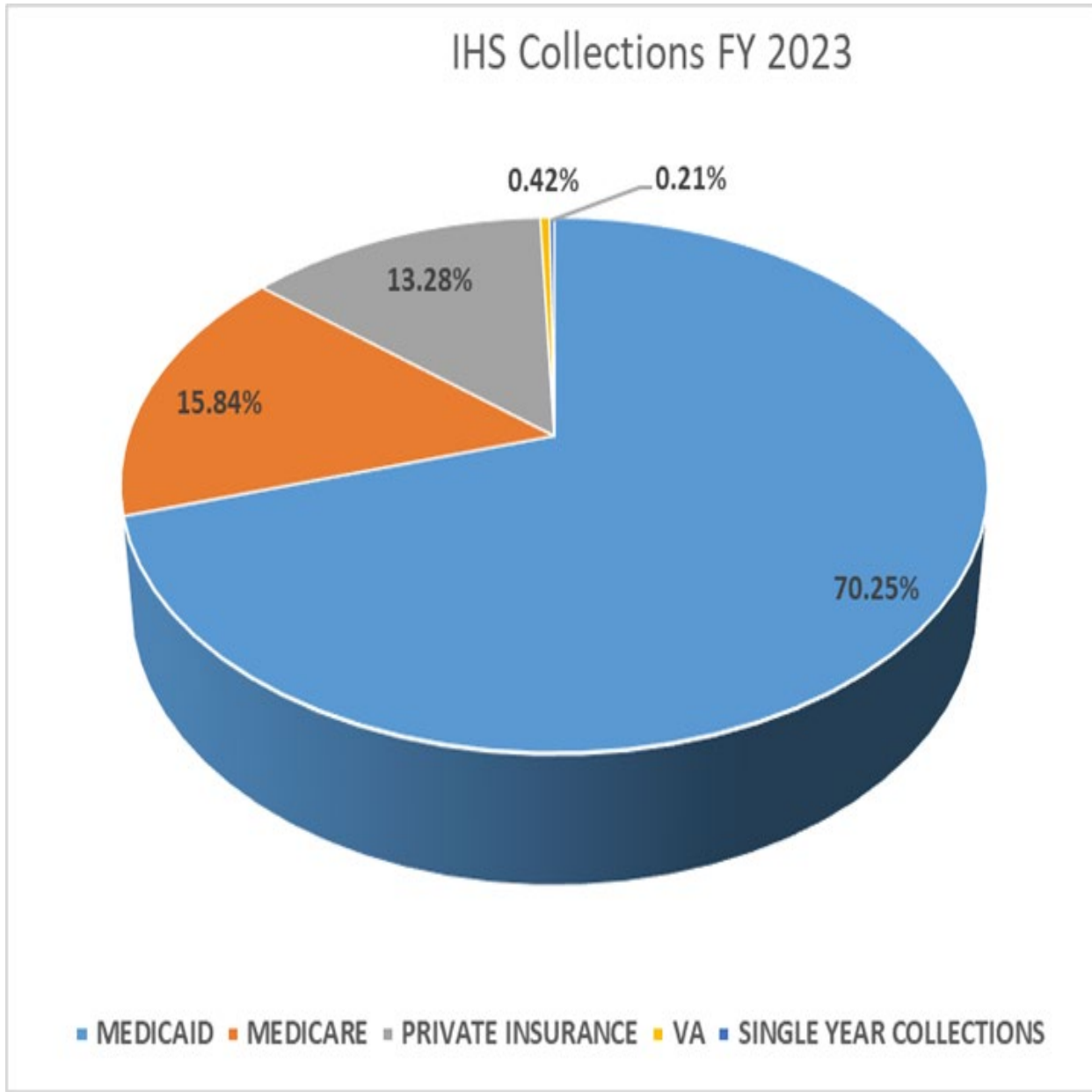
Third Party Medicaid Eligible Patients with % Change between Years

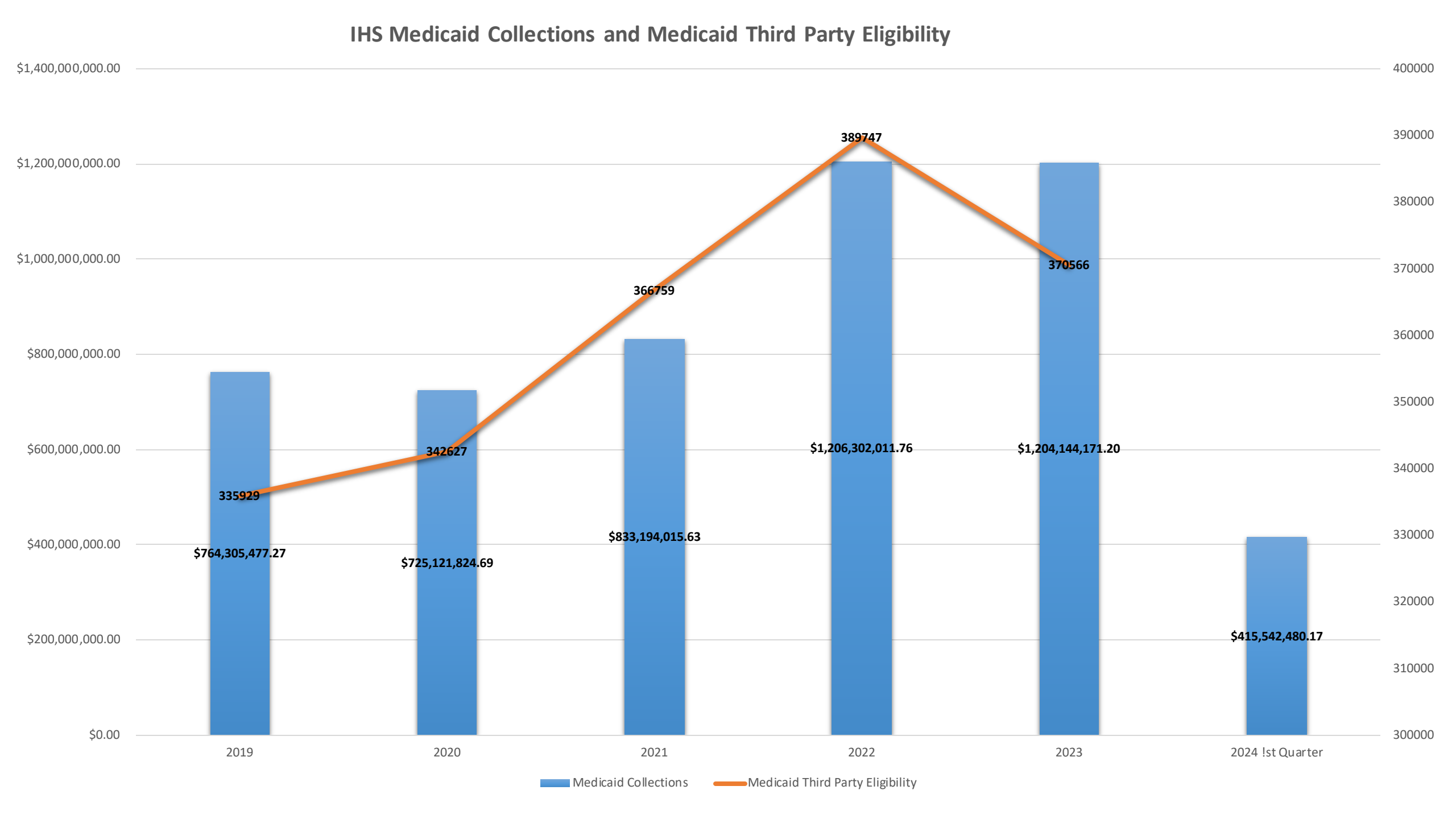


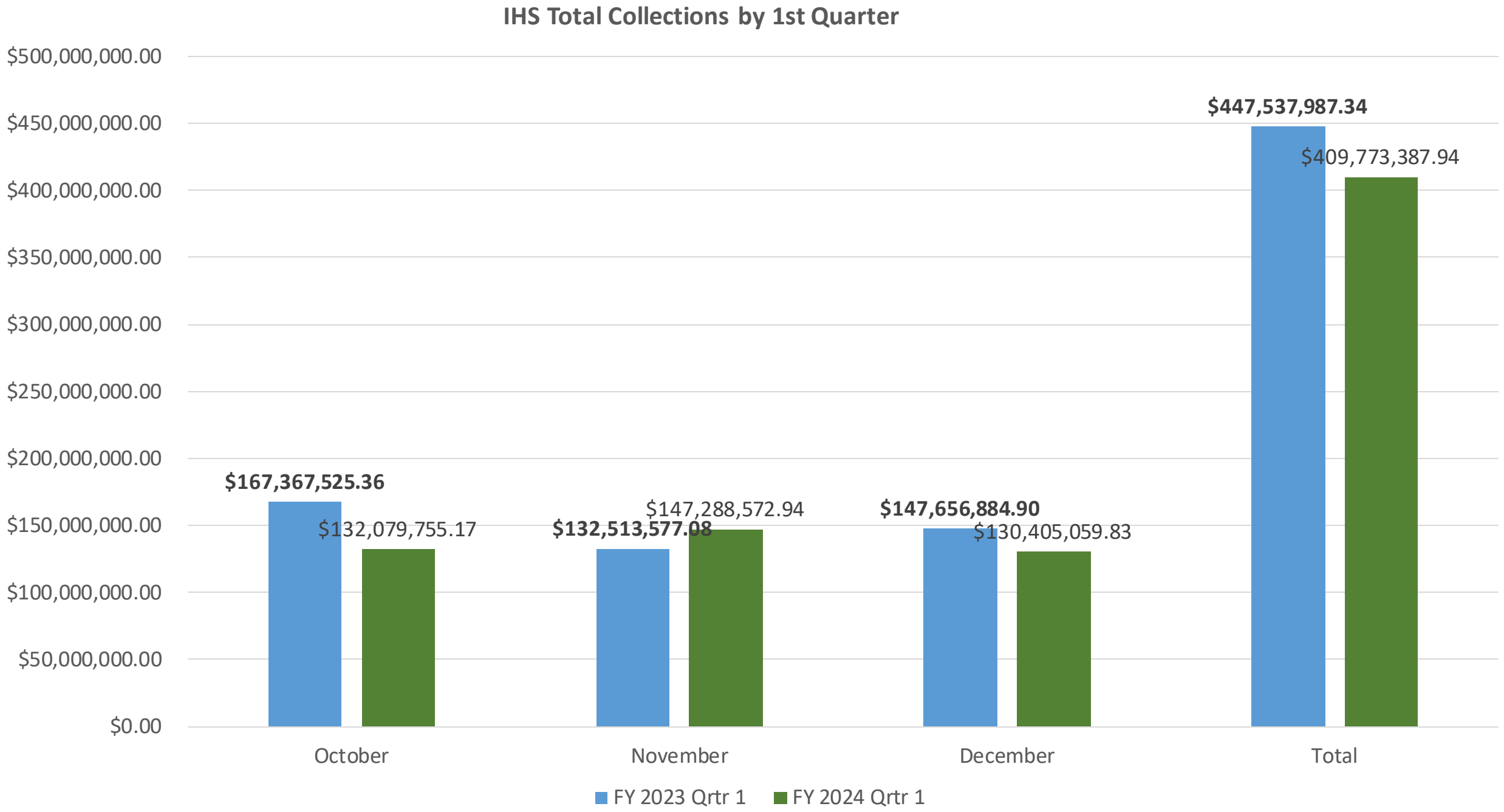
IHS Total Collections



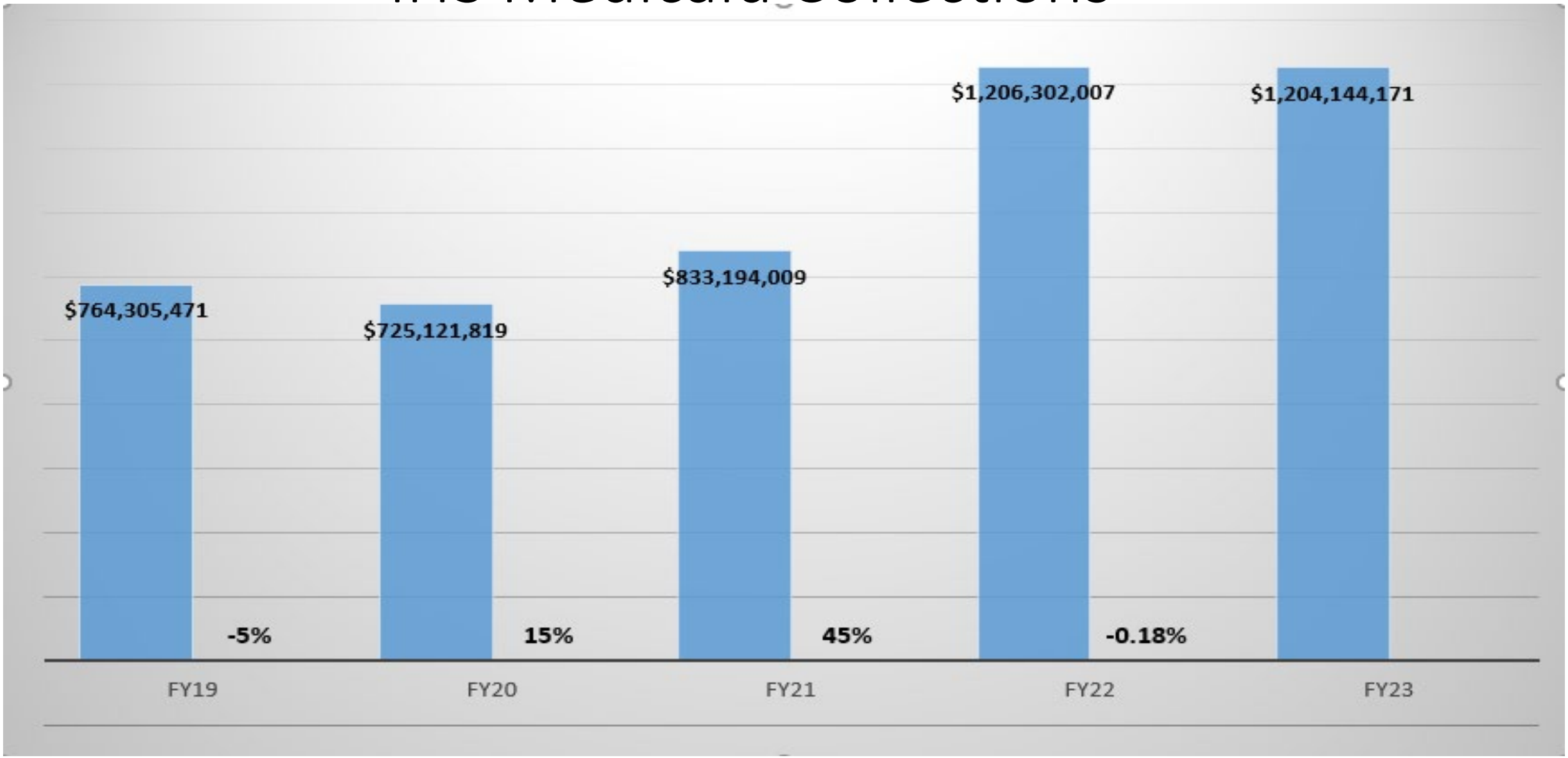

IHS Collections FY 2023 $
$7,121,041
$3,628,796
$227,633,561
$271,454,585
$1,204,144,171
MEDICAID
MEDICARE
PRIVATE INSURANCE
VA
SINGLE YEAR COLLECTIONS

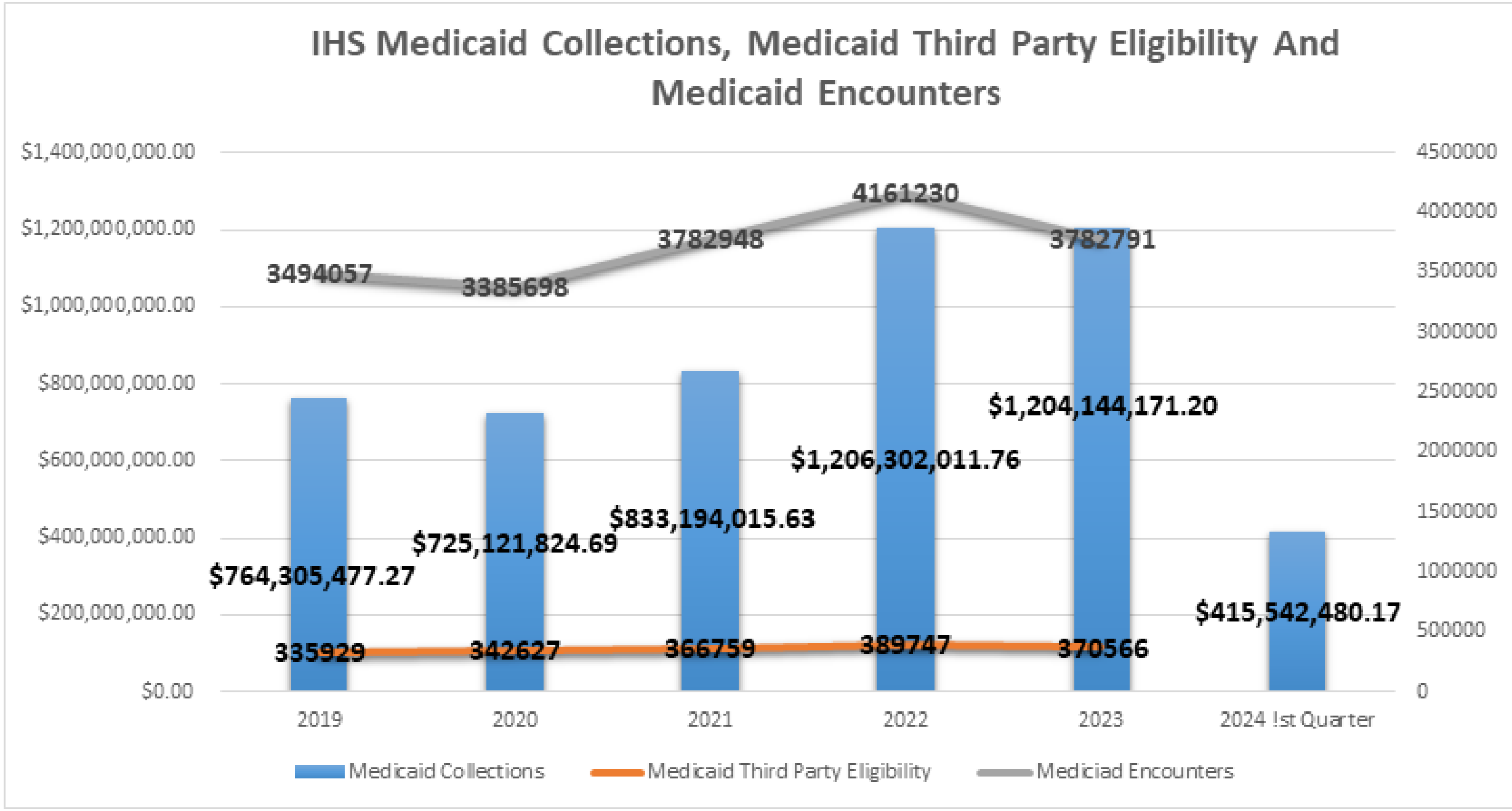

IHS Collections FY 2023
0.42%
0.21%
13.28%
15.84%
70.25%
MEDICAID
MEDICARE
PRIVATE INSURANCE
VA
SINGLE YEAR COLLECTIONS


IHS Medicaid Collections and Medicaid Third Party Eligibility
$1,400,000,000.00
$1,200,000,000.00
$1,000,000,000.00
$800,000,000.00
$600,000,000.00
$400,000,000.00
$200,000,000.00
$0.00
400000
390000
380000
370000
360000
350000
340000
330000
320000
310000
300000
335929
342627
366759
389747
370566
$764,305,477.27
$725,121,824.69
$833,194,015.63
$1,206,302,011.76
$1,204,144,171.20
$415,542,480.17
2019
2020
2021
2022
2023
2024 !st Quarter
Medicaid Collections
Medicaid Third Party Eligibility


IHS Total Collections by 1st Quarter
$500,000,000.00
$450,000,000.00
$400,000,000.00
$350,000,000.00
$300,000,000.00
$250,000,000.00
$200,000,000.00
$150,000,000.00
$100,000,000.00
$50,000,000.00
$0.00
$167,367,525.36
$132,079,755.17
$132,513,577.08
$147,288,572.94
$147,656,884.90
$130,405,059.83
$447,537,987.34
$409,773,387.94
October
November
December
Total
FY 2023 Qrtr 1
FY 2024 Qrtr 1

IHS Medicaid Collections

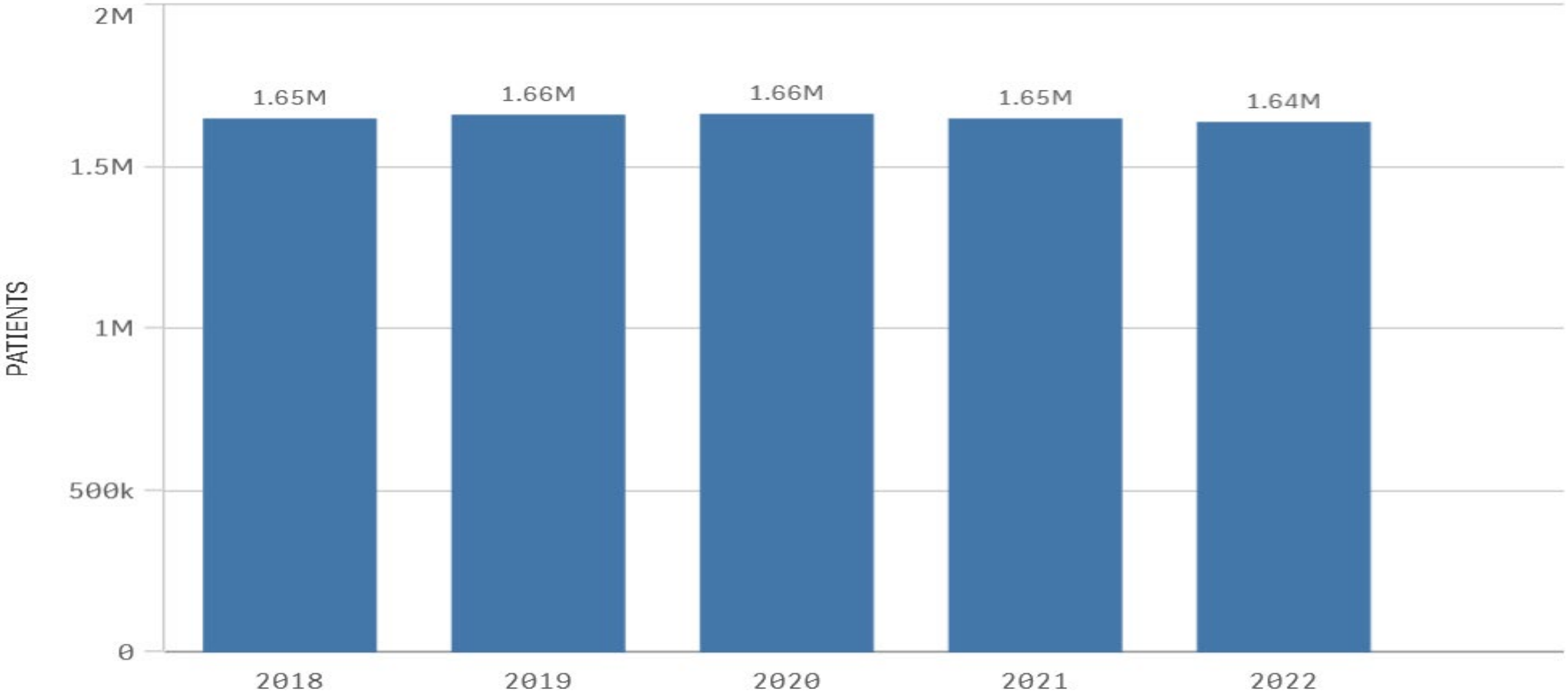



IHS Medicaid Collections, Medicaid Third Party Eligibility And Medicaid Encounters
$1,400,000,000.00
$1,200,000,000.00
$1,000,000,000.00
$800,000,000.00
$600,000,000.00
$400,000,000.00
$200,000,000.00
$0.00
4500000
4000000
3500000
3000000
2500000
2000000
1500000
1000000
500000
0
3494057
3385698
3782948
4161230
3782791
$764,305,477.27
$725,121,824.69
$833,194,015.63
$1,206,302,011.76
$1,204,144,171.20
$415,542,480.17
335929
342627
366759
389747
370566
2019
2020
2021
2022
2023
2024 !st Quarter
Medicaid Collections
Medicaid Third Party Eligibility
Mediciad Encounters

IHS Medicaid Collections Analysis

	FY19	FY20	FY21	FY22	FY23
October	$67,266,986	$68,637,662	$71,461,039	$92,664,212	$123,009,644
November	$62,089,705	$68,348,083	$70,274,473	$80,009,051	$95,778,315
December	$53,243,699	$60,784,051	$63,775,349	$110,813,215	$106,975,120
January	$64,151,086	$63,658,238	$59,232,782	$77,704,535	$103,621,084
February	$56,724,941	$66,336,379	$58,493,215	$90,799,707	$90,880,664
March	$72,795,672	$73,348,720	$72,237,691	$110,681,127	$117,917,400.73
April	$64,781,213	$45,765,910	$69,672,485	$86,191,915	$96,898,398.64
May	$72,112,890	$59,146,734	$72,359,520	$98,373,204	$100,912,940.41
June	$59,729,533	$57,239,058	$75,702,083	$135,268,523	$100,027,747.20
July	$64,101,401	$58,644,998	$72,561,725	$105,109,456	$77,221,294.45
August	$67,586,138	$52,091,444	$73,456,623	$117,689,156	$103,288,726.40
September	$59,722,207	$51,120,542	$73,967,024	$100,997,906	$87,612,835.88
Total	$764,305,471	$725,121,819	$833,194,009	$1,206,302,007	$1,204,144,171
% +/- over Prior Year	-	-5%	15%	45%	-0.18%
Monthly Average	$63,692,123	$60,426,818	$69,432,834	$100,525,167.25	$100,345,347.60
AIR Rate for Outpatient	455	479	519	640	654
Change in AIR Rate for Outpatient	-	5%	8%	23%	2%

IHS User Population



Indian Health Service

NIHB Outreach and Enrollment Efforts

KRISTEN BITSUIE
TRIBAL HEALTH CARE OUTREACH AND EDUCATION POLICY COORDINATOR
MARCH 13, 2024

The federal government has a trust responsibility to provide federal health services to maintain and improve the health of American Indian and Alaska Native people

In 1976, Congress authorized the Indian Health Service to bill Medicaid for services provided to eligible enrollees "to enable Medicaid funds to flow into IHS institutions… [because] these Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian." recognizing that "the Federal government has treaty obligations to provide services to Indians, it has not been a State responsibility."

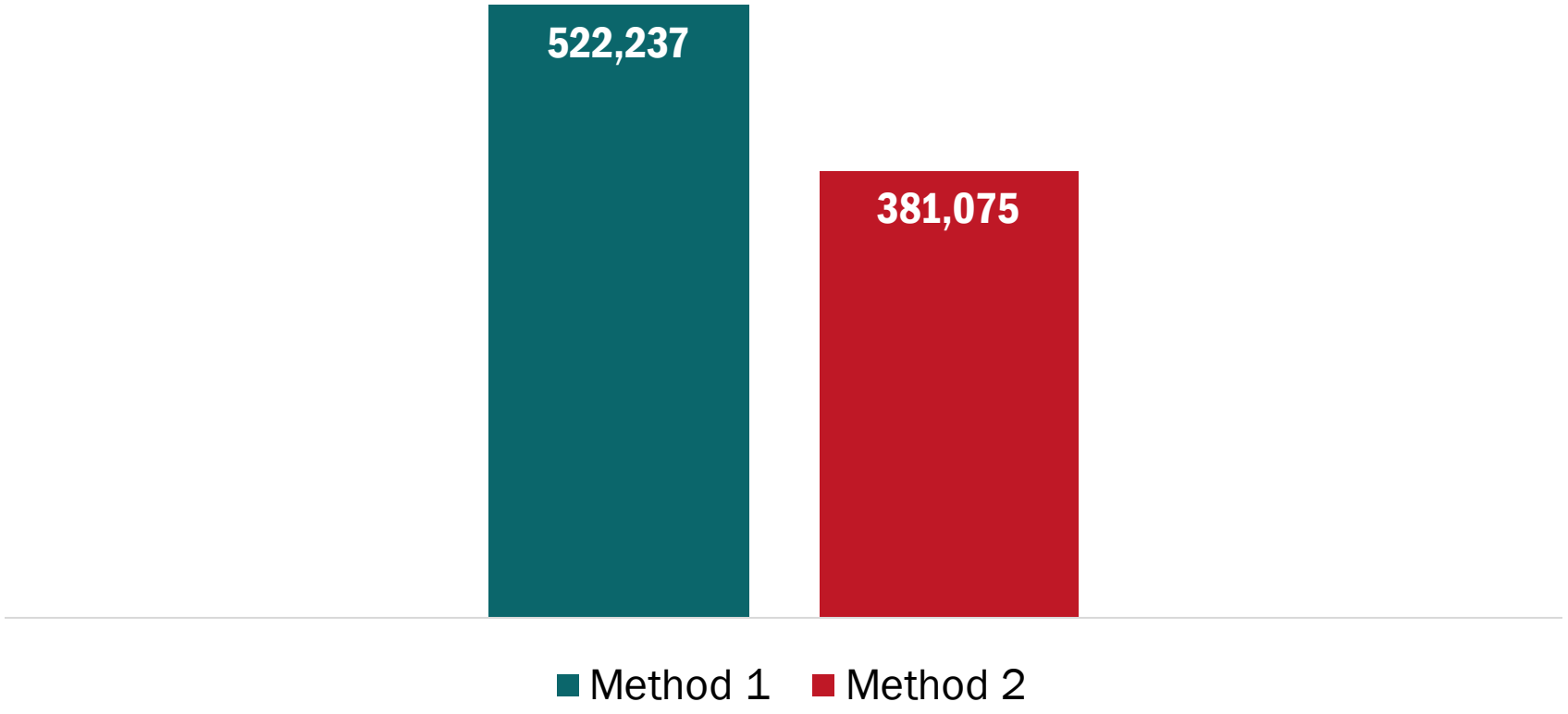
OUTREACH AND EDUCATION COMPONENTS

- Community outreach events
- Tribal health education network
- Utilizing enrollment data
- Health insurance coverage success stories
- Culturally responsive teaching
- Raise awareness about health coverage
- Provide education and information

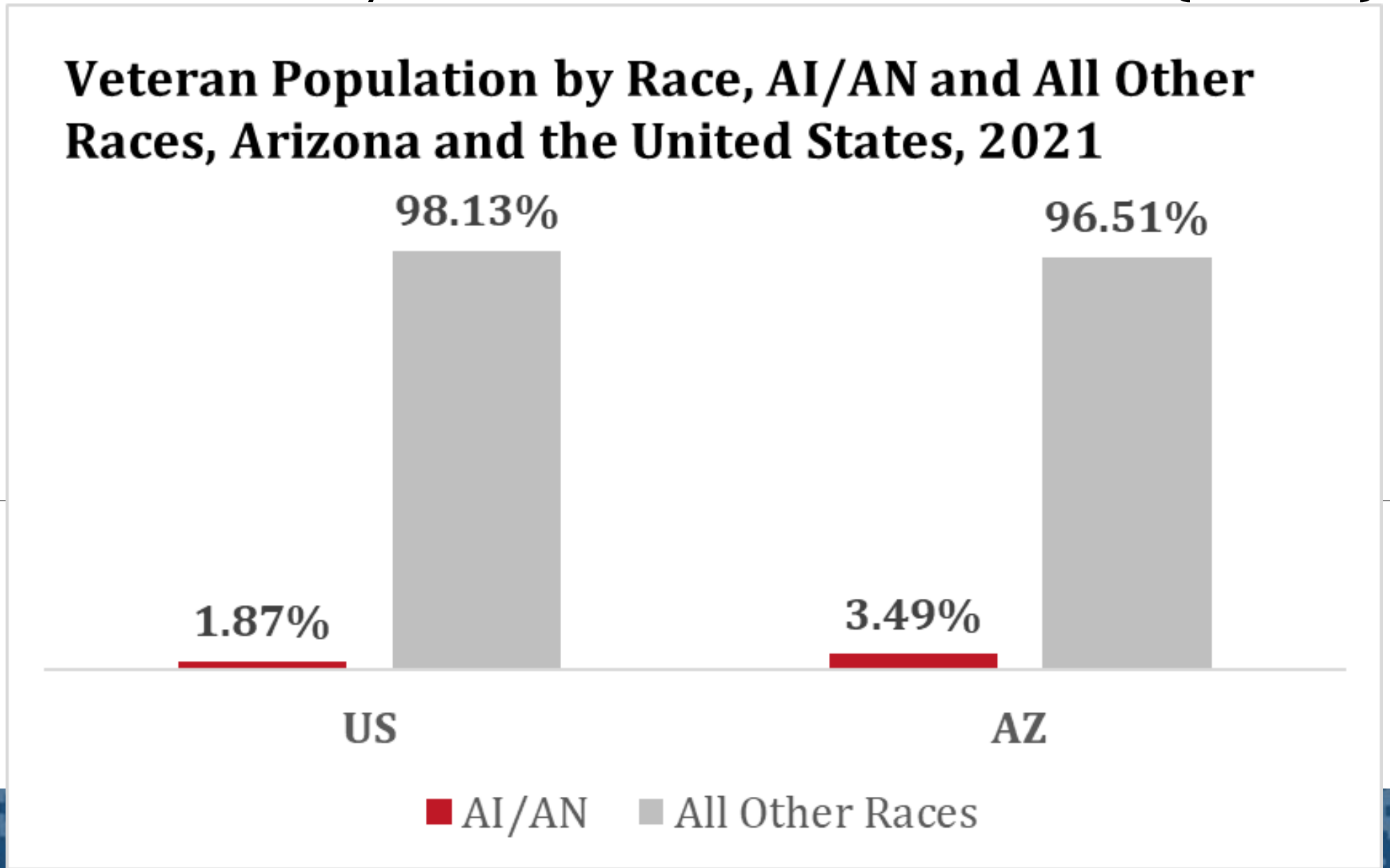
CHALLENGES IN TRIBAL COMMUNITIES

- Long waiting time
- Medicaid caseworkers lack of knowledge of AI/AN special protections
- Some states are not data-sharing
- Health laws and flexibilities
- Offices are overwhelmed with document requests
- Lack of transportation
- Working with state Medicaid agency
- Medicaid application is taking too long to process
- States that are data-sharing do not include reason
- Submission of supporting documents
- Elders who turned 65 YO during the pandemic
- Uninsured children are increasing
- Mail delivery to P.O. boxes
- Access to technical assistance
- Staying up-to-date on the latest CMS announcements
- Complex application process
- Geographical issues: remote or isolated
- Limited or no internet connection
- Working with state Medicaid agency or Tribal Liaison

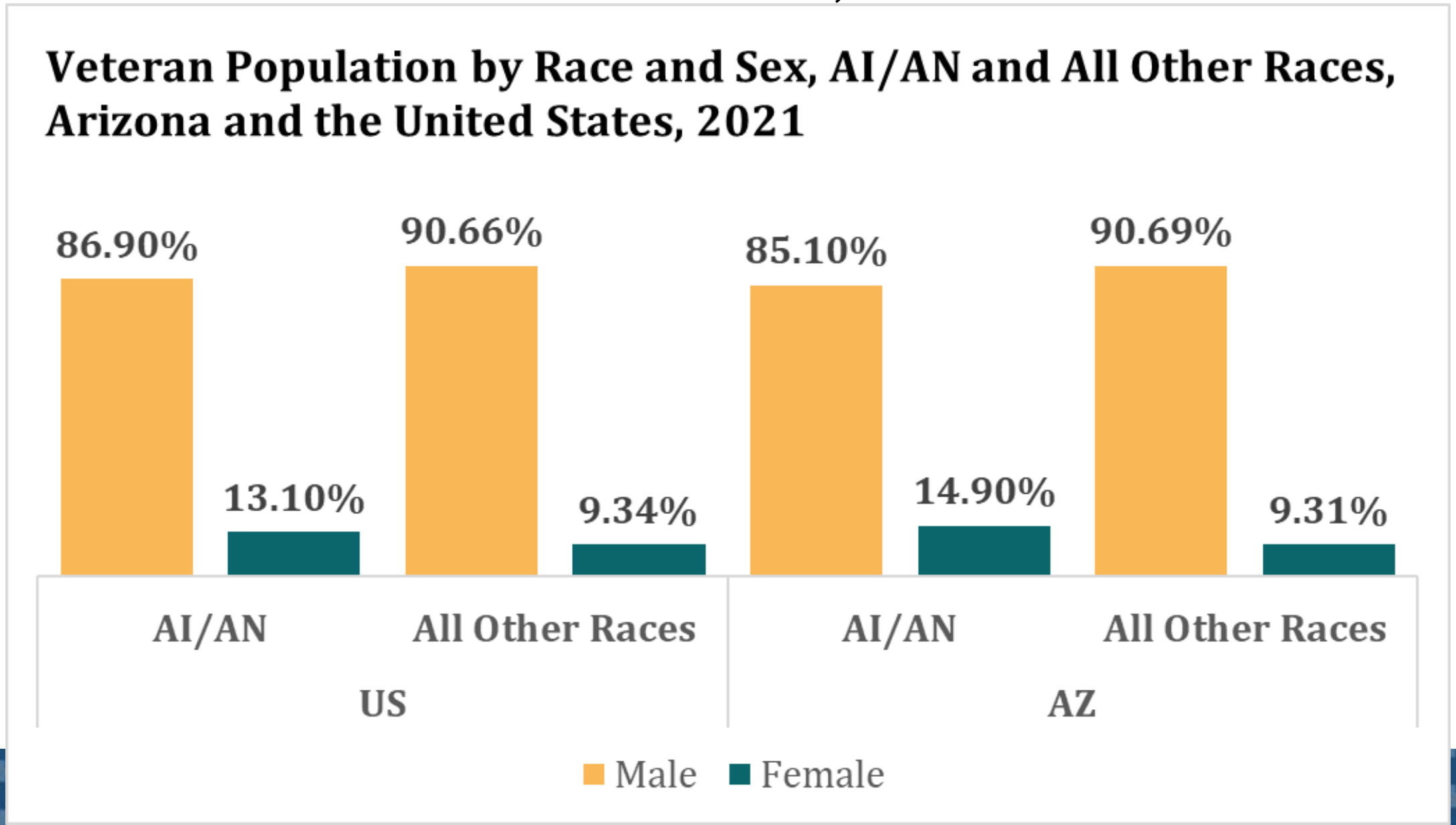
MEDICAID UNWINDING AI/AN DISENROLLED ESTIMATES: UNITED STATES



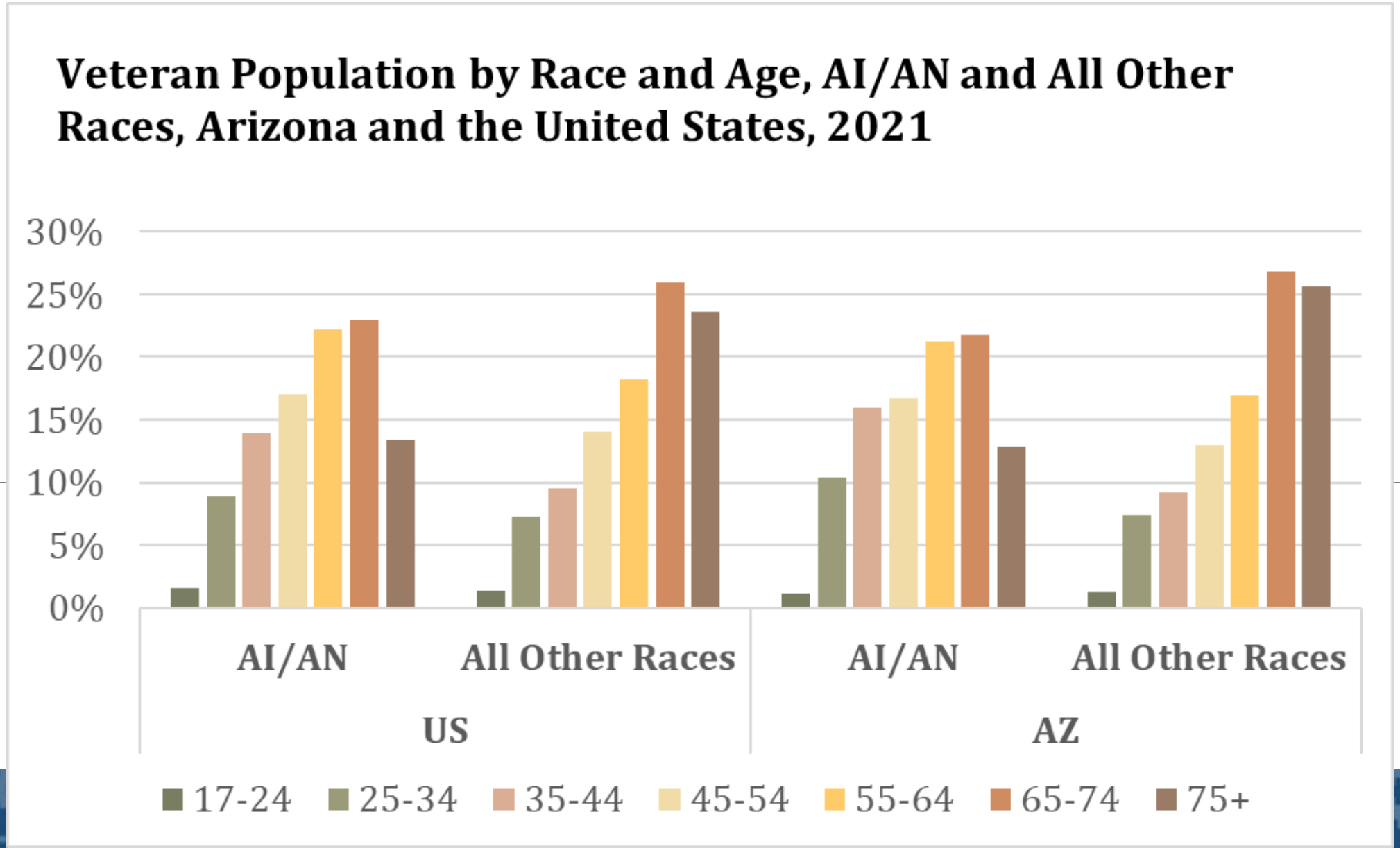
The percentage of AI/AN veterans from Arizona (3.49%) is higher than that of AI/AN veterans in the US overall (1.87%).



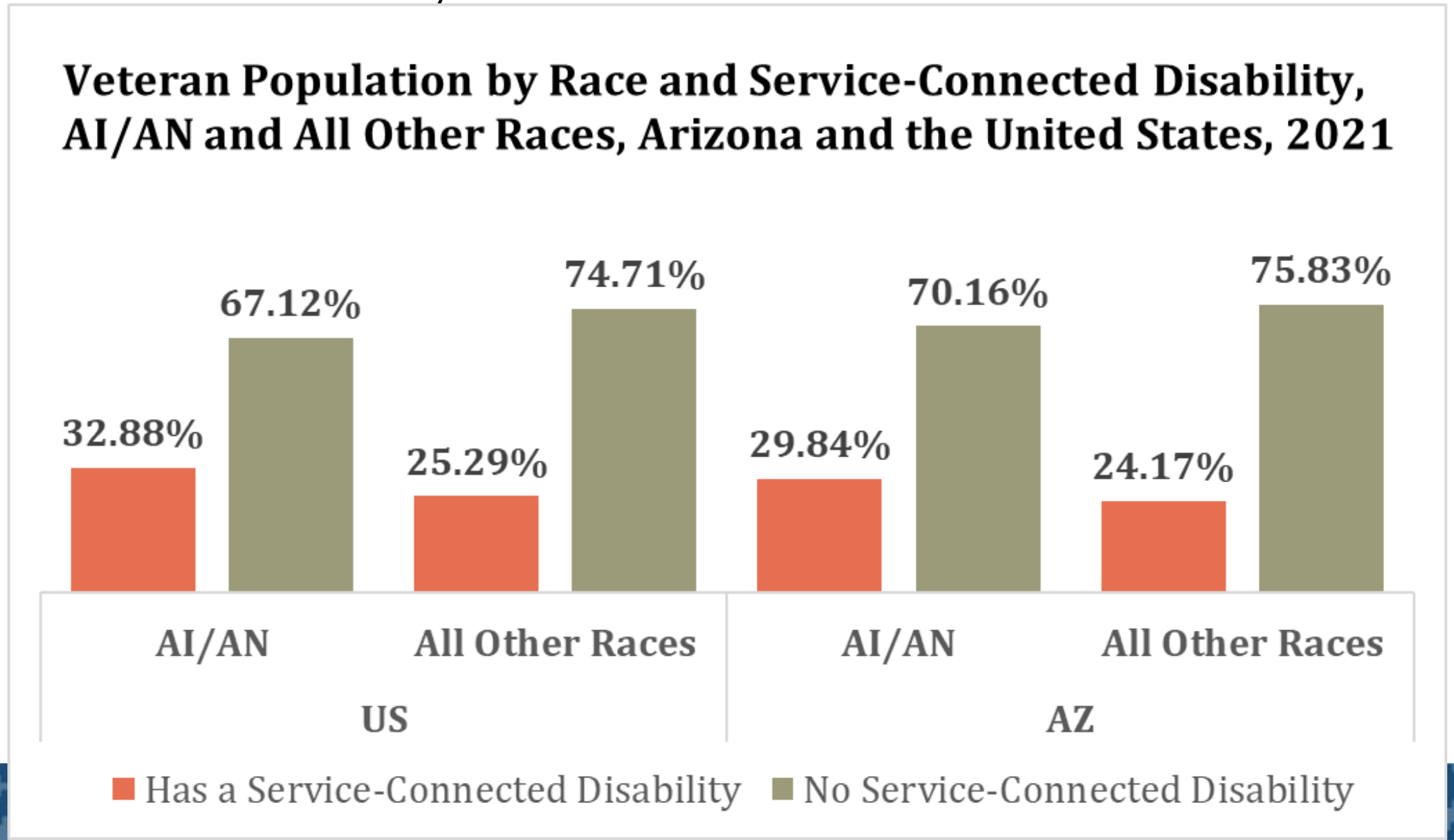
The percentage of AI/AN veterans who are female is higher than that of all other races combined, in both AZ and the US.



AI/AN veterans are slightly younger than veterans from all other races combined, in both AZ and the US.



AI/AN veterans are slightly more likely to have a service-connected disability than all other races combined.



MEDICAID ANNOUNCEMENT

12 Months of Mandatory Continuous Coverage for Children in Medicaid and CHIP

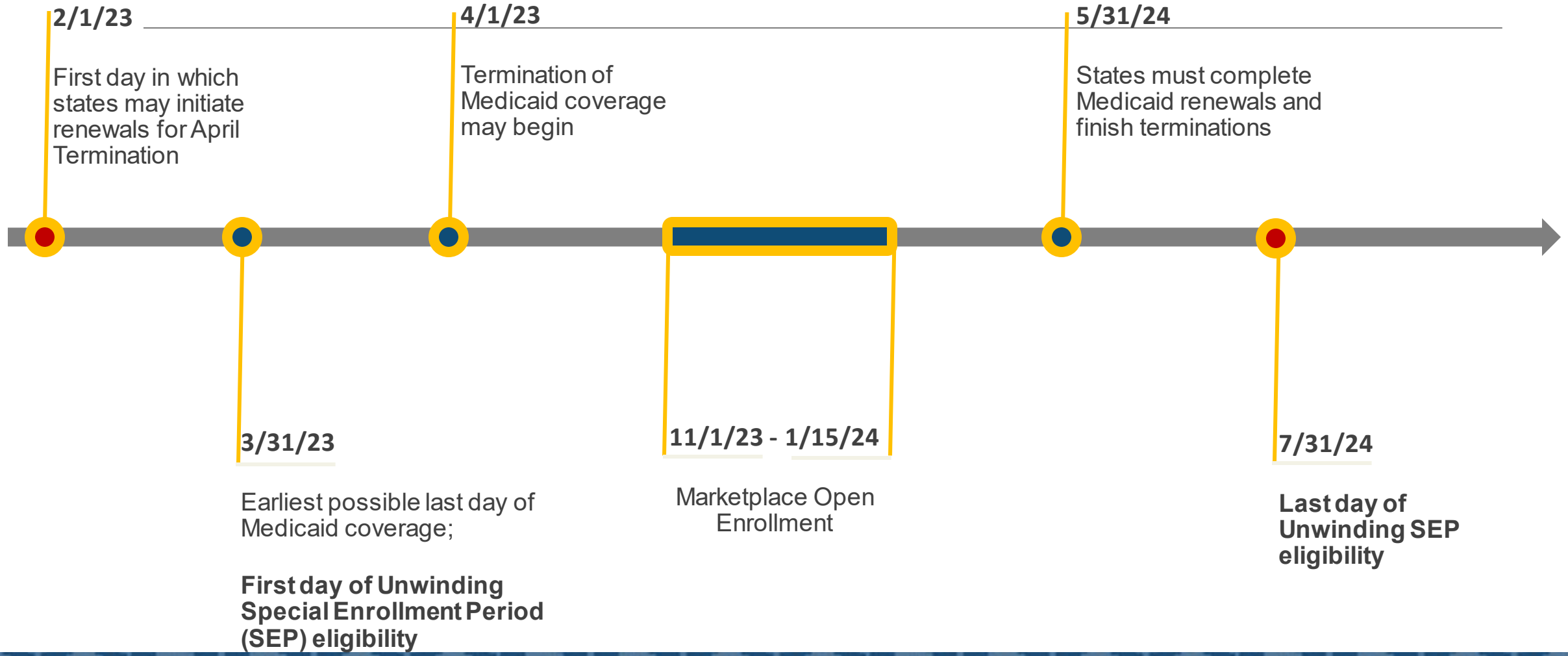
- On September 29, 2023: The U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS), sent a letter to state health officials reinforcing that states must provide 12 months of continuous coverage for children under the age of 19 on Medicaid and the Children's Health Insurance Program (CHIP) beginning January 1, 2024.
- This means that children who enroll in Medicaid or CHIP are guaranteed 12 months of continuous coverage even if their household's circumstances change, preventing gaps in coverage and periods of uninsurance due to income fluctuations or missed paperwork.

MARKETING & COMMUNICATIONS OVERSIGHT IMPROVEMENTS FOR PLAN YEAR 2024

MA Organizations can't:

- Advertise benefits that aren't available to beneficiaries in the service area(s) where the marketing appears
- Market any products or plans, benefits, or costs, unless the MA organization or marketing name(s) as listed in HPMS of the entities offering the referenced products or plans, benefits, or costs are identified in the marketing material
- Advertise about savings available that are based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a person with Medicare

Transition from Medicaid to Marketplace Timeline Increased Assister Support



When You Have Difficulties Paying for Medicare Coverage

National Indian Health Board

A storyboard series from the National Indian Health Board
For more information, visit nihb.org/tribalhealthreform/

Male | Diné | Navajo Area | Medicare, QMB program

"He was referred to the Patient Benefits Coordinator, who assisted him with enrolling into Medicaid, and found that he would qualify for Qualified Medicare Benefits (QMB)."*

For some people like this silversmith from the Diné Tribe of the Navajo Nation, paying for Medicare Part B premiums, copays, and deductibles can be challenging. He was living on a limited income, and after a trip to the IHS to see an eye doctor, he found out he desperately needed cataract surgery. When he went to get treatment, he was referred out of IHS to a specialty clinic but did not have health insurance because he could not afford it. He was referred to the Patient Benefits Coordinator, who assisted him with enrolling into Medicaid, and found that he would qualify for Qualified Medicare Benefits (QMB)*. He was excited to find out that through QMB, he would receive extra assistance and not have to pay any out-of-pocket costs. As a result of his coverage under the limited income and resource benefits program, his Tribal clinic was able to preserve funding for Tribal citizens in dire health need who have limited resources. In turn, he was able to get his cataract surgery, and he was able to continue teaching silversmithing to his grandchildren.

**QMB is a state program that pays for Medicare premiums, co-insurance, and deductibles.*

NIHB STORY BOARDS

When You Do Not Qualify for Medicaid, There Are Other Health Insurance Choices

National Indian Health Board

A storyboard series from the National Indian Health Board
For more information, visit nihb.org/tribalhealthreform/

Family of 5 | Confederated Tribes of Coos, Lower Umpqua and Suislaw Indians | Portland Area | CHIP, Marketplace, employer-sponsored health insurance

"She reached out and applied to the health insurance marketplace. She was then able to obtain coverage through the health insurance marketplace, which directly helped the entire family to continue to receive quality health services."

For those like a 35-year-old Native Mother in the Portland area, qualifying for Medicaid can be a challenge. She was pushed out of the qualifying income bracket due to an increase in her husband's income, and she and her family lived outside of their Purchased/Referred Care Delivery Area (PRCDA)*. Because of this, she and her husband did not qualify for Medicaid because they were over-income, so they had to rely heavily on private health insurance coverage**. Luckily, her three children were eligible for coverage through the Children's Health Insurance Program (CHIP), and her husband gained employer-sponsored health insurance. However, adding herself to her husband's employer plan was too expensive for the family, so instead, she reached out and applied to the health insurance marketplace. She was then able to obtain coverage through the health insurance marketplace, which directly helped the entire family to continue to receive quality health services and help save valuable Purchased/Referred Care dollars for other American Indians and Alaska Natives in dire health need.

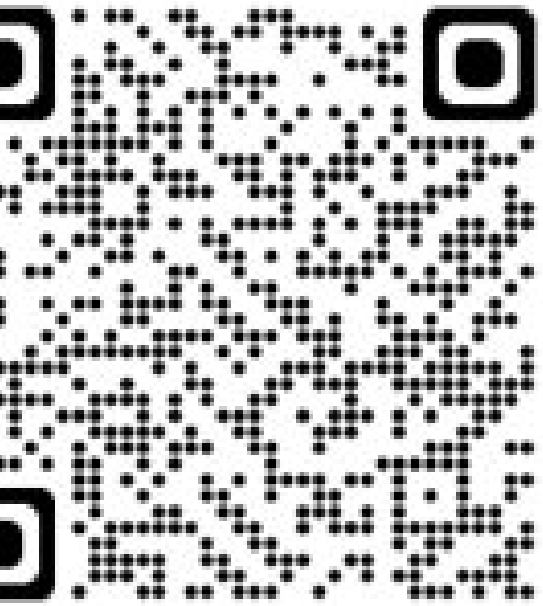
** PRCDA refers to the geographic area within which Purchased/Referred care will be made available by the IHS to members of an identified Indian community who reside in the area. Purchased/Referred Care funding, previously known as Contract Health Services, health services/specialty care provided at the expense of the Indian Health Service (IHS) from other public or private medical or hospital facilities other than those of the Service unit (e.g., dentists, physicians, hospitals, and ambulances.)*

*** The key difference between private and public health insurance is the qualification factor. Private health insurance does not have income restrictions for a potential insurer, whereas some public health insurance does due to its increased affordability.*

Season 2 coming soon in 2024: The Hope & Healing Podcast

Six Episode Series (Season 1):

1. **Introduction** | Kristen Bitsuie
2. **Medicaid 101** | Angie Wilson
3. **Medicare 101** | Adam Archuleta
4. **Marketplace 101** | Yvonne Myers
5. **Health Equity** | Jim Roberts
6. **Emerging Hot Topics** | Melissa Gower & Winn Davis



Kristen Bitsuie
Tribal Healthcare Reform Outreach and Education Policy Coordinator

National Indian Health Board
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Direct: 202-507-4084

"*Outreach and Education efforts about the importance of health insurance coverage may have helped to increase enrollment.*"

– U.S. GAO Report to Congressional Requesters


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