Tribal Outreach and Education

National Indian Health Board

MEDICAID/CHIP DEFINITION OF INDIAN

For the purpose of Medicaid & CHIP, the definition of Indian is defined as any American Indian and Alaska Natives eligible for services from an Indian Health Care provider

MEDICAID AND CHIP PROTECTIONS

- Do not have to pay Medicaid premiums or enrollment fees if they are eligible to receive care from the Indian Health Care providers or through referral to a non-Indian provider such a Purchased/Referred Care
- Do not have to pay cost sharing, such as deductibles, coinsurance or copayments for any Medicaid service from any Medicaid provider if they have ever received a service or referral from and Indian Health Care provider
- Children who are American Indian/Alaska Native cannot be charged any premium, enrollment fee, copayment, coinsurance or deductible in CHIP
- Certain types of Indian payments and resources are not counted when determining Medicaid and CHIP eligibility
- Certain types of Indian trust income and resources are exempt from Medicaid estate recovery rules

MEDICAID/CHIP BENEFITS

- No Copays, Deductibles, Co-Insurance, Premiums for AI/ANs
- Enroll Year Around
- Non-emergency Transportation
- Transitional Medicaid Assistance
- Family Planning
- Primary, Preventive, Dental Care, Vision Care
- Physical, Occupational, Speech, Language therapies

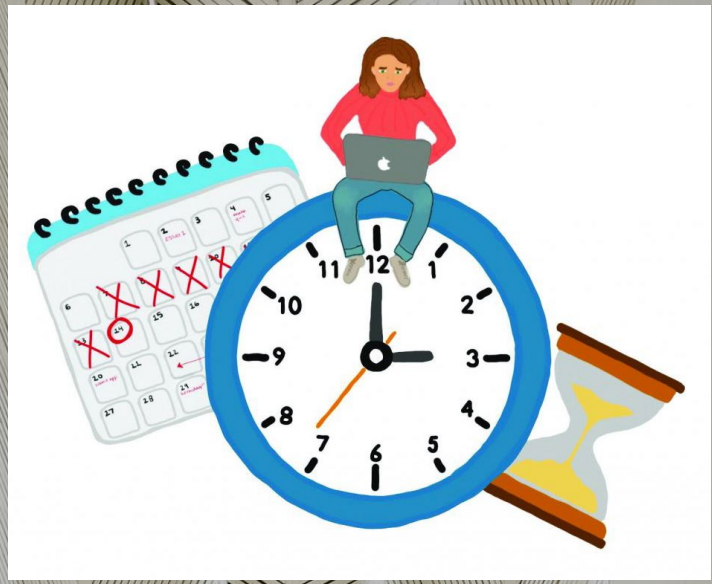
EPSDT

Early and **P**eriodic **S**creening, **D**iagnostic and **T**reatment

- EPSDT at its heart is all about early identification and intervention. It makes Medicaid align with pediatric best practice in providing care to children.
- The mandate requires State Medicaid Programs to adopt best practices in early screening of infants/toddlers/children/youth to identify health and developmental issues
  - Developmental screening at 9 months, 18 months and 30 months
  - Early screening for vision and dental problems
  - And States have to report on their screening statistics so there's the effect of knowing your state is being judged on where it ranks in addressing children needs
- The other piece of EPSDT being valuable is the Treatment mandate
  - Once a diagnosis is made, the state is obligated to get the child treatment. Additionally, the State is responsible to arrange for services even if the services fall outside of what the State typically pays for—i.e. massage therapy, chiropractic, etc.

CHALLENGES

- Mail delivery to P.O. boxes
- Access to technical assistance
- Staying up-to-date on the latest CMS announcements
- Understanding changes in health laws and flexibilities
- Complex application process
- Geographical issues: remote or isolated
- Lack of transportation
- Limited or no internet connection
- Working with state Medicaid agency
- Submission of supporting documents



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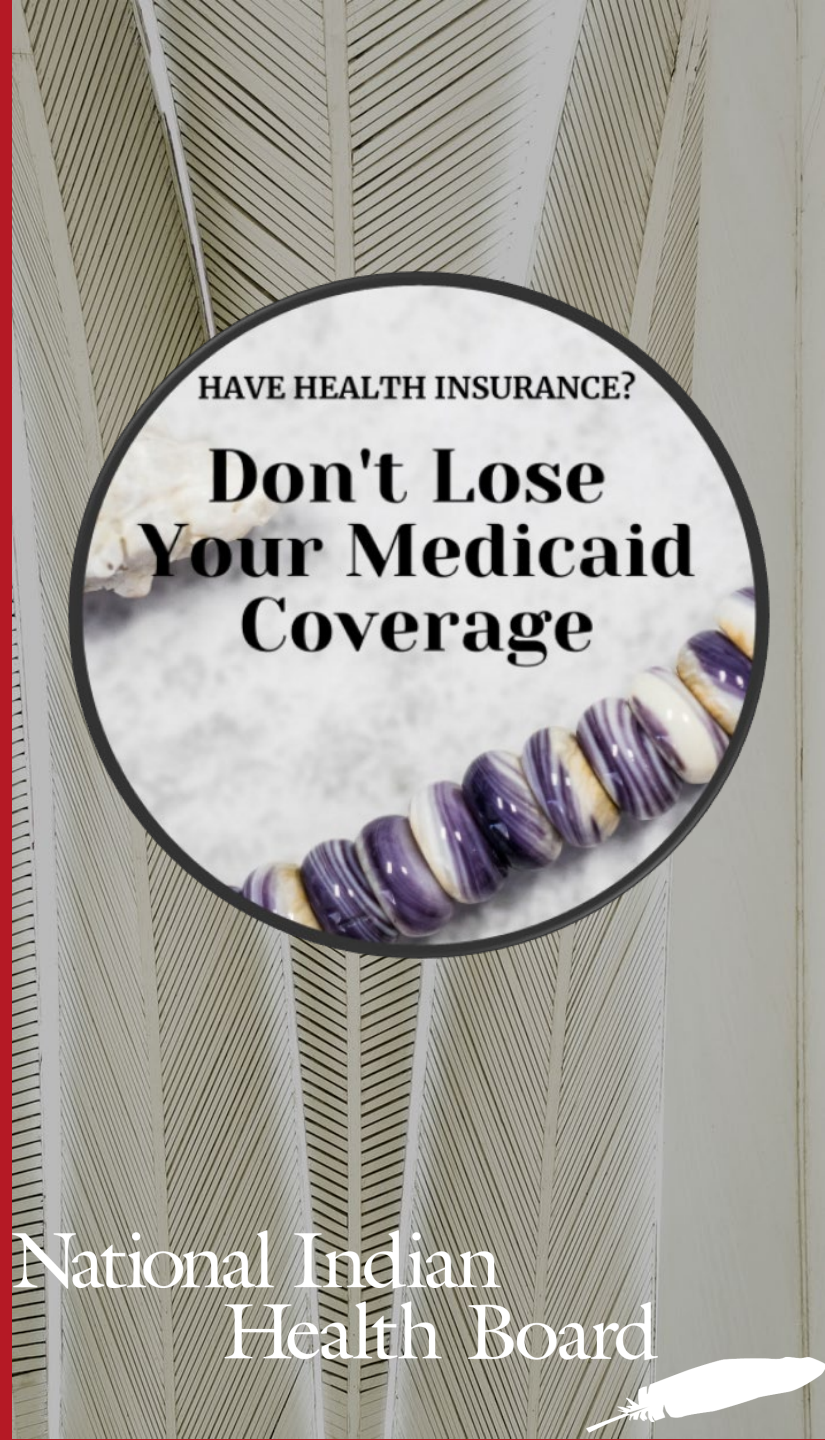
LESSONS LEARNED

- Tribal enrollment assisters understand the unique enrollment requirements and application process for Tribal citizens
- Foster strong partnership with other enrollment assisters
- Build relationships with organizations in the community
- Outreach materials customized to fit Tribal communities
- Social media is a useful tool for outreach and education
- Sharing health insurance enrollment experiences
- Understanding the Tribal community’s culture, history, and traditions
- Communication is unique in Tribal communities

BEST PRACTICES

- Utilizing enrollment data
- Navigating social media
- Partnering with community organizations or organizations with outreach grants
- Internal training at Indian Health Service and Tribal facilities
- Placing Tribal enrollment assisters at different departments
- Running internal reports on uninsured
- Receiving data sharing from state Medicaid
- Involving internal staff by using their reach
- Being visible
- Elders are the greatest teachers and messengers



EXAMPLES OF OUTREACH AND EDUCATION

PRINT	ELECTRONIC	VISUALS	PERSONAL CONTACT
Fact sheets	Social Media	Signage	Meetings
Brochures	Websites	Posters	Community events
Flyers	Electronic News	Banners	Target audience
Newsletters	Emails	Presentations	Partner organization
News releases	Public Service Announcements	Exhibit displays	Word of Mouth
Mail	Bulletin Boards		CHR/WIC
	Texting		

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.

Medicaid Postpartum Coverage

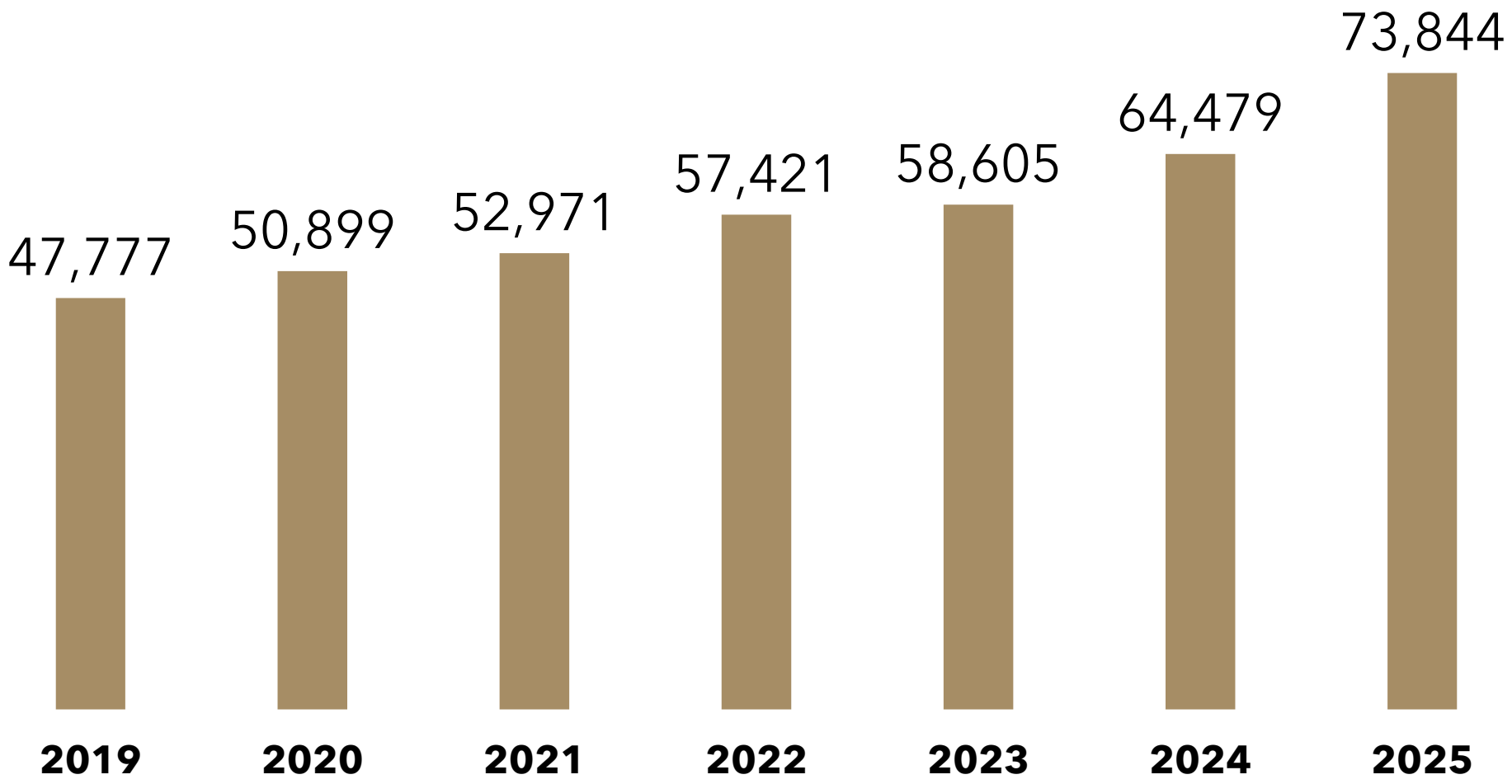
- As of April 1, 2022, the American Rescue Plan Act of 2021 allowed states the option to extend Medicaid postpartum coverage from 2 to 12 months

MARKETING & COMMUNICATIONS OVERSIGHT IMPROVEMENTS FOR PLAN YEAR 2024

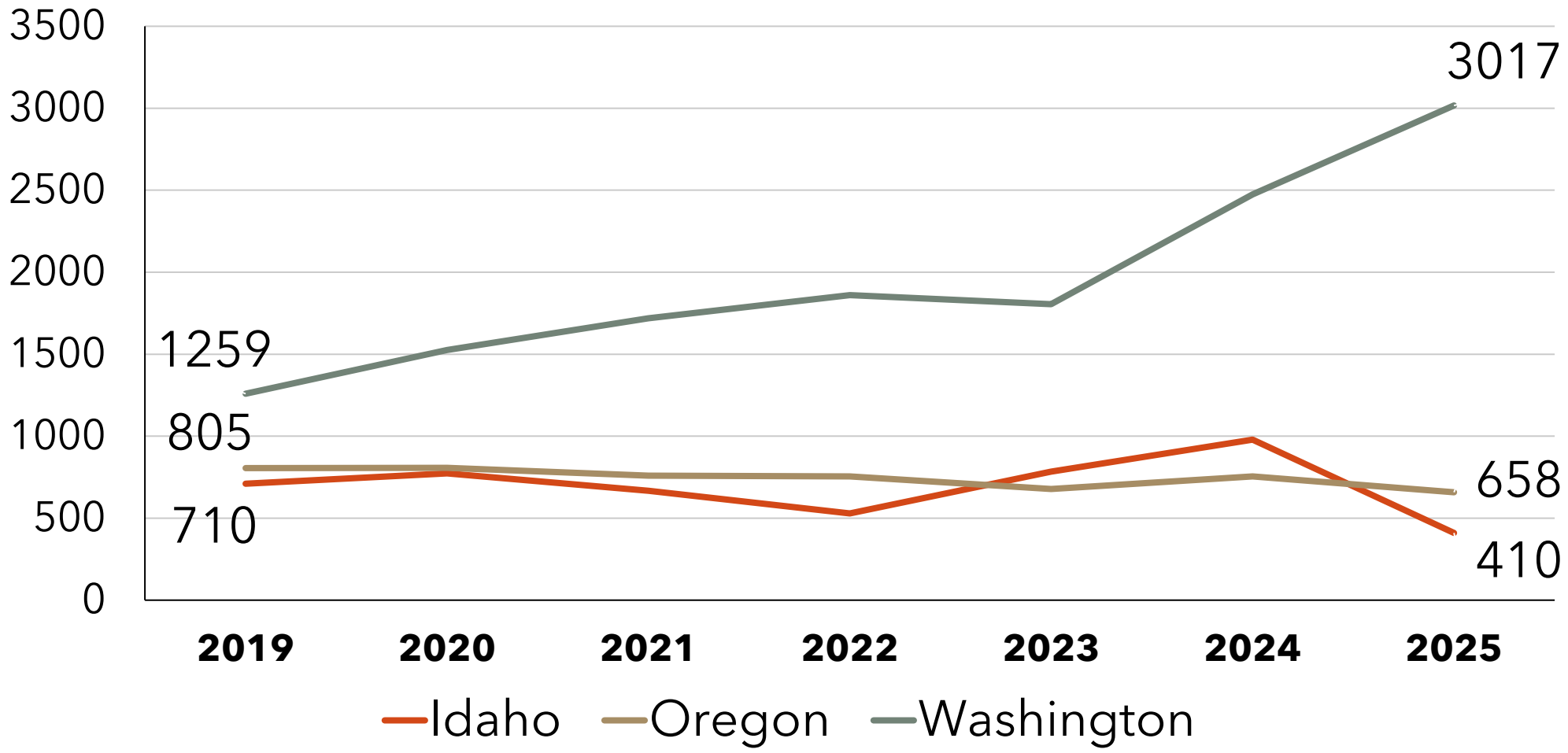
MA Organizations can't:

- 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

AI/AN MARKETPLACE OPEN ENROLLMENT IN THE US



HEALTH INSURANCE MARKETPLACE AI/AN OPEN ENROLLMENT



ENROLLMENT DATA

- All data following are from American Community Survey 2013, 2018, and 2023 5-year estimates, U. S. Census Bureau.
- All population data include foreign-born. American Indian Alaska Native is defined as “alone or in combination with one or more other races.”
- Any questions on data, please contact Jeannie Le, MPH, Tribal Health Data Lead or Rochelle Ruffer, Ph.D., Tribal Health Data Project Director at data@nihb.org.

AI/AN ENROLLMENT IN THE UNITED STATES

AI/AN Enrollment	2013	2023	Change	Percentage Change
Medicaid	1,443,631	2,287,100	843,469	58.4%
Medicare	583,116	949,303	366,187	62.8%
Uninsured	1,216,197	1,029,407	-186,790	-15.4%

AI/AN MEDICAID ENROLLMENT

State	2013	2023	Change	Percentage Change	Medicaid Expansion Date
Idaho	9,175	15,266	6,091	66.4%	11/1/2019
Oregon	32,077	55,832	23,755	74.1%	1/1/2014
Washington	58,218	85,670	27,452	47.2%	1/1/2014

AI/AN MEDICARE ENROLLMENT

State	2013	2023	Change	Percentage Change
Idaho	4,562	7,561	2,999	65.7%
Oregon	12,068	20,893	8,825	73.1%
Washington	20,965	32,991	12,026	57.4%

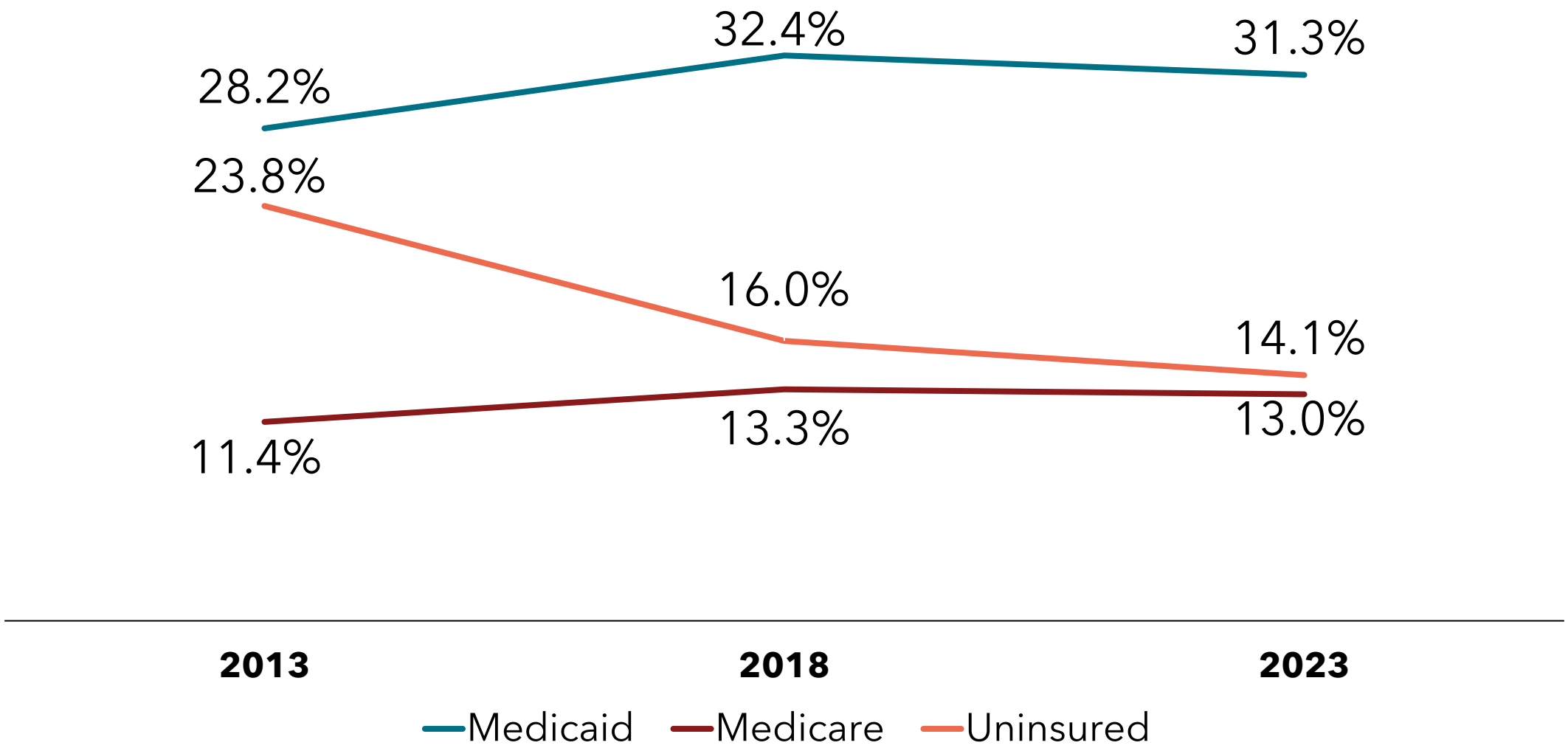
AI/AN UNINSURED

State	2013	2023	Change	Percentage Change
Idaho	10,542	9,069	-1,473	-14.0%
Oregon	26,037	12,952	-13,085	-50.3%
Washington	42,429	25,260	-17,169	-40.5%

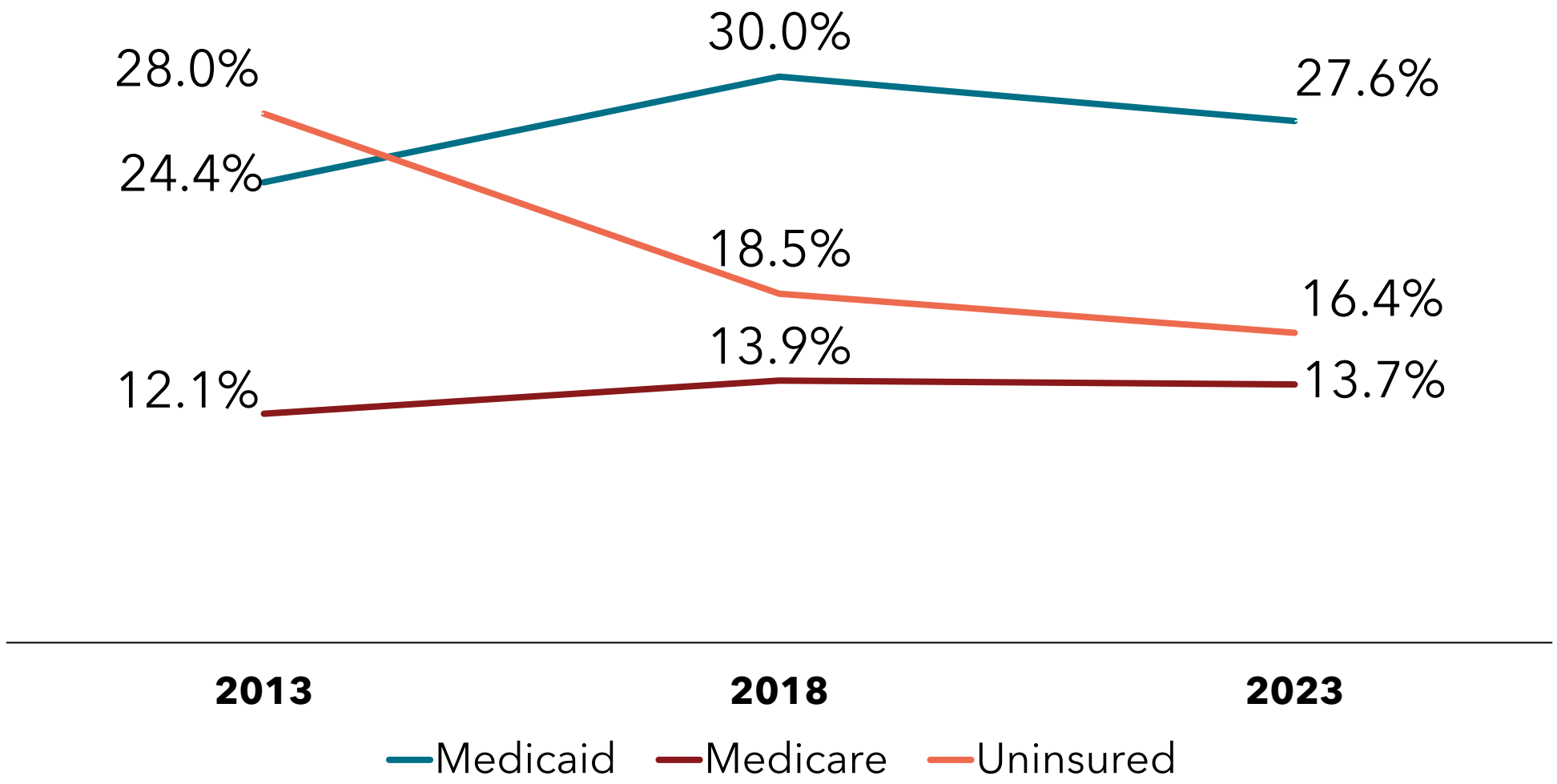
ENROLLMENT RATES BY STATES

For the United States, Idaho, Oregon, and Washington

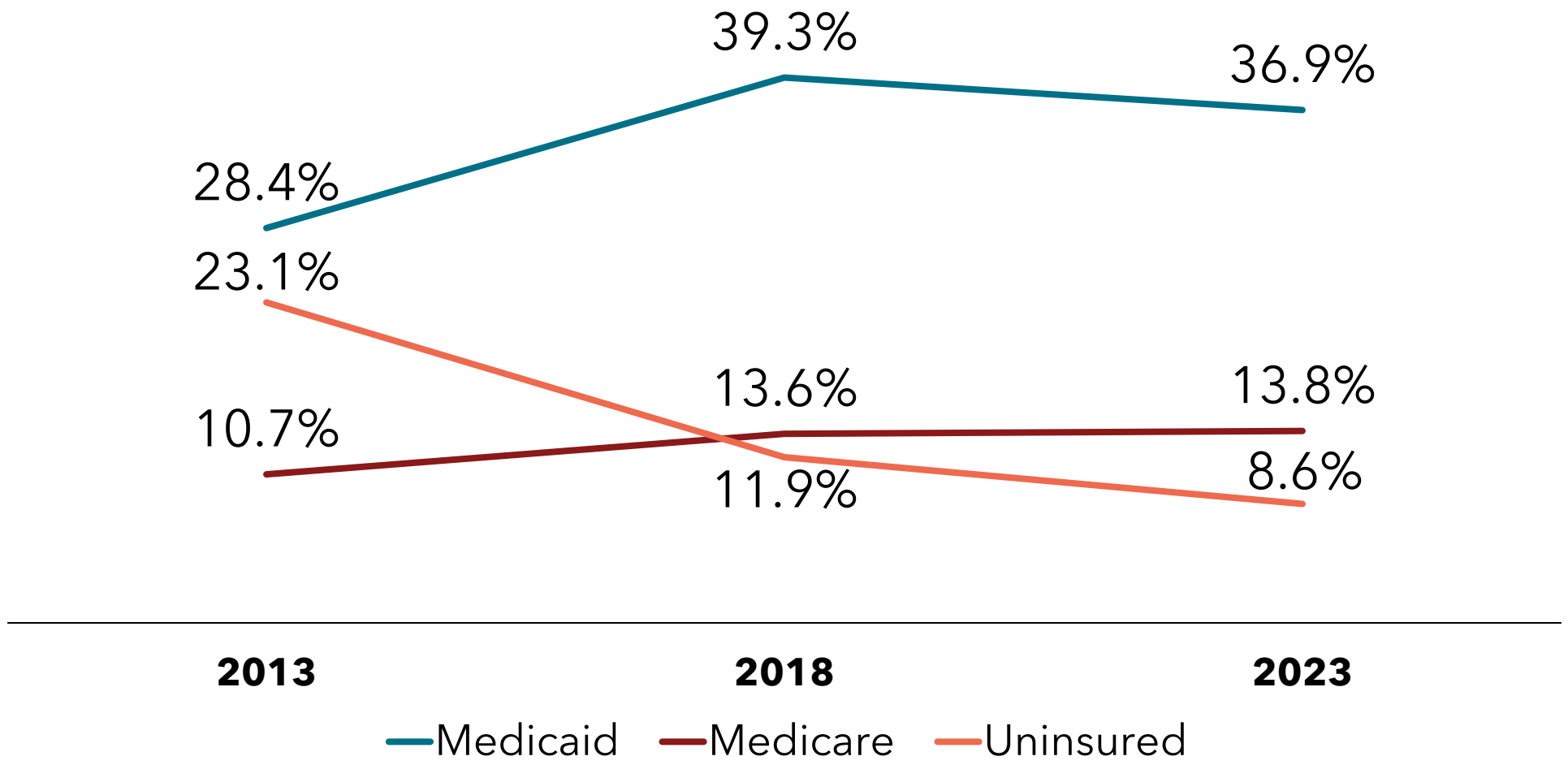
United States: From 2013-2023, the AI/AN **Uninsured** rate decreased, and AI/AN **Medicaid** and **Medicare** enrollment rates increased.



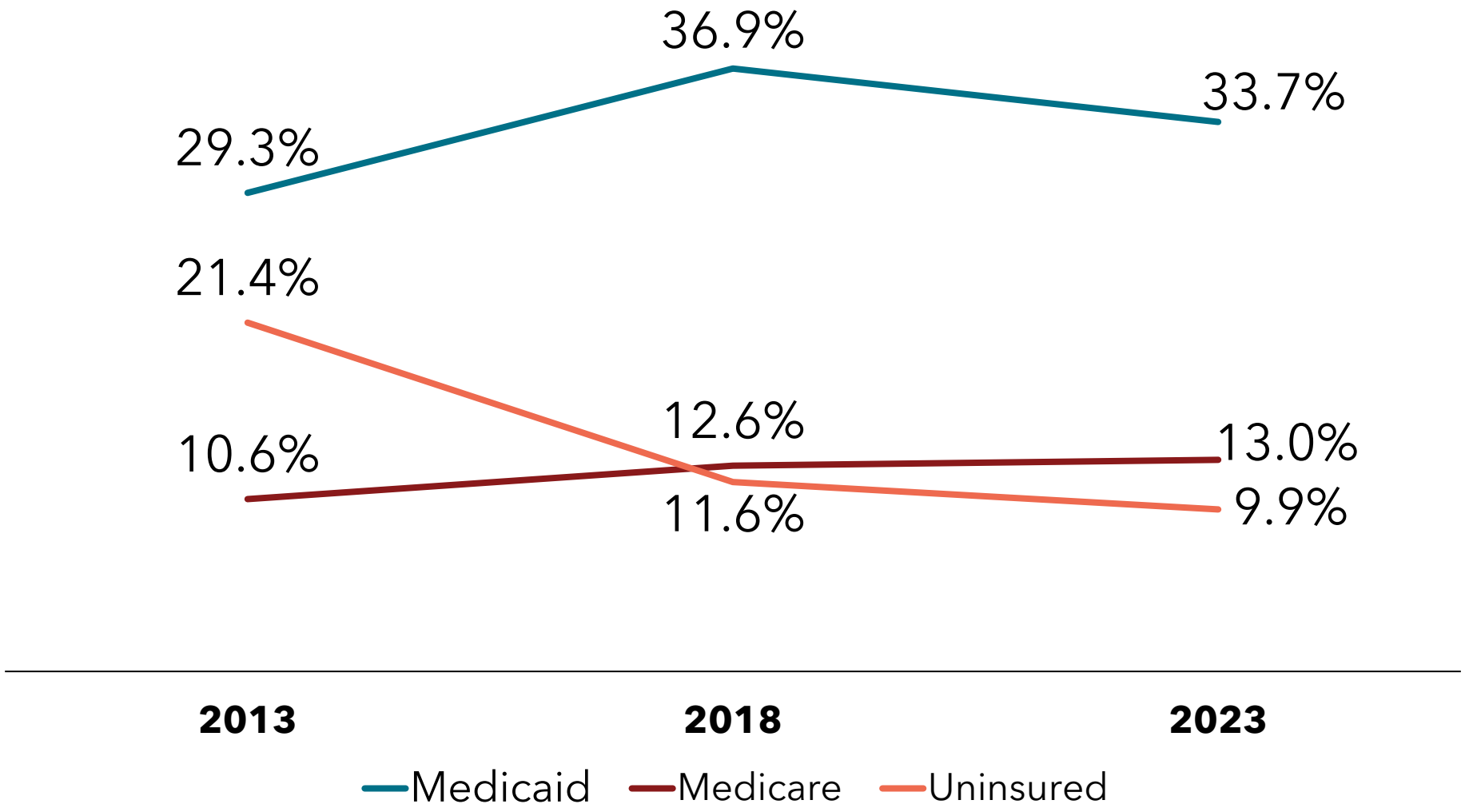
Idaho: From 2013-2023, the AI/AN **Uninsured** rate decreased, and the AI/AN **Medicaid** and **Medicare** enrollment rates increased.



Oregon: From 2013-2023, the AI/AN **Uninsured** rate decreased, and the AI/AN **Medicaid** and **Medicare** enrollment rates increased.



Washington: From 2013-2023, the AI/AN **Uninsured** rate decreased, and the AI/AN **Medicaid** and **Medicare** enrollment rates increased.



NIHB STORY BOARDS

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.*

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

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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 IN 2025: 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

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THANK YOU!

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