National Indian Health Board

Medicaid Unwinding & Coverage Trends Across Tribal Nations

Presented by:

Kristen Bitsuie
Tribal Healthcare Reform Outreach and Education Program Coordinator
National Indian Health Board

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.”

AI/AN Medicaid Unwinding in Montana Data Sources

Date MT unwinding data last updated	July 2023	Date unwinding began in MT	June 2023	Baseline date (month before unwinding in MT)	May 2023

All data used in this summary were updated as of October 2, 2023. We used the following sources of data for our calculations:

- 2021 American Community Survey (ACS)
- Kaiser Family Foundation (KFF) Medicaid Enrollment and Unwinding Tracker
- Montana Medicaid Enrollment Dashboard (Montana DPHHS)

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AI/AN Medicaid Unwinding in Montana
Data Limitations

The following limitations should be kept in mind when reviewing and applying the results of our data analysis:

- 2021 ACS data undercounts Medicaid enrollment.
- The estimates represent potential Medicaid unwinding numbers for American Indian/Alaska Natives at the time of the data analysis. We acknowledge that the data is constantly changing and updating.
- We are unable to determine the proportion of American Indian/Alaska Natives on Medicaid that have been disenrolled, relative to the overall population and other racial/ethnic groups.

AI/AN Medicaid Unwinding in Montana Methods (Part One)

Method A: Multiply Montana's Medicaid disenrollment rate by the number of AI/AN enrolled in Medicaid in Montana in 2021 (ACS).

Montana's Medicaid disenrollment rate was calculated by dividing the number of Medicaid disenrollments in Montana (KFF) by total number of Medicaid enrollments in Montana. Data on total number of Medicaid enrollments were from the month prior to when unwinding began (baseline) in Montana.

Potential estimate of # of AI/ANs disenrolled from Medicaid in Montana using Method A: 9,459

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AI/AN Medicaid Unwinding in Montana Methods (Part Two)

Method B: Multiply the number of Medicaid disenrollments in Montana (KFF) by Montana's AI/AN Medicaid enrollment rate in 2021 (ACS).

The AI/AN Medicaid enrollment rate in 2021 for Montana was calculated by dividing the number of AI/AN enrolled in Medicaid in Montana by the total number enrolled in Medicaid in 2021 in Montana.

Potential estimate of # of AI/ANs disenrolled from Medicaid in Montana using Method B:

13,612

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AI/AN Medicaid Unwinding in Montana Methods (Part Three)

Method C: Multiply the number of Medicaid disenrollments in Montana (KFF) by Montana's AI/AN Medicaid enrollment rate in July 2023 (Montana DPHHS).

The AI/AN Medicaid enrollment rate in July 2023 for Montana was calculated by dividing the number of AI/AN enrolled in Medicaid in Montana in July 2023 by the total number enrolled in Medicaid in July 2023 in Montana.

Potential estimate of # of AI/ANs disenrolled from Medicaid in Montana using Method C: 12,372

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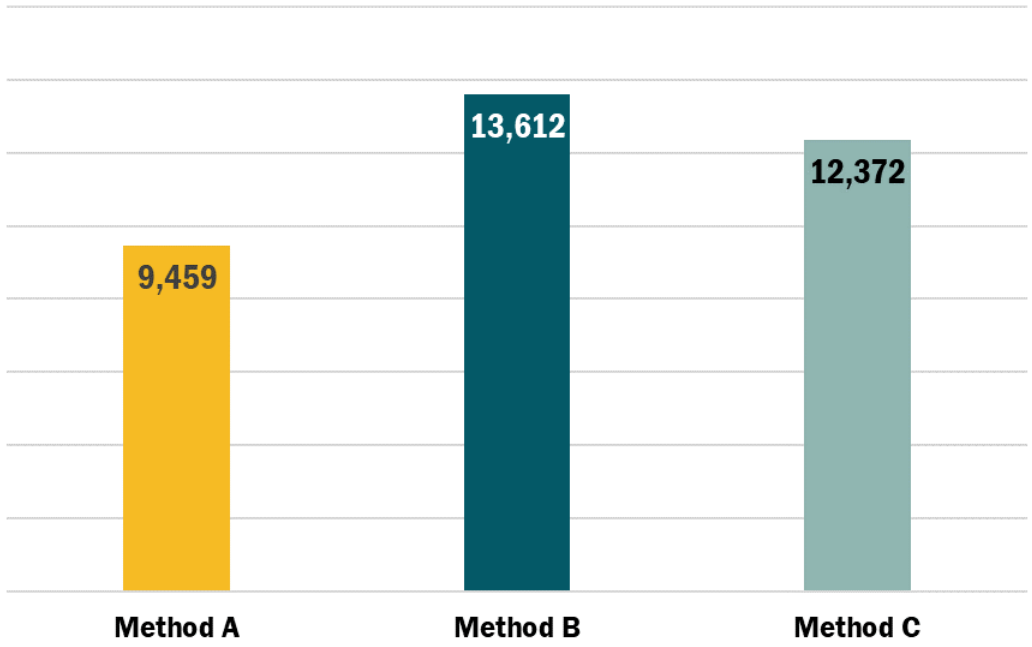
AI/AN Medicaid Unwinding in Montana Comparison of Estimates



Method A: Multiply Montana's Medicaid disenrollment rate by the number of AI/AN enrolled in Medicaid in Montana in 2021 (ACS).
Method B: Multiply the number of Medicaid disenrollments in Montana (KFF) by Montana's AI/AN Medicaid enrollment rate in 2021 (ACS).
Method C: Multiply the number of Medicaid disenrollments in Montana (KFF) by Montana's AI/AN Medicaid enrollment rate in July 2023 (Montana DPHHS).

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Questions about the Calculations or Data Sources:

Rochelle Ruffer, rruffer@nihb.org
Jeannie Le, jle@nihb.org

References

Kaiser Family Foundation. (2023, October 2). Medicaid Enrollment and Unwinding Tracker. Retrieved October 2, 2023 from https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/

Montana Department of Public Health and Human Services. (2023). Montana Medicaid Enrollment Dashboard. Retrieved October 2, 2023 from https://dphhs.mt.gov/interactivedashboards/medicaidenrollmentdashboard

United States Census Bureau. (2023). ACS 1-Year Estimates Public Use Microdata Sample, Vintage 2021. https://data.census.gov/mdat/#/

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End of COVID-19 Public Health Emergency

CMS policies changed to address the PHE so the expiration impacts some rules, including**:**

- Waivers and flexibilities
- Coverage for vaccines, testing, and treatment
- Telehealth and Extension of Medicare Telehealth Flexibilities (Consolidated Appropriations Act (CAA) 2023)
- Coverage Transition (COVID-19 PHE/Unwinding)

End of the COVID-19 PHE Preparations

- CMS used a combination of emergency authority waivers, regulations, enforcement discretion, and sub-regulatory guidance to ensure access to care and give health care providers the flexibilities needed to respond to COVID-19 and help keep people safer
- **Flexibilities**
  - Emergency Interim Regulations
  - Blanket Waivers
  - Sub-regulatory Guidance
- **Many have terminated at the end of the PHE**, as they were intended to address the acute and extraordinary circumstances of a rapidly evolving pandemic and not replace existing requirements

Waivers & Flexibility Timeline

May 11, 2023
The Public Health Emergency (PHE) for COVID-19 declared under section 319 of the Public Health Services Act, expired at the end of the day, May 11, 2023.

May 11, 2023
Most blanket waivers ended in response to emergencies or natural disasters including scope of practice and health and safety waivers. OTC testing coverage ended
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June 30, 2023
SNF enforcement discretion allowing pharmacies to administer vaccines in SNF ended.

December 31, 2023
Medicaid increased FMAP rate will end.

December 31, 2023
Virtual supervision flexibility to expire.

April 30, 2024
End of hospital reporting requirements.

December 31, 2024
End of reporting requirements for nursing homes

December 31, 2024
Extension of Acute Hospital of Care at Home ends.

December 31, 2024
Most Medicare telehealth flexibilities provisions end.

Coverage for COVID-19 Tests

After May 11, 2023

- People with Medicare:
  - Generally, Medicare doesn't cover or pay for over-the counter products. The demonstration that offered free COVID-19 over-the-counter tests ended.
  - Laboratory tests for COVID-19 ordered by your provider will still be covered with no out-of-pocket costs.
  - If you're enrolled in a Medicare Advantage Plan, you may have more access to tests depending on your benefits. Check with your plan.
- Medicaid and CHIP Beneficiaries:
  - COVID-19 over-the-counter tests and laboratory testing are available through September 30, 2024.
  - After that date, coverage and costs for COVID-19 testing may vary by state.
- Private Insurance: mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests ended; coverage will vary depending on the health plan.

COVID-19 Vaccines

After May 11, 2023

- People with Original Medicare: continue to have access to COVID-19 vaccinations without out-of-pocket costs.
  - Cost sharing for COVID-19 vaccines may have changed for people with Medicare Advantage (MA) Plans
- Medicaid and CHIP: continued coverage for COVID-19 vaccines and treatments without cost sharing through September 30, 2024
  - Medicaid covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including COVID-19, without cost sharing for most people with Medicaid
  - Providers may submit reimbursement claims for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund
- Private Insurance: Most forms of private health insurance must continue to cover COVID-19 vaccines given by an in-network provider without cost sharing

COVID-19 Treatments

After May 11, 2023

- People with Medicare: Generally, the end of the COVID-19 PHE doesn't change access to treatments like oral antivirals, such as Paxlovid and Lagevrio. Part B covers FDA-authorized COVID-19 monoclonal antibody treatments and products, if all of these apply:
  - You tested positive for COVID-19.
  - You have a mild to moderate case of COVID-19.
  - You're at high risk of progressing to a severe case of COVID-19 and/or at high risk of requiring hospitalization
- Medicaid and CHIP Beneficiaries: After September 30, 2024, coverage and cost sharing for treatments may vary by state
- Private Insurance: The transition forward from the PHE won't change how treatments are covered, and in cases where cost sharing and deductibles apply now, they will continue to apply.

Temporary Medicare Telehealth Changes

Through December 31, 2024 (Consolidated Appropriations Act, 2023)

- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) can serve as a distant site provider for non-behavioral/mental telehealth services
- Generally, any provider who can bill Medicare can bill for telehealth through December 31, 2024
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using phones (audio only)
- You don’t need an in-person visit within 6 months of the first behavioral/mental telehealth service, and yearly thereafter
- Telehealth services can be given by a variety of providers (physical therapist, occupational therapist, speech language pathologist, or audiologist)

Permanent Medicare Telehealth Policy

- Medicare patients can get telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using phones (audio only)

Summary: Telehealth policy changes after the COVID-19 Public Health Emergency

Telehealth Services after the end of the PHE (May 12, 2023)

- CMS significantly expanded the list of services that can be provided by telehealth. Some of these services will continue to be covered under Medicare through December 31, 2024. For details, see this list of Medicare-covered telehealth services.
- All telehealth services need to follow HIPAA rules. Covered health care providers have a 90-day transition period to comply in good faith with the HIPAA Rules without penalties until August 9, 2023.

CMS recently published policy updates for Medicare telehealth services

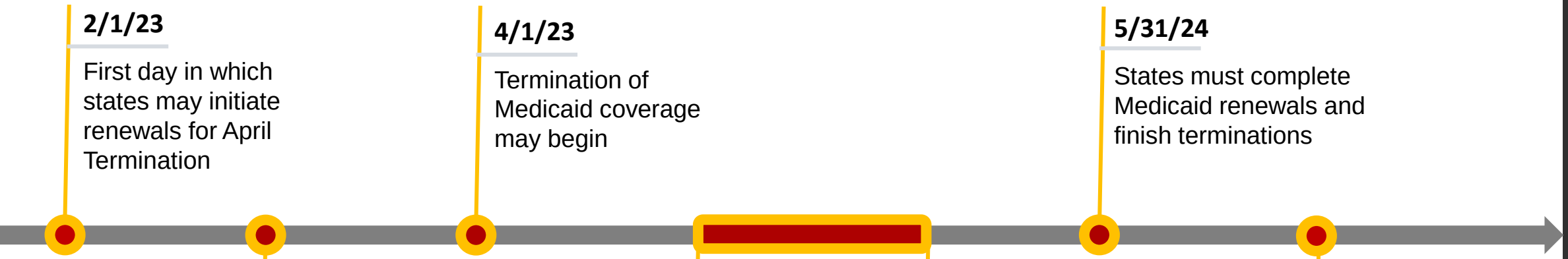
- CMS clarified that temporary telehealth services added during the COVID-19 Public Health Emergency (PHE) will continue through the end of Calendar Year (CY) 2023.
- Telehealth services provided in the office setting will continue to be paid at the non-facility rate (higher payment) through the end of CY 2023.

Telehealth: Medicaid & CHIP

- For Medicaid and CHIP, telehealth flexibilities aren't tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic
- Coverage will ultimately vary by state
- To assist states with the continuation, adoption, or expansion of telehealth coverage, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth:

  Medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

Transition from Medicaid to Marketplace Timeline Increased Assister Support



2/1/23

First day in which states may initiate renewals for April Termination

3/31/23

Earliest possible last day of Medicaid coverage;

First day of Unwinding Special Enrollment Period (SEP) eligibility

4/1/23

Termination of Medicaid coverage may begin

11/1/23 - 1/15/24

Marketplace Open Enrollment

5/31/24

States must complete Medicaid renewals and finish terminations

7/31/24

Last day of Unwinding SEP eligibility

Affordability Program: Premium Tax Credits

- Consumers with certain household incomes who aren't eligible for other qualifying coverage, like through a job, Medicare, most Medicaid coverage, or CHIP, may be eligible for savings through the Marketplace.
- If consumers projected annual household income for the coverage year falls between 100 % and 400 % of the Federal Poverty Level (FPL), they may qualify for a premium tax credit (PTC). Per the Inflation Reduction Act, Congress waived the 400% FPL cap through 2025.

Note:

- PTCs are only available to consumers who enroll in an individual market Marketplace plan through the Marketplace.
- Eligible consumers can use all, some, or none of their PTCs in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

Affordability Program: Premium Tax Credits (Cont.)

- Reconciling APTC:
  - The amount of PTC a consumer is eligible for may change throughout the coverage year, if there are changes to the consumer's changes to the consumer's household income, household income, household size, or other determining factors.
  - It's very important that consumers report life changes to the Marketplace.
  - When consumers file their income taxes, they'll have to reconcile any ATPC that were paid on their behalf to reduce their monthly premiums with the amount of PTC they were ultimately eligible for based on their actual annual household income.
- If consumers use APTC in excess of the PTC they are determined eligible for, they may be required to repay all or some of the difference when they file their federal income tax return.
- If consumers use less PTC than they're determined eligible for when they file their federal income tax return, they may receive the difference as a refundable credit.

Reason to Keep/Sign Up for Part B?

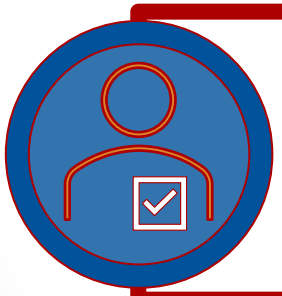
Consider:

- Most people pay a monthly premium
  - Usually deducted from Social Security/RRB benefits
  - Amount depends on income
- Part B may supplement employer coverage
  - Contact your benefits administrator to understand the impact to your employer plan
  - If you don't have other coverage, declining Part B will mean you don't have full coverage
- Sometimes, you must have Part B

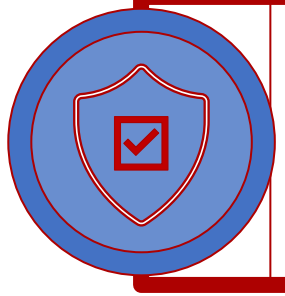
When You Must Have Part A & Part B

To buy a Medicare Supplement Insurance (Medigap) policy

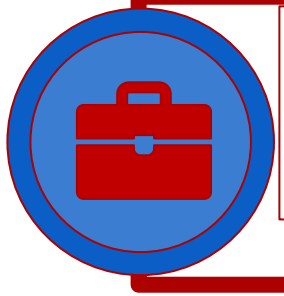
To join a Medicare Advantage Plan



Eligible for TRICARE for Life (TFL)



Eligible for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)



Employer coverage requires you to have it (has fewer than 20 employees)

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How Part D Works

- It's optional
  - You can choose a plan and join
  - May pay a lifetime penalty if you join late
- Plans have formularies (lists of covered drugs), which:
  - Must include range of drugs in each category
  - Are subject to change—you'll be notified
- Your out-of-pocket costs may be less if you use a preferred pharmacy
- If you have limited income and resources, you may get Extra Help

When Can I Enroll in a Part D Plan? (continued)

What if I'm in a Medicare Advantage Plan on January 1 but switch to Original Medicare?	You may add Medicare drug coverage if you switch during the Medicare Advantage OEP (January 1–March 31).
Can I join, switch, or drop a drug plan if I qualify for a Special Enrollment Period (SEP)?	Yes.
What if I'm new to Medicare and enrolled in a Medicare Advantage Plan during my IEP?	You can make a change within the first 3 months you have Medicare.
When's the 5-star SEP?	December 8–November 30 each year, you can switch to Medicare drug coverage that has 5 stars for its overall rating.

Marketing & Communications Oversight Improvements for Plan Year 2023

- Strengthened oversight of third-party marketing organizations (TPMOs) to detect and prevent the use of confusing or potentially misleading activities to enroll beneficiaries in Medicare Advantage Plans and Medicare drug plans
- Reinstated the inclusion of a multi-language insert in all required documents to inform beneficiaries of the availability of interpreter services
- Required a disclaimer for limited access to preferred cost sharing pharmacies
- Plan websites needed to have instructions on how to appoint a representative, and website posting of enrollment instructions and forms

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 person with Medicare

Marketing & Communications Oversight Improvements for Plan Year 2024 (continued)

- Ads will be prohibited if they don't mention a specific plan name
- The TPMO disclaimer must add
  - SHIPs as an option for beneficiaries to get additional help
  - Include the number of organizations/plans represented
- MA organizations can't use
  - Superlatives unless a source of documentation/data support language
  - Data older than the prior contract year (must be specifically identified)
  - Use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way.
    - Use of the Medicare card image is permitted only with authorization from CMS

Qualifying for Extra Help

You automatically qualify for Extra Help if you get:

- Full Medicaid coverage
- Supplemental Security Income (SSI)
- Help from Medicaid paying your Medicare premiums (Medicare Savings Programs; sometimes called “partial dual”)

If you don’t automatically qualify you must:

- Apply online at ssa.gov/benefits/medicare/prescriptionhelp.html
- Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778, and ask for the “Application for Help with Medicare Prescription Drug Plan Costs” (SSA-1020)

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Certified Application Counselor Designated Organization (CDO) program- Application Process

CMS invites **new applicant organizations** who want to become a CDO for Plan Year 2024 to apply during CMS's Open Season **August 1-December 15, 2023.**

To apply to become a CDO:

1. Access and complete the CDO application at https://mats.secure.force.com/CDOApplication/. CMS will review your application and send a determination email with your application status. Please allow up to 10 business days for this review.
2. If CMS approves your application, you must access the CDO Organizational Maintenance Web Form (link provided in approval email) and submit a signed CMS-CDO agreement. CMS will then review your signed agreement and send a determination email. If CMS approves your agreement, you will receive a Welcome Packet email with a unique CDO ID. Please allow up to 5 business days for this review.

Components of Outreach and Education

- 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

Empowerment:
Succeeding individually and as a community

Outreach & Education Strategies and Tips

- Building Relationships
  - Be flexible
  - Focus on building trust
  - Remain non-judgmental
  - Provide resources
  - Be the support
- Spam and Health Identity Theft

Medicaid Announcement

- 12 Month 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.

More Information About the Marketplace

- Sign up to get email and text alerts at HealthCare.gov/subscribe
- Healthcare.gov/Tribal
- Updates and resources for organizations are available at Marketplace.cms.gov
- Twitter@HealthCareGov
- Facebook.com/Healthcare.gov?_rdr=p
- YouTube.com/playlist?list=PLaV7m2-zFKpgZDNCz7rZ3Xx7q2cDmpAm7

Helpful Resources

- **Link to AI/AN Trust Income and MAGI Fact Sheet:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIAN-Trust-Income-and-MAGI.pdf
- **Cost Sharing Protections Brochure:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Understanding-Cost-Sharing-brochure.pdf
- **Medicaid Application (see Appendix B):** https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf

Helpful Websites

01	**Medicare**	Medicare.gov
02	**Medicaid**	Medicaid.gov
03	**Social Security**	ssa.gov
04	Health Insurance Marketplace®	HealthCare.gov
05	**Children's Health Insurance Program**	InsureKidsNow.gov
06	**CMS National Training Program**	CMSnationaltrainingprogram.cms.gov
07	**State Health Insurance Program**	shiphelp.org

Helpful Contacts

For questions about Medicaid or CHIP – Contact your state Medicaid or CHIP office directly

- Find the contact information for your state Medicaid office at Medicaid.gov/renewals

For questions about the Health Insurance Marketplace® – Visit HealthCare.gov or contact a local enrollment assister in your area

- Find a list of enrollment assisters in your area at LocalHelp.HealthCare.gov
- Call 1-800-318-2596. TTY users: 1-855-889-4325.

For questions about Medicare – Visit Medicare.gov

- Call 1-800-MEDICARE (1-800-633-4227). TTY users: 1-877-486-2048.
- To get help with the Medicare enrollment form, contact local Social Security office. Find an office near you at ssa.gov/locator or call Social Security at 1-800-772-1213. TTY users: 1-800-325-0778.
- Contact your local State Health Insurance Assistance Program (SHIP) at Shiphelp.org.

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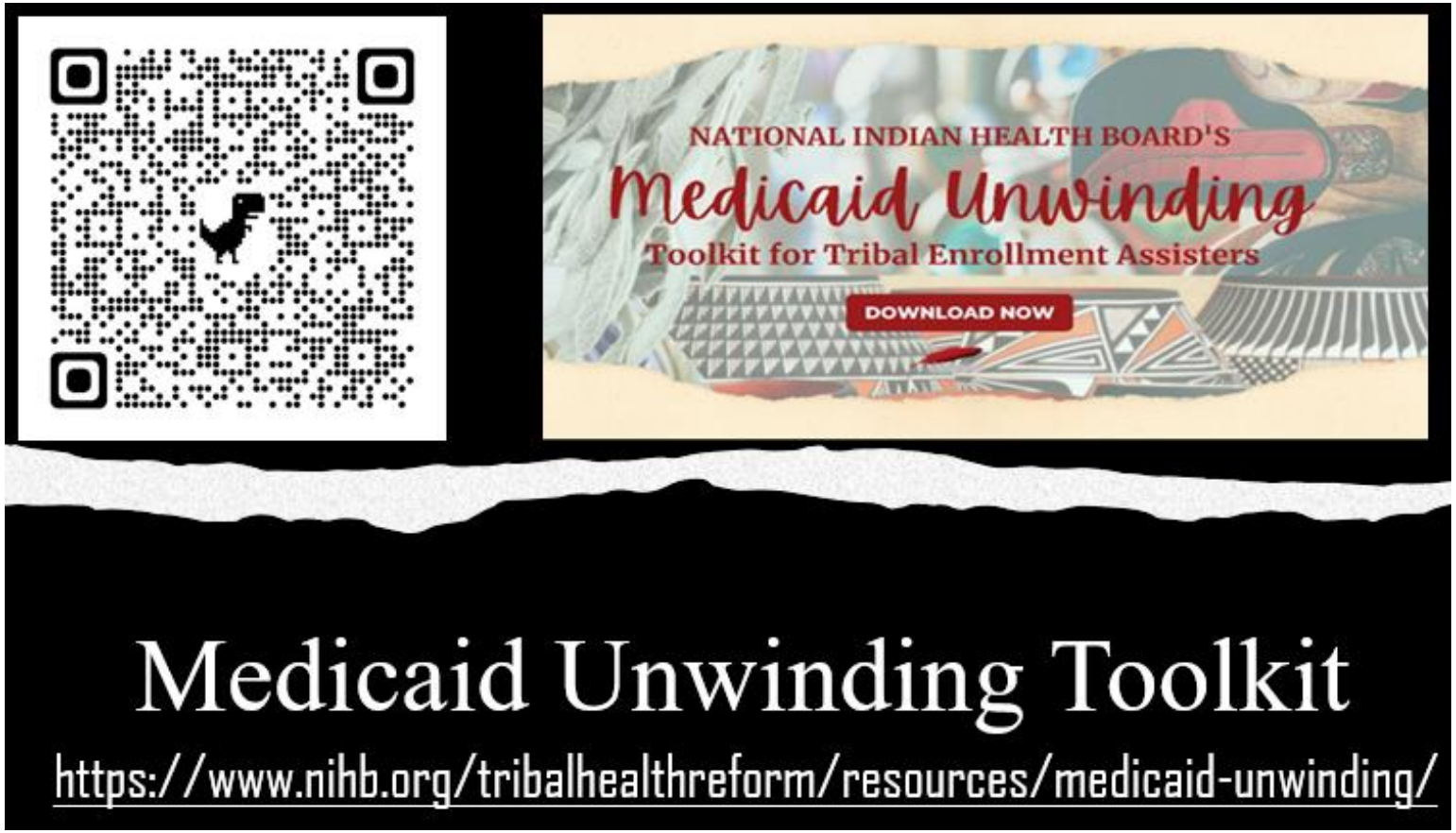
NIHB's Medicaid Unwinding Toolkit for Tribal Enrollment Assisters

Social Media graphics

Tips

Learning from other organizations



Enrollment Data

Resources

Reminders

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Thank you!

Kristen Bitsuie

National Indian Health Board
Tribal Health Care Reform Outreach and Education Policy Coordinator

Email: Kbitsuie@nihb.org
Phone: 202-507-4084