NAVAJO NATION COMMENTS TO NEW MEXICO HUMAN SERVICES DEPARTMENT ON THE CENTENNIAL CARE: ENSURING CARE FOR NEW MEXICANS FOR THE NEXT 100 YEARS AND BEYOND
APRIL 2012

The Navajo Nation opposes mandatory enrollment of Medicaid-eligible American Indian and Alaska Native individuals into the Managed Care Organizations (MCOs) and urges the Human Services Department and the Medical Assistance Division to require the MCOs to contract with the Indian Health Service, Tribal and 638 Tribal Organization facilities as a provider network to reimburse them at the Medicaid All Inclusive Rate, and to contract directly with the Navajo Nation for a Health Home pilot project.

I. Overview of the Navajo Nation

The Navajo Nation is the largest federally-recognized tribe in the United States, with the largest land base, Diné Bikéyah or Navajoland, that encompasses nearly 27,000 square miles of considerable rural and geographically remote frontier area—larger than 10 of the 50 states in the United States—extending into all or parts of 13 counties in portions of Arizona, New Mexico and Utah. In addition, the Navajo Nation extends into three regions of the U.S. Department of Health and Human Services, including Region VI, Region VIII and Region IX.

In 2010, an estimated 332,129 individuals reported being Navajo; of which 169,321 and about 4,346 non-American Indian and Alaska Native (AI/AN) live on the Navajo Nation.[1] The remaining Navajos reside in nearby border towns or major metropolitan areas across the United States. Furthermore, an estimated 2,009,671 people live in New Mexico; of whom an estimated 219,512 reported being AI/AN reside in New Mexico.[2] New Mexico is diverse in population with 45.6% Hispanic, 40.0% White and 9.7% AI/AN.[3] Though Navajo people reside in the counties of Bernalillo, Cibola, McKinley, San Juan, Sandoval and Socorro, a majority of that population live in the McKinley County (71.2%) and San Juan County (36.6%) of their respective county population.[4]

As of February 2012, the New Mexico Salud reported serving 1,497 or 13.96% (McKinley County) and 2,525 or 23.55% (San Juan County) Native Americans; OptumHealth reported serving 4,031 or 22.78% (McKinley County) and about 4,294 or 24.26% (San Juan County) Native Americans; Coordination of Long Term Services (CoLTS) reported serving 2,534 or 36.37% (McKinley) and 1,766 or 25.34% Native Americans; and 2,736 Native Americans are enrolled in the State Coverage Insurance. A large portion of the Native American population, including enrolled Navajo members, will be impacted by any changes to Medicaid and Insurance programs.

[1] The U.S. Census Bureau; The American Indian and Alaska Native Population: 2010.
[2] Ibid.
[3] Ibid.
[4] http://www.city-data.com/county/McKinley_County-nm.html; http://www.city-data.com/county/San_Juan_County-nm.html

The chart below shows the total enrollment of AI/AN in the seven Medicaid plans for the counties of McKinley and San Juan. For most of the programs, the percentage of program operating in each county is above 20%, as highlighted in yellow. The reported statistics does not differentiate Navajos from the general Native American population.

Program	McKinley		San Juan	
	# of Enrolled Native Americans	% of Enrolled Native Americans	# of Enrolled Native Americans	% of Enrolled Native Americans
1) OptumHealth	4031	22.78%	2494	24.26%
2) CoLTS (AmeriGroup)	1366	53.91%	898	50.85%
3) CoLTS (Evercare)	1168	46.09%	868	49.15%
4) SALUD (BCBSNM)	220	14.70%	398	15.76%
5) SALUD (Lovelace)	351	23.45%	674	26.69%
6) SALUD (Molina)	157	10.49%	189	7.49%
7) SALUD (Presbyterian)	769	51.37%	1264	50.06%

Chart produced by: **Kraynal Alfred, M.P.P.**
Note: The stats in this chart reflect the current number of enrolled Native Americans. Dual enrollment in Medicare and Medicaid is possible, which is not indicated in the report. The supplied data does not differentiate Navajos from the general Native American population.
Data Source: Datawarehout Tables – Captbase and captline queries
Accessed: March 12, 2012; emailed by Roselyn Begay on March 8, 2012

Over the years, the unemployment rate on the Navajo Nation has expanded from 27.9% in 1990 to 42.16% in 2001 and to 50.52% in 2007. More specifically, the unemployment rate on the Navajo Nation was more than 10 times higher than in New Mexico.[6] In 2007, 36.76% of Navajo individuals were living below poverty level as compared to New Mexico at 18.13%, thus qualifying Navajo individuals for Medicaid programs. Living in poverty leads to chronic anxiety, strain and frustration. It contributes to depression, lack of self-esteem and apathy—all of which are significant causal factors in child abuse and neglect and chronic health problems.

The Navajo Nation has always been greatly concerned with the quality of health care delivered to the Navajo people. Providing education about health care services and patients' rights is critical because 82% of Navajo population speaks the Navajo language in their homes[7]; which suggests that language may be attributable to the difficulty in accessing healthcare services and benefits, as people whose primary language is not English may have difficulty reading directions, completing necessary paperwork and navigating the complex health care system.

II. Overview of the Navajo Health Care System

The Indian Health Service (IHS) provides health care services directly through its facilities and indirectly through contract health services delivered by a non-IHS facility or provider through contracts with the IHS. Five federal service units and five tribal organizations provide health care on the Navajo Nation. Three of the six hospitals are

[6] 2009-2010 Comprehensive Economic Development Strategy; The Navajo Nation; Prepared by Division of Economic Development.
[7] U.S. Census of 2000.

located in New Mexico and range in size from 32 beds in Crownpoint, NM to 99 beds at the Gallup Indian Medical Center in Gallup, NM.[8] Of the twelve IHS Areas, the Navajo Area represents the largest direct care program provided by IHS. In Fiscal Year 2010, the Navajo Area's user population was 246,000 or 18% of the entire IHS user population with a total of 16,000 hospital admissions and 1.2 million ambulatory care visits.[9] Additionally, the Navajo Divisions of Health and Public Safety provides a variety of health-related services in the areas of aging, controlled substance abuse, nutrition, community health, public health nursing, emergency medical services and public health emergency response.

The IHS spends $1,600 per person per year for health services in its hospitals and health clinics which is about 50% below per person per expenditure by public and private health insurance plans.[10] The Navajo Area IHS receives Federal funding that only meet about 55% of the health care needs for the patient population it serves and provides health care services at $1,187 per person. It should be noted that the amount of per capita spending on health care varies among IHS Areas. Health centers operate full-time clinics some of which provide emergency services. Some smaller communities have health stations that only operate on a part-time basis.

III. Health Disparities

It is widely publicized that AI/AN suffer the most grievous health disparities nationwide. The U.S. Commission on Civil Rights reported in 2003 that *"the federal government's rate of spending on health care for Native Americans is 50% less than for prisoners".* Federal funding for Indian health care has been inadequate and has not kept pace with the rising costs of health care, such as increased costs of prescription drugs, specialty care, competitive salaries to attract health professionals, and health information technology.

The Navajo population experiences significant burdens related to disease; life expectancy for the Navajo people is 72.3 years which is lower than the average U.S. life expectancy of 76.5 years. The mortality rate is 31% higher than the U.S. rate. The leading cause of death among the Navajo population is attributed to unintentional injuries followed by heart disease. The Navajo people are at an especially high risk for behavioral health problems, including alcohol/substance abuse, accidents, suicide and homicide. According to IHS, alcohol-related illness and death among the AI/AN population was 5.6 times higher than the U.S. population. Moreover, obesity and diabetes have become major health threats to the Navajo people. The figure below depicts the impact of these disparities on the local Navajo Nation health care system.[11]

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[8] http://www.ihs.gov.

[9] Navajo Area IHS User Population By Service Unit; Fiscal Year 2006-2010.

[10] IHS, *FY 2000 Budget Request, Justification of Estimate,* p. 30.

[11] Navajo Area Indian Health Service. September 25, 2003.

Unfavorable compared to the U.S. population:	Navajo Area Rate (95% Navajos)	U.S. Rate
All Deaths	628.9	479.1
Diabetes Deaths	35.9	13.5
Cervical Cancer Deaths	4.6	2.5
Alcohol Related Deaths	49.8	6.3
Suicide Deaths	16.8	10.6
Homicide Deaths	19.7	8.0
Tuberculosis Deaths	2.4	0.3
Pneumonia/Influenza Deaths	30.8	12.9
Births	21.7%	14.5%
Teen Births (13-19 yrs)	16.9%	12.7%
Prenatal Care in First Trimester	56.4%	82.5%
Infant Deaths (under 1 yr. of age)	8.2	7.2
Post neonatal Deaths (28-360 days)	4.4	2.5

Navajo culture and traditional healing system, including healing ceremonies, are greatly utilized in maintaining the people's health and wellbeing. The healing ceremonies are conducted to correct infringements or causes of diseases and their complications. The traditional practitioners, through their prayers, chants and dance bring about harmony, healing and wellness to patients, their families and communities.

Physicians should be familiar with cultural appropriate practices. For patients who only speak and understand the Navajo language, a physician who makes a referral to an off reservation health facility should remember to advise the family to travel with the patient and to act as a translator. Often times, families express concern that they were "sent without proper preparation". Here are some examples of what families are most concerned about: where the facility is located, what should they expect; where the expenses come from to allow them to lodge and eat; who will pay for the referral of the patient; can they have a medicine person go to that facility to provide traditional healing service for the patient; and, finally, how will aftercare services be paid and provided for the patient. Hence, traditional healing system must always be part of the overall approach toward addressing illnesses.

IV. Navajo Nation Comments and Recommendations

In preparation for changes to the New Mexico Medicaid program, the stakeholders of the Navajo Nation health care system developed comments and recommendations on March 13, 2012 for submission to the to the Human Services Department (HSD) and the Medical Assistance Division.

First and foremost, in reforming the New Mexico Medicaid programs and services, the Navajo Nation respectfully requests the Human Services Department and the Medical Assistance Division to do no harm to the most vulnerable eligible population—AI/AN Medicaid beneficiaries. The Indian health system includes the IHS, Tribes and tribal organizations, and urban Indian organizations (I/T/U) which is severely under-funded and profoundly relies on third party revenues from Medicare, Medicaid, Children Health Insurance Program and private insurance to support the delivery of quality health care.

Additionally, the Indian health system is experiencing a shortage of professional health care providers and any reduction in Medicaid revenues will only worsen the situation and widen the health disparities among the AI/AN. Therefore, the state must work with the New Mexico 22 Pueblos, Nations and Tribes. Recently, Arizona Governor Janice Brewer and AHCCCS Director Thomas Betlach have diligently worked with the Arizona Tribes, including the Navajo Nation, to exempt IHS and 638 facilities from Medicaid cuts and reductions for services rendered in their facilities for individuals with income up to 100% Federal Poverty Level. On April 6, 2012, the Centers for Medicare and Medicaid Services (CMS) approved Arizona's Section 1115 Research and Demonstration Waiver proposal through September 30, 2016. Similarly, the Navajo Nation respectfully requests the state to consider exempting the IHS and 638 facilities from any negative program cuts caused by the Centennial Care by including a provision to protect the federal pass through funding in the state's proposed application for a consolidated CMS Research and Demonstration Waiver.

The following issues are highlighted concerns formulated by Navajo Nation health care providers:

A. Overarching Issue One:

The Centennial Care Concept Paper lacks a clear explanation about the financial structure. Several key concerns are listed below:

1. How will Medicaid changes impact the health delivery system (e.g. administrative procedures and medical services) provided by health care facilities operating on the Navajo Nation?
2. What kind of health care system will benefit the Navajo people?
3. How will IHS and 638 facilities contract with the Managed Care Organizations (MCOs)?
4. If the MCOs adopt an auto-enrollment policy, how can the MCOs ensure that eligible Navajo patients are not assigned to providers located half a state away?

B. Overarching Issue Two:

The Centennial Care proposes to enroll Medicaid-eligible AI/AN population in Managed Care.

Background:

On March 10, 1997, the Navajo Nation Council approved Tribal Resolution No. CMA-20-97 opposing the New Mexico Medicaid Managed Care initiative entitled "Salud" which promoted "opt in" of Medicaid Managed Care. The Navajo Nation objected to auto enrollment of Medicaid-eligible Navajo individuals into the New Mexico Salud program because the MCOs assigned many Navajo Medicaid beneficiaries living in Northern New Mexico to facilities located in the southern portion of New Mexico. As a result, a significant number of Navajo Medicaid beneficiaries were auto enrolled by MCOs but continued to seek health care services through the IHS facilities for which the facility was not reimbursed and thus loss substantial third party revenues.

The Resolution outlines significant concerns that apply to concepts described in the proposed Centennial Care plan.

Subsequently, on October 1, 1999, then New Mexico Governor Gary E. Johnson issued a letter informing Navajo Nation President Kelsey A. Begaye of a policy change in which he stated,

> *"Despite my earlier concerns over the opt-in option, I have come to believe that your sovereign status is determinative in this regard and that what amounts to promises made on behalf of this Administration in the past must be kept. Therefore, after extensive study of the issue, together with your input, I have come to the conclusion that Native Americans should be able to opt in to Salud rather than having to opt out of the program."*

A copy of Governor Johnson's letter is hereto attached.

The Navajo Nation Council has not repealed Resolution No. CMA-20-97 that opposed the auto enrollment of Medicaid-eligible Navajo individuals into the Salud program and therefore it remains in effect. Relevant concerns expressed in the resolution should be addressed.

Recommendations:

If the HSD adopts auto-enrollment of Medicaid-eligible AI/AN population in Managed Care despite of the Navajo Nation's long standing position, the Navajo Nation urges the HSD and Medicaid Assistance Division to require the MCOs to contract with IHS and 638 facilities as part of their provider network and require the MCOs to reimburse the IHS and 638 facilities at the Medicaid All Inclusive Rate due to the 100% pass through for which the State does not contribute any State general fund money. This requirement will assure AI/AN access to and quality health care, and protect the Indian health system from adverse financial impact.

C. Overarching Issue 3:

Since the Centennial Care Concept Paper has been completed, there is limited opportunity for additional input into the development of the concept by the New Mexico 22 Pueblos, Nations and Tribes, including the Navajo Nation. Even though a section on Native Americans is provided, it is concerning that the integration of the Indian health care system is not more fully explained. Into the future, the Navajo Nation requests to be included during the development of policies, procedures and strategies.

Background:

New Mexico HSD acknowledges and officially interacts with the New Mexico's 21 Pueblos, Nations and Tribes on a government-to-government relationship. The Centennial Care Concept Paper identified four priorities by which to modernize the

state's Medicaid program. This section provides recommendations and concerns for each priority.

Overall Recommendation:

The Navajo Nation strongly recommends that the HSD provide adequate and appropriate Tribal Consultation regarding development of the Request for Proposal (RFP) guidelines and requirements for which respondents will comply with and recommends that a Tribal representative serve on the RFP Finalization Team and Proposal Review Team as a voting member. This will provide another opportunity for Tribes to provide substantial input in development of the requirements that will benefit and protect the Medicaid-eligible AI/AN population and the Indian health system.

Additionally, the Navajo Nation recommends establishment of a system of care that supports self-determination and culturally relevant holistic self-care, and an advisory panel to facilitate culturally-appropriate long term care for chronic conditions both holistic western best practice and Native Traditional/Faith-Based Pastoral interventions/healing/treatments.

Although the completed concept paper envisions a new service delivery system to provide the right care, the right time at the right place, it does not include "cultural adaptations" to western best practices or evidenced based practices. With a comprehensive service delivery system that is cost-effective focusing on quality and promoting integrated care, it is an injustice and dis-service to provide services that are not culturally appropriate. Cultural adaptations to western best practices or evidenced based practices refers to program modifications that are culturally sensitive and tailored to a cultural group's traditional worldviews. Dimensions of cultural adaptations include cognitive information processing characteristics, affective-motivational characteristics, and environmental characteristics. Effective cultural adaptations include move from surface to deep structure, understand cultural nuances, and require cultural competence.

Priority One: A Comprehensive Service Delivery System

Managed Care Organization

- Focus on health literacy with and for recipients
- Comprehensive care coordination process
- Include behavioral health to maximize integration of care
- Protect behavioral health funding in the system
- Maximize technology for rural and frontier regions
- Better use of school health clinics

Recommendation 1:

The Navajo Nation believes it can be a key partner, as a contractor, to provide the health literacy by replicating the Community Health Representative (CHR) program

because the standards of practice the CHR provides has increased to encompass a wide range of activities, including health education, medical surveillance, environmental health services, case management and coordination, basic routine and emergency medical care, and transport or delivery of patients and medical supplies. This will help address the non-clinical barriers to health with the lowest cost possible workforce. The barriers include medication and follow-up on non-compliance, lack of behavioral change in addressing harmful habits such as a sedentary lifestyle, substance abuse, poor diet and lack of sleep.

Recommendation 2:
The Navajo Nation urges the HSD to not repeat the manner in which the CoLTS program was implemented and administered. The existing three MCOs contracting with the CoLTS program require outrageous justifications for care provided. Those MCOs do not reimburse the IHS and other Native American providers in a timely manner and fail to coordinate care—they do not provide adequate follow-up and do not provide continuum of care for its members.

Recommendation 3:
The Navajo Nation recommends the state to require the MCOs to provide comprehensive behavioral health services that meet the provisions of the Indian Health Care Improvement Act and the Tribal Law and Order Act. The comprehensive services must include all controlled substances and mental health disorders prevention and treatment, and ensure these services are delivered in a manner consistent with Native traditional health care practices, including traditional healing, spiritual values and culturally-appropriate care. Additionally, the Navajo Nation recommends the state to consider a program called Health Psychology which is utilized by the University of Colorado.

Behavioral healthcare is a core component of essential services to persons seeking primary healthcare. Ensuring access to preventive, ongoing, and appropriate behavioral health services is a primary responsibility and mission of general healthcare providers.

Furthermore, it is not uncommon for Medicaid eligible AI/AN individuals to cross state borders to receive care from IHS providers in other states or refer patients who require specialty care to out-of-state such as residential programs, specifically Youth Residential Treatment Centers. The Navajo Regional Behavioral Health Center (NRBHC)—a healing center located in Shiprock, NM—provides quality, holistic, behavioral health services in a residential setting. NRBHC is a CODI-SAMHSA model project of National Significance to be the first of its kind in Indian Country as a Co-Occurring Healing Center/Campus to improve services for individuals with co-occurring issues by offering an array of holistic culturally responsive western and spiritual (Traditional Healing and Faith-Based Pastoral) interventions/healing/treatment program. This facility and their Medicaid eligible

patients who are New Mexico residents should be able to enroll in the Medicaid program.

Priority Two: Personal Responsibility

Engage recipients in their personal health decisions.

- Reward recipients for engaging in healthy behaviors
  - Gift card for recipients who engage in quantifiable healthy behavior (e.g. well child visits);
  - Gift card for recipients with chronic illnesses who follow a specific plan of care; and
  - Debit card that earns points for additional healthy behaviors.
- Targeted cost sharing strategies
  - $3.00 co-pay for any legend/brand drug dispensed when there is a generic drug available – exception of psychotropic drugs; and
  - Sliding scale co-payment on recipients with incomes above 100% of the Federal Poverty Level who use emergency room for non-emergency care.

Recommendation:

The Navajo Nation requests the state fulfills its promise to not impose co-payment for services provided in IHS and 638 facilities consistent with provisions of the Affordable Care Act.

Priority Three: Payment Reform

Rewarding plans and providers who practice cost-effective medicine targeted at outcomes rather than process

- Use pilot project approach to produce the desired result
  - Pediatric asthma
  - Readmissions to hospitals within 30 days of discharge
- Peer-to-Peer Physician effectiveness reporting

Recommendations:

The Navajo Nation requests the state to reward providers offering "cultural adaptation" of Western evidenced based practices or best practices as specified above, and recommends the MCOs to extend clinical hours to evening and weekends for individuals who are unable to seek health care services between 8am and 5pm.

The Navajo Nation is concerned about individuals with chronic illness who reside in geographic rural and remote area who may require readmission for the same diagnosis within 30 days of discharge, or a patient who may seek service from a different provider for the same diagnosis within 30 days. The Nation is concerned about the MCOs denying payment for these events which could result in the demand on the limited Contract Health Service program funding.

Additionally, the Navajo Nation is interested to participate in a pilot project as a Health Home for adult diabetes in which it would manage and coordinate an array of services with the IHS utilizing a bundled rate. The Navajo Nation respectfully requests to contract directly with the state for this pilot project on a State-Tribal government-to-government relationship through a Memorandum of Agreement or an Intergovernmental Agreement.

Priority Four: Administrative Simplification

- Combine all Medicaid waivers (except for the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver.
- Reduce the number of managed care plans from seven to a more manageable number
  - Reduce costs; and
  - Focus on managing and monitoring our private contractors.

Recommendation:

The Navajo Nation urges New Mexico officials to fully integrate administrative procedures with the IHS and 638 administrative procedures, with special attention placed on billing, claims and payments, and systems integration training be provided to increase efficiency and effectiveness.

Native American Participation

Improve Health Outcomes and Promote Economic Opportunities for Native American Communities

- Native Americans will fully participate in the Managed Care service delivery structure
- Encourage and promote greater involvement by and with the Native American community
  - Health plans will contract with the Tribes for on-reservation case management and transportation services, where such services are available and offered by the Tribes;
  - Encourage and incentivize Tribes to develop care coordination teams and health homes that meet state requirements to provide integrated care for their members with chronic medical/behavioral health conditions; and
  - Explore the concept of "mini block grants" to Tribes who are willing to provide an array of services to their members for a set amount of money.

Recommendations:

Historically, the MCOs did not understand the Indian health system. Therefore, the MCOs may cover certain geographical areas within the state, and allow the IHS and 638 facilities to continue providing the services it provides.

Additionally, for many years the Navajo Nation has been advocating for a Tri-State Medicaid Agency designation by CMS due to its location covering three states and

three federal regions which requires Navajo individuals eligible for Medicaid program to comply with varying eligibility requirements and covered benefits. Fortunately, the permanent reauthorization of the Indian Health Care Improvement Act of 2010 included a provision for a Navajo Nation Medicaid Feasibility Study. While the study has yet to be funded and implemented, the Navajo Nation requests the state to consider the Nation as a pilot project or "mini block grant" to serve as a home health through which it would demonstrate providing an array of culturally appropriate health care services, including but not limited to: comprehensive case management, transportation services, care coordination, health promotion and disease prevention activities, comprehensive transitional care from inpatient to other settings including appropriate and adequate follow up, individual and family support, referral to community and social support services, and implement the use of reliable health information technology to link services as feasible and appropriate.

Implementation of the Affordable Care Act

The Affordable Care Act will create a "Newly eligible" population that consists of individuals who are below the age of 64 with incomes up to 133% of the FPL,. The "Newly eligible" population will become eligible to receive health care services through Medicaid

- The benefit package can be less comprehensive than the current Medicaid benefit
  - Enroll Federal health care expansion population into Medicaid; and
  - Offer the federally required benchmark benefit package for the expansion population.

Recommendation:

The Navajo Nation is concerned about the benefit coverage for newly eligible individuals may be inadequate, especially since some benefits covered under traditional Medicaid may not be covered under the new Medicaid category. These individuals will receive "benchmark" or "benchmark-equivalent" coverage consistent with the requirements of section 1937 of the Social Security Act. The Navajo Nation recommends the state to select the national Federal Employees Health Benefits Program plan option as its federally required benchmark benefit package.