The Center for Medicare and Medicaid Services

Tribal Technical Advisory Group

Data Symposium

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Tribal Technical Advisory Group
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
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Data Symposium Agenda

I. Welcome, Opening Prayer, Introductions
II. Opening Remarks
III. Diabetes among American Indian and Alaska Native (AI/AN) peoples and Medicare
IV. Medicaid and the Children's Health Insurance Program
V. Federal and State Marketplace and Qualified Health Plan enrollment
VI. Closing Remarks

CMS
Tribal Technical Advisory Group

CMS established TTAG in 2004 so that Tribes could provide input and advice on CMS programs and policies that influence American Indian and Alaska Native (AI/AN) peoples.

TTAG serves as an CMS advisory committee on important health care matters associated with:

- Medicare,
- Medicaid and Children Health Insurance Programs, and
- The Affordable Care Act.

American Indian and Alaska Native Peoples & the U.S. Federal Trust Responsibility

The United States has a federal trust responsibility to provide health care for AI/ANs due to treaties signed with Tribal nations.

This responsibility has been recognized by Congress in numerous federal statutes:

- Snyder Act, 25 U.S.C. § 13
- Johnson-O'Malley Act, 25 U.S.C. § 452
- Transfer Act, 42 U.S.C. § 2001
- Indian Health Care Improvement Act that was recently amended and permanently reauthorized as part of the Patient Protection and Affordable Care Act, 25 U.S.C. § 1601(1)

American Indian and Alaska Native Peoples & the U.S. Federal Trust Responsibility

The federal government's trust responsibility to AI/ANs is addressed in a number of ways. These include:

Indian Health Service (IHS): Funding for **I**HS hospitals and clinics, **T**ribal hospitals and clinics, and **U**rban health clinics that are known collectively as I/T/Us.

Indian Health Care Improvement Act: In 1976, changes were made to permit I/Ts to bill Medicare and Medicaid for services provided to AI/ANs.

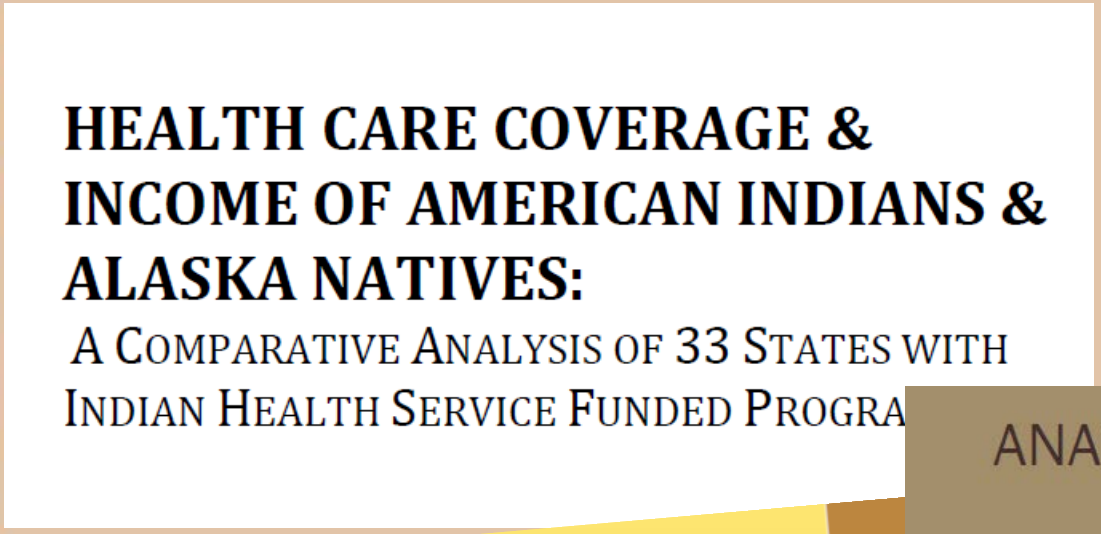
Affordable Care Act (ACA): The ACA includes specific provisions for Tribal members with regard to marketplace enrollment and cost-sharing.

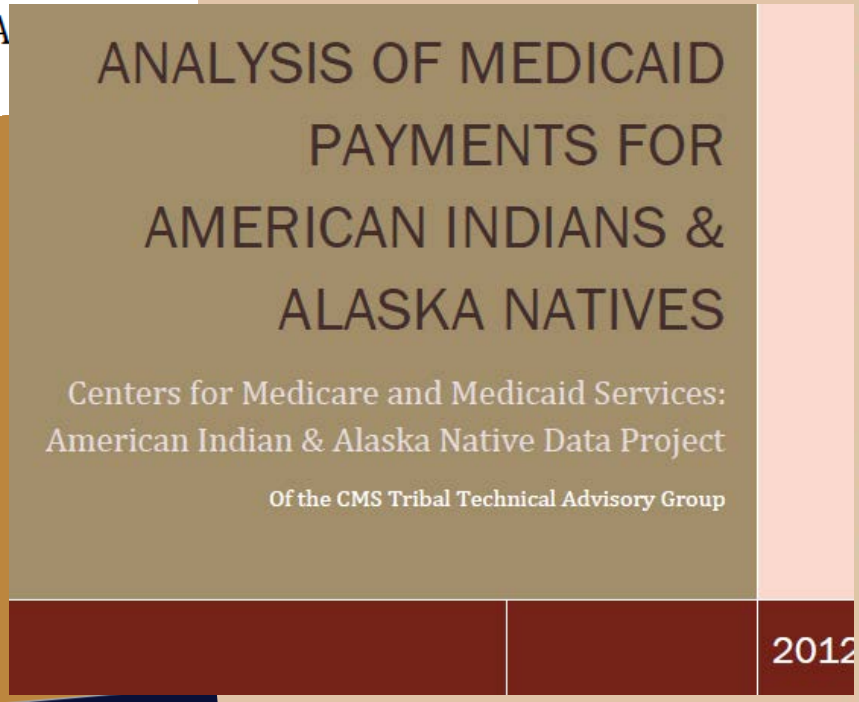
CMS TTAG Data Project Goals

1) Provide information for TTAG, Indian Health Service (IHS), and other AIAN health organizations to inform their efforts to improve the health status of AIANs and the efficient use of resources.
2) Provide information for CMS to facilitate their efforts to better serve AIANs with Medicare and Medicaid coverage.

The TTAG American Indian and Alaska Native Strategic Plan for 2013 to 2018 provides more specific information on TTAG Data Project goals and objectives.

TTAG Data Project Reports





CMS TTAG Goal for Hosting the 2015 Data Symposium

1. Provide updated information on AI/AN with regard to
   - Health status;
   - Medicare, Medicaid, and private coverage enrollment and enrollment in federal and state marketplaces; and
   - Utilization and payments for services.
2. Discuss how this information may be used to inform TTAG, IHS, and other Native organizations in their work. What are the policy issues?
3. What types of analyses should the TTAG Data Project focus on in the future to answer key questions that have not yet been addressed?

Improve Health Status

A number of studies have documented AI/AN health disparities with respect to diabetes, adolescent mental health, accidents, oral health, and other conditions.

Diabetes prevalence 2010-2012 age 20 years and older [1]

AI/AN: 15.9% Non-Hispanic white: 7.6%

Nearly 1/3 of AI/AN adults with diabetes were found to have cardiovascular disease in FY2010.[2] AI/ANs have a high rate of premature mortality due to heart disease. [3]

A 2014 study documented 46% higher mortality among AI/ANs registered to use IHS services than non-Hispanic whites living in the same areas. [4]

[1] CDC, 2014; [2] O'Connell, 2013; [3] Veazie, 2014; [4] Espey, 2014

Increase Available Resources

The Indian Health Service (IHS) serves 2.2 million AI/AN.

IHS budget appropriation: $4.6 billion for FY 2015

IHS third-party collections (e.g., Medicare, Medicaid, private):
$849 million for FY 2014

Personal health care expenditures per capita comparison:

IHS expenditure on user population: $3,099

U.S. population expenditure: $8,097

Source: http://www.ihs.gov/newsroom/factsheets/ihsyear2015profile/

Increase Available Resources

IHS AI/AN adults are more likely to be uninsured.

The percentage of American Indian and Alaska Native (AIAN) adults who have no health coverage [1] by household income. 2009-2011.

Household income level as percent of the federal poverty level (FPL)	**All** AIAN adults aged 19-64 years old	AIAN adults aged 19-64 years old **with access to IHS services**
Under 100% FPL	44%	54%
101% - 138% FPL	46%	58%
139 - 300% FPL	36%	49%
301% - 400% FLP	24%	39%

[1] "No coverage" indicates that the survey respondent did not report employer sponsored or private insurance, or Medicare, Medicaid, Tricare, or Veteran's Administrative health coverage.

Data source: American Community Survey 2009-2011

TTAG Data Project Findings: Fox and Korenbrot, 2013

Use Resources More Wisely

Increasing access to and use of preventive, primary care, and specialty services may reduce preventable utilization of hospital emergency department and inpatient services.

- A recent TTAG Data Project Medicare analysis showed IHS AI/AN had higher use of hospital inpatient services that Non-Hispanic white enrollees.[1]
- A CRIHB study documented that AI/AN have higher rates of avoidable hospitalizations than the non-Indian general population in California.[2]

This is particularly important as AI/AN who use IHS and Tribal services are more likely to have household incomes that are below the federal poverty level and to live in rural areas than Non-Hispanic white persons.

[1] LeBeau and O'Connell, 2014; [2] Korenbrot, 2003

AI/AN Medicare Enrollees and Diabetes

Approximately 95% of AI/AN aged 65 years and older who use IHS and Tribal services are enrolled in Medicare. [1,2]

In 2010, 27% of IHS AI/AN Medicare enrollees were enrolled due to disability. [3]

In 2010, 31% of IHS AI/AN Medicare enrollees are dually enrolled in Medicaid. [3]

A recent TTAG Data Project study found that AI/AN Medicare enrollees have higher mortality and lower expenditures than non-Hispanic white enrollees. [3]

[1] O'Connell, 2014; [2] LeBeau & O'Connell, 2015; [3] LeBeau and O'Connell, 2014

AI/AN Medicare Enrollees and Diabetes

These statistics document the need for increased access to and use of

- Prevention services,
- Primary care services, and
- Specialty services.

Not only among AI/AN Medicare enrollees but among AI/AN of all ages – in order to reduce premature mortality (that is mortality before the age of 65 years) and to improve the health status of AI/AN elders.

AI/ANs and Medicaid and the Children Health Insurance Program

Medicaid and CHIP provide an important source of reimbursement for IHS, Tribal, and urban providers.

Federal government provisions include:

- States received a 100% Federal Medical Assistance Percentage (FMAP) for payments for services provided by I/Ts for AI/AN Medicaid enrollees.
- States may not impose cost-sharing on AI/AN Medicaid enrollees (e.g., Medicaid premiums, cost-sharing for services).
- States must consult with Tribal communities on Medicaid and CHIP policy matters.
- Considerations for specific types of AI/AN resources when assessing income.
- Additional provisions address issues related to managed care enrollment and Medicaid managed care organizations contracting with IHS and Tribal providers.

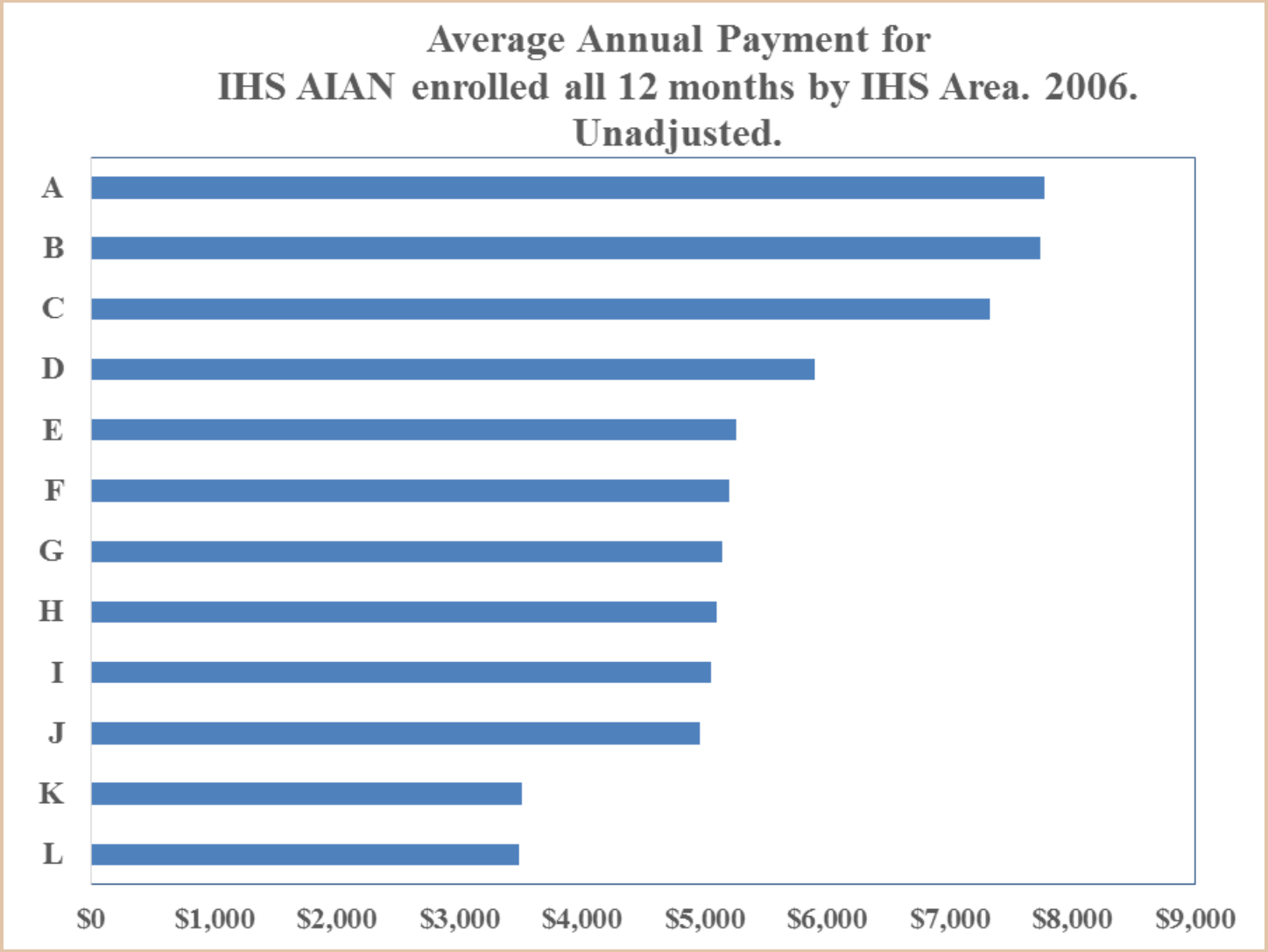
AI/ANs and Medicaid and the Children Health Insurance Program

In 2006, approximately 470,000 AI/AN who were enrolled in Medicaid used IHS and Tribal services.

In 2013 and 2014, TTAG worked with CMS to incorporate changes in the Transformed Medicaid Statistical Information System to better monitor IHS AI/AN eligibility and payments.

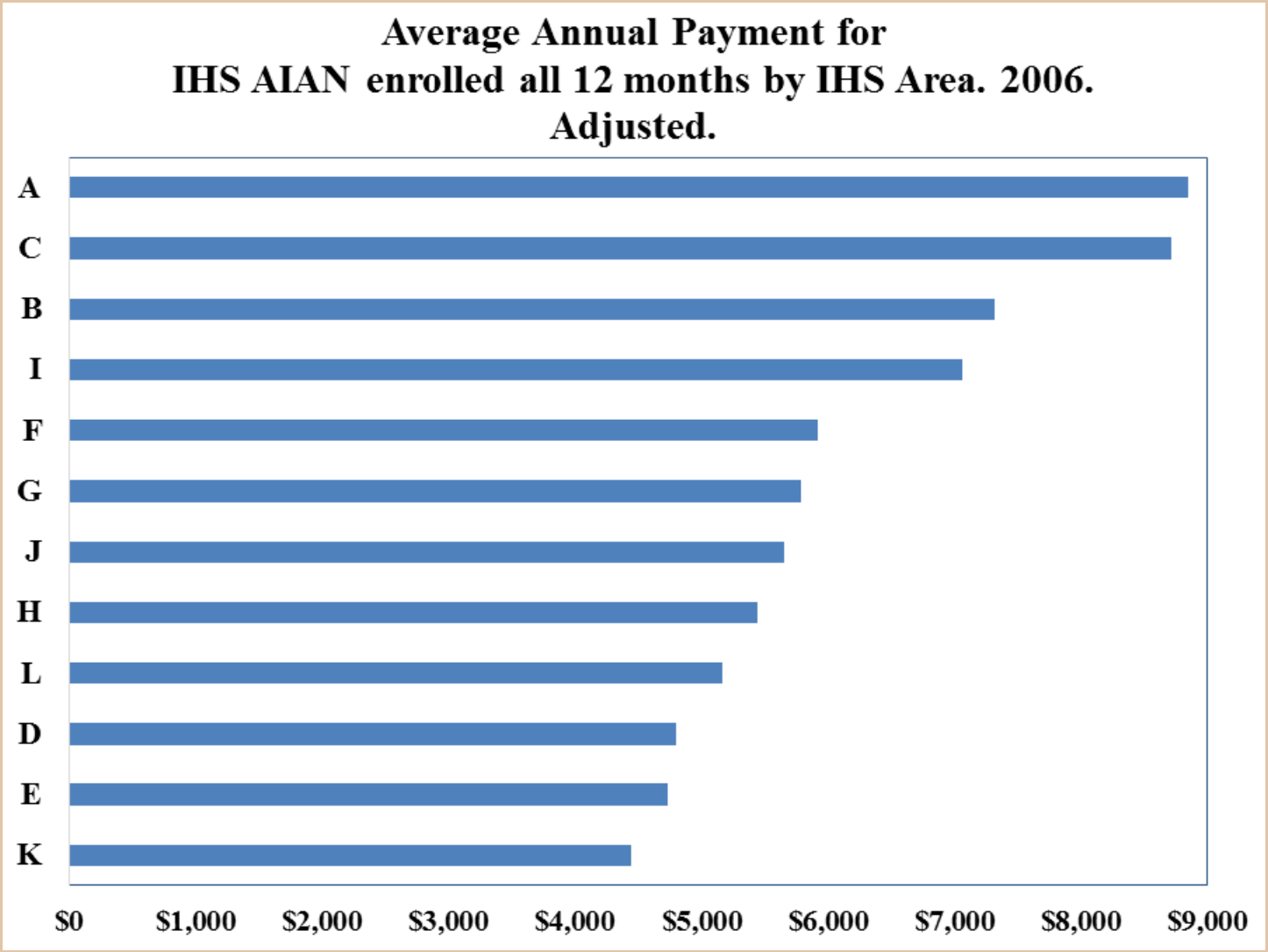
Payment information may be used to assess policies related to coverage and payment. TTAG Data Project 2012 findings documented variation in Medicaid payments across IHS Areas. It is important to understand reasons for such variation, reasons that include state variation in eligibility and benefits, and variation in provider billing.

Medicaid - AI/AN Statistics
Variation in Payment by IHS Area



TTAG Data Project Findings: Crouch and Korenbrot, 2012

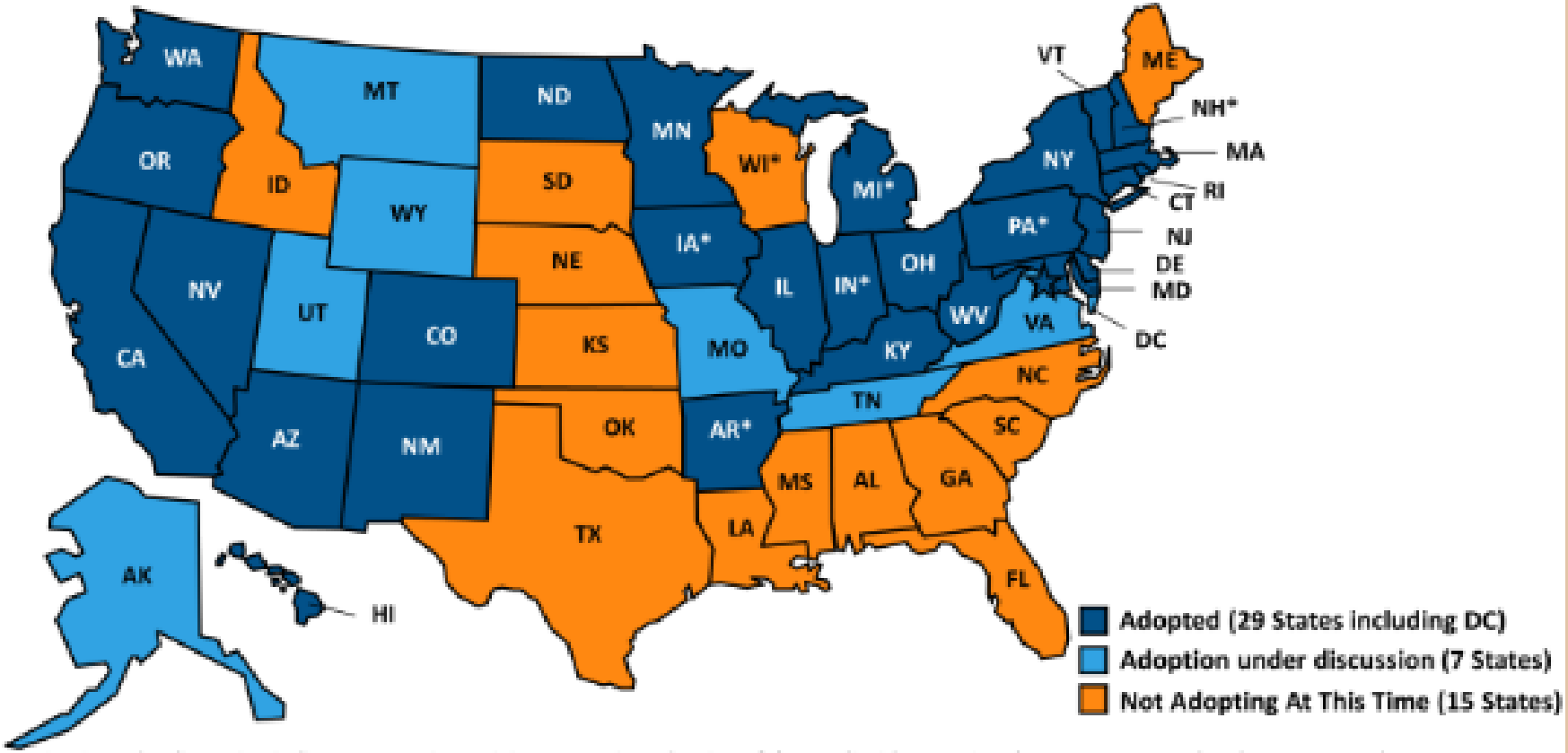
Medicaid - AI/AN Statistics
Variation in *Adjusted* Payment by IHS Area



TTAG Data Project Findings: Crouch and Korenbrot, 2012

Medicaid Expansion States

Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. Coverage under the IN waiver is set to begin February 1, 2015. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 27, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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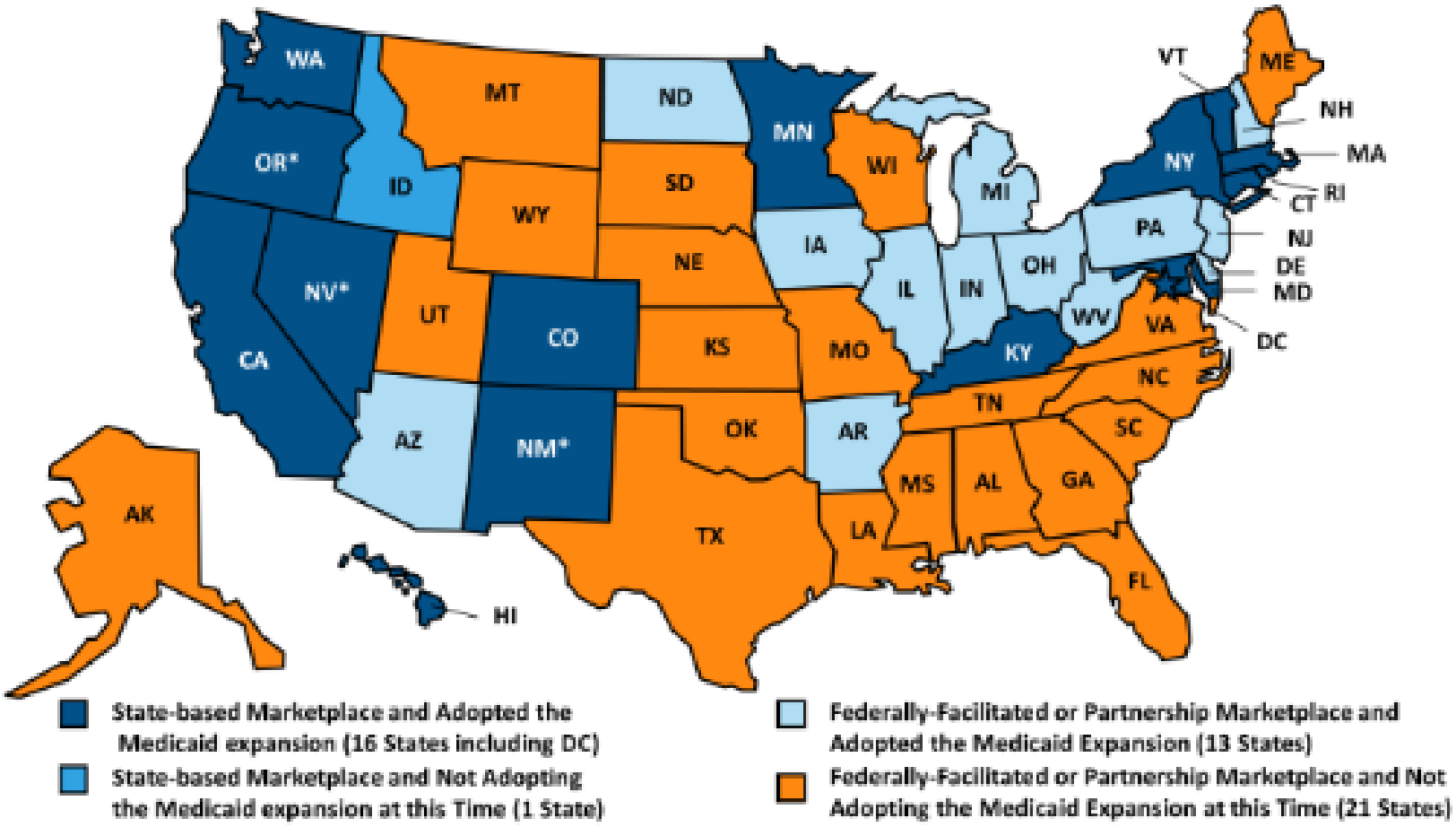
Differences in State Expansion

Current Status of State Individual Marketplace and Medicaid Expansion Decisions



NOTES: *NM, NV, and OR are federally-supported state-based Marketplaces in 2015.
SOURCE: State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, KFF State Health Facts, updated January 27, 2015.
http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/.

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AI/AN and Federal and State Marketplace Provisions and Enrollment

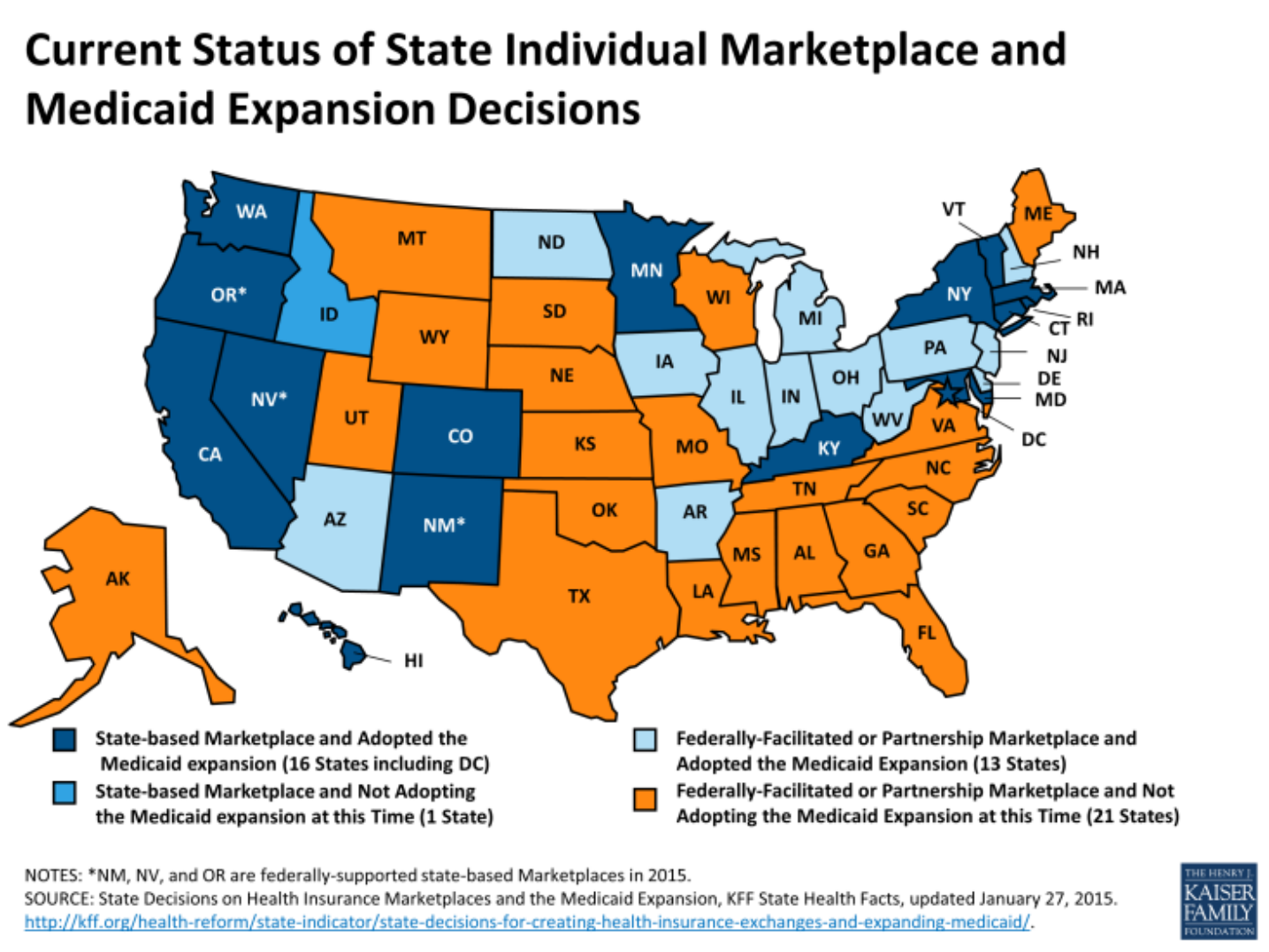
The Affordable Care Act contains special provisions for AI/ANs:

- AI/ANs eligible to use IHS/Tribal services are not required to have coverage.
- Special Enrollment Periods (SEP): AI/ANs can enroll in a Marketplace throughout the year, not just during the yearly Open Enrollment period.
- In Federally-facilitated Marketplace (FFM) states, non-tribal members applying on the same application as a tribal member can take advantage of this SEP. For State-based Marketplace states, it depends on the state.

AI/AN and Federal and State Marketplace Provisions and Enrollment

- **AI/ANs with income <u>at or below 300% of FPL</u>:**
  - Can enroll in a <u>zero cost sharing plan</u> which means no copays, deductibles or coinsurance when receiving care from Indian health care providers or when receiving "Essential Health Benefits" through a QHP.
  - In addition, there is no need for a referral from an Indian health care provider when receiving care through the QHP.
- **AI/ANs with income <u>above 300% FPL</u>:**
  - Can enroll in a <u>limited cost sharing plan</u> which means no copays, deductibles or coinsurance when receiving care from Indian health care providers or when receiving "Essential Health Benefits" through a QHP.
  - Will need a referral from an Indian health care provider to avoid cost sharing when receiving Essential Health Benefits s through a QHP.

Federal and State Marketplaces



http://www.nihb.org/tribalhealthreform/health-insurance-marketp

AI/AN and Federal and State Marketplace Provisions and Enrollment

1) According to a May 2014 Department of Health and Human Services (DHHS) report, approximately 48,000 AI/AN who were Tribal members enrolled in a plan through the Federally- facilitated Marketplace (FFM).
2) AI/AN enrolling in the FFM experienced a number of issues related to:
    1) Eligibility of family members
    2) Verification of Tribal enrollment
3) DHHS reported that enrollment by Tribal members lower than expected.

TTAG Data Project

Potential Future Data Analysis Projects 2015-2017

1) Medicaid and private insurance coverage and enrollment through federal and state marketplaces:
   - American Community Survey data (track changes over time)
   - Requesting access to Marketplace data (recent enrollment data)
2) Medicaid enrollment, utilization, and payments:
   - Dual enrollment in both Medicare and Medicaid
   - Long term care
   - Preventive use of high cost inpatient services and analyses for waivers created to improve services while keeping costs neutral
3) Provide Medicare utilization and payment updates, and examine rates of preventable hospitalizations.