Pueblo of Jemez
State of New Mexico Centennial Care
Position Statement
May 2012

The Pueblo of Jemez opposes the NM Medicaid modernization plans as detailed in the *Centennial Care* concept paper, issued February 21, 2012.

The Centennial Care concept paper is presented under the guise of "ensuring care of New Mexicans for the next 100 years", but its resultant product is to reduce costs by limiting medical services and care coordination to all New Mexicans. Specific to Native Americans, those same limitations are imposed, along with a direct threat by the state to tribal sovereignty and authority. This assessment is based on the following:

A. The Centennial Care Plan Poses a direct threat to Tribal Sovereignty and Authority

P.L. 93-638 law authorizes tribal nations to contract their shares of health care funds that would have been spent by the IHS on their individual tribal membership. This law authorizes individual tribal nations to then determine and design the best health care system for that tribal population. Most tribes use a series of surveys, health data and expenditure analysis, prevalence data and a number of other health measures to determine the shape and scope of their tribal health system, for which the tribe then conducts financial planning. A part of that financial planning includes 3rd party revenue collection, inclusive of Medicaid reimbursements.

NM HSD's Centennial Care concept paper poses a direct threat to the intent of PL 93-638 and tribal sovereignty in the following ways:

1. State-Tribal Government to Government Relationship

- The state of New Mexico has failed to have NM tribes at the table when discussing the options to improve Medicaid services and find ways to cut costs. The "consultation meetings" held with the tribes were listening sessions as the NM Medicaid had finalized its plan at the time of consultation. Further, many comments and/or objections to the "Centennial Care Plan" have been undocumented in the submitted application.

- It stands to reason that if the state of New Mexico believed it had conducted meaningful consultation with tribes, documented evidence, including the positive and negative responses from tribal leaders, would have been submitted along with the NM Medicaid application. This would have provided CMS with a clear picture of the challenges to the proposed system and the efforts to directly engage tribes.

- The absence of the documented responses from tribal leaders to the state compels CMS to hear the objections from the tribes directly and to consider the submitted application in light of tribal comments. Meaningful tribal consultation begins early and continues throughout the process –

before anything is finalized. Simply conducting "Outreach" to Native American communities does not satisfy consultation.

- The state has put all its efforts into tailoring a Medicaid Modernization Program that benefits for-profit organizations and ignores both federal (IHS) and tribal governments' crucial roles in the healthcare delivery system in NM.

- In fact, NM Medicaid did not request any health information from tribes, though the Centennial Care plan indicates that the changes to the system are based solely on the poor health outcomes of the current Medicaid system. Most tribes use a series of surveys, health data and expenditure analysis, prevalence data and a number of other health measures to determine the shape and scope of their tribal health system. This is another example of how New Mexico failed to include tribal officials in formulating policies affecting their communities.

- NM Medicaid has placed the burden on the Managed Care Organizations (MCOs) to establish business relationships with the tribes of New Mexico to implement its Medicaid Modernization (Centennial Care) plan. This runs contrary to the government to government requirement.

- NM Medicaid describes a fully MCO-run Medicaid system for New Mexico.. Although there is a recommendation in the Native Americans section that the MCOs selected by the state be required *"to contract with the IHS and or 638 clinics as part of their network..." (27),* there is no indication as to the timeframe or the scope of that relationship. Thus, there is no confidence that I/T/Us will be immediately and successfully integrated as part of the health care of our Medicaid eligible tribal members. Moreover, this relationship with MCOs does not meet the state's requirement to engage in a government to government relationship with the tribes.

2. Federal Authorities

- The Centennial Care paper describes the NM Medicaid intent to eliminate the "opt-out" provision for I/T/Us, similar to what has occurred with other MCOs in New Mexico (i.e. CoLTS). Under this scenario, I/T/Us cannot determine care coordination on behalf of the patient, but must submit to MCO directed care – contrary to the intent of the Indian Self-Determination Act.

- In 2000, the Indian Health Care Improvement Act was amended to include Public Law 106–417, also called the "Alaska Native and American Indian Direct Reimbursement Act of 2000." This act allows for **direct billing** of Medicare, Medicaid, and other third party payers, and for expansion of such eligibility to tribes and tribal organizations.

- The Affordable Care Act (ACA) of 2010 contained the reauthorization of the Indian Health Care Improvement Act (IHCIA), not only confirming, but also expanding tribal authority to plan and design tribal health care systems and direct bill CMS for reimbursement. The provisions in IHCIA give tribes the authority to provide services not otherwise offered in the past, such as long term care, hospice, assisted living, home and community-based services for disabled and elderly persons, etc.

B. The Centennial Care Plan limits access to Health Care for Native Americans

The Centennial Care paper indicates that when a Medicaid eligible individual applies for Medicaid, he/she must select a health plan (MCO). This means that the individual automatically goes into the MCO "system" because fee-for-service, an option **personally selected by 85% of the Native American Medicaid population**, will no longer exist. Navigating through these MCOs that are largely located in urban areas will frustrate and confound many patients. The danger is that patients will give up entirely on applying for or renewing Medicaid benefits, thus eliminating their entitled medical financial assistance and the revenues I/T/Us have come to depend on in maintaining or improving health care services. Based on the description, it is a very real concern that I/T/Us could find themselves without an ability to collect from any source for services rendered at tribal health clinics for Medicaid eligible patients. This appears to be one way to reduce eligibility without violating federal mandates.

- The state has not considered the potential of the tribes, instead of MCOs, to provide these services in their communities for Native Americans and non-Native Americans.

- Currently, the number of Native Americans on Medicaid fee-for-service plans is 85%. This speaks volumes about the personal choice of the individual Native American consumer because of the **unavailability** of managed care organizations in rural areas.

- MCOs will add more burdensome layers (stratify) to our Medicaid eligible population and attempt to coordinate care through the MCOs designated system. Following the state's plan, our patients, prior to any effective I/T/U contracts being in place with MCOs, will be taken out of the I/T/U system, and their Medicaid benefits placed in for-profit systems. This would eliminate their entitled medical financial assistance and the revenues I/T/Us have come to depend on in maintaining or improving health care services.

- The state believes that the requirement for MCOs to contract with Indian Health Service, tribes and urban organizations (I/T/Us) is a sound alternative or reasonable trade-off for eliminating the opt-out provision/benefit. On the contrary, this has always been a requirement of the MCOs and not always a successful reality in years past.

- The NM Medicaid also wants to end the practice of paying three months of past medical bills for new Medicaid recipients, even though they were eligible for Medicaid at the time of service. This would certainly place an undue financial burden on I/T/U's using Contract Health Services Program funds. Already I/T/Us struggle with limited funding and the high demand for contract health services (CHS). Eliminating the three month retro-active coverage will have a *significant* financial impact on I/T/Us and further limit their ability to pay for services beyond the primary care setting.

- This proposed plan could leave the I/T/Us with not only a loss of potential new revenues, but also an actual reduction in revenues from prior levels (where claims had previously been paid by Medicaid).

- The Pueblo of Jemez uses Medicaid and other third party resources to supplement the cost of care for our patients through our tribally designed health system. An interruption or reduction in the flow of third party revenue would negatively impact I/T/Us' ability to maintain current levels of service and certainly would not allow for expansion of services. Such an outcome would be directly counter to the Congressional intent in enacting IHCIA and Public Law 106–417: Alaska Native and American Indian Direct Reimbursement Act of 2000 and subsequent legislation.

- Even if an I/T/U were immediately brought into the MCO via contract, it has been the experience of I/T/Us currently working with MCOs in the state that payments are not processed in a timely manner in the general in the first year of business.

- NM Medicaid plans for a *"proliferation of patient centered medical and health homes"* (pg. 14) would bring I/T/Us into the care coordination system, but are considered long range plans. Simply put, the I/T/U (federal) system does not belong under a for-profit organization.

- The Centennial Care Proposal describes MCOs as being initially responsible for basic care coordination and health home development over the next several years. I/T/Us have had this in place for decades.

C. The Centennial Care Plan will not result in financial savings for New Mexico for its Native American Medicaid patients

The MCOs stand to gain exponentially under this proposed plan, especially when Native Americans are forced to enroll in an MCO. The state intends to "stratify" its members by *"...risk and capitation and adjusted by risk to maximize directing resources to those most in need of healthcare services...."* This means that the state intends to **advance pay** MCOs for members in their plans. The advanced payment is based on a capitated rate which is basically an all-inclusive rate. MCOs will receive a higher capitated rate for high risk populations they intend to serve. Because the health disparities Native Americans suffer when compared to the rest of the U.S. are three times worse, these MCOs will be guaranteed a higher per capita rate for Native American members required to enroll. The state currently **does not pay** a capitated fee for these Medicaid fee-for-service members.

Under the Centennial Care Plan, the MCO will profit, but the cost to the state of New Mexico will increase.

The following is a description of additional concerns challenging the NM Medicaid position that this is a fiscally sound plan:

- NM Medicaid has failed to provide documented evidence of any forecasted cost savings in the Medicaid program, especially when factoring in the 100% FMAP the state receives from the federal government for Native Americans seen at I/T/U facilities.

- Moreover, when services provided to a Native American patient who is fee-for-service, but seeks care at a non-IHS facility, the state contributes less than 30% after a 70% FMAP (approximately). At what point has the Native American patient become a financial burden of the state?

- NM Medicaid has not convinced the tribes that eliminating the fee-for-service option for Native Americans will save any significant amounts of money.

- The elimination of the opt-out provision will mean a huge influx of money to the MCOs as they will receive the highest per-capita rate for Native Americans who will mandatorily be members of their plans and on whom the state does not currently spend this level of funds.

- The average per-capita rate is between $700 and $800 per member per month without the Behavioral Health "carve-in." The state will receive 100% FMAP for Native Americans seen at I/T/U facilities. Currently, I/T/Us bill Medicaid claims at the OMB $294 per visit rate. Thus, the MCOs stand to gain a substantial profit when the capitated rate is calculated to include behavioral health services.

D. The Centennial Care Plan is culturally inappropriate to the Native American population of this State.

- Tribal health clinics already offer a "health home" to our tribal members.

- Under the NM Medicaid model, care coordination would begin through an initial phone interview with an MCO employee. This is concerning primarily because technology assessment of the state indicates that the highest risk populations with the least amount of telephone access are rural New Mexicans, specifically Native Americans.

- Clients will go through a "stratification of risk" assessment, which the Centennial Care paper indicates will be based on "evidence-based, best practices." Tribal data concerning standards of care and improved health outcomes have not been included as part of the MCO consideration. In contrast, this data has always been and remains part of the tribe's consideration for care coordination for Native Americans.

- NM Medicaid indicates that after the initial phone interview, the client will then be assigned a "risk group care coordinator" who will complete a comprehensive assessment. Based on the description of the need to interview family members and care givers, the comprehensive, if not both interviews will require a face to face visit.

- Many of our tribal communities, especially elders, use English as a second language. Communicating health concerns, discussing medical terminology, diagnosis, treatments plans and family dynamics is most effectively done by our tribal clinic based service coordinators, not the MCO. This is an issue that current MCOs still struggle with and which will simply not be attainable under the proposed MCO run Medicaid model.

- In fact, our tribal benefits coordinators are providing uncompensated intensive care coordination for the existing state MCOs for our tribal members.

- Finally, at the point the MCOs shift the care coordination responsibility to the health home site, the Centennial Care paper does not indicate if and how the MCOs will be required to properly reimburse the tribes for care coordination service. It appears that moving forward, as it occurs with current MCO relationships; the percentage of the capitation rate that the MCOs receive for care coordination will not be passed on the entity actually conducting that coordination.

E. The Pueblo of Jemez offers both State and Tribal remedies:
State Remedies:

1. NM Medicaid must retain the "opt out" provision for tribes for all state- MCO relationships.

2. Mini-Grants: The Centennial Care paper describes that the NM Medicaid will establish two pilot site projects. One is to develop health homes in pilot sites in Albuquerque, and the other is related to developing bundled rates for hospital stays. This urban location of the first pilot project is out of touch with NM, which is primarily rural. By January 2014, the Pueblo of Jemez, like many other tribal health centers will have its own provider network, operating very much along the same lines as a managed care entity. Therefore, the Pueblo of Jemez proposes that the state issue mini-grants to tribal health entities to establish tribal health homes as pilot sites in the first year of this modernization effort.

    a. The tribal health homes would fully participate as partners in the state's plans for Medicaid modernization.
    b. Tribal sites will receive IT infrastructure on par with the other pilot sites for access to such things as the Medicaid Management Information System, which the state pays for with existing MCOs;
    c. Tribal sites will have access to the consolidated credential and re-credentialing processes;
    d. Tribal sites will have access to (if desired) the state's contracted Third Party Administrator;
    e. Tribal sites will direct bill for Medicaid.

These first two remedies to alleviate many concerns related to tribal sovereignty, protect direct reimbursements to tribes and ensure culturally appropriate health care delivery.

- Tribal Participation must be required in the development of the RFP's for the MCOs and on the selection committee of the MCOs. Tribal Subject Matter Experts (SME) must participate in selection or evaluation of proposed evidence based, best practices identified as applicable to Native American populations. There must be equitable tribal representation on the governing board that will provide direction and oversight to the state's Modernized Medicaid system.

- MCOs must be required under any and all circumstances to retain claims processing within the state of New Mexico.

- MCOs must be required to return percentage of profits to the rural communities.

Tribal Remedy:

1. CMS Tribal Consultation (Exhibit B): Unlike any other population in the state of New Mexico, tribes have the option to work directly with CMS. Specifically, under the CMS Tribal Consultation Policy, signed into effect in November 2011: *"...consultation must occur on an ongoing basis so that Indian Tribes have an opportunity to provide meaningful and timely input on issues that may have a substantial direct effect on Indian Tribes."* (page 3) The state of New Mexico continues, as planned to seek CMS authorization and waivers to implement its Medicaid Modernization as described in the Centennial Care document. Thus, the tribes are within their authority to dispute the matter directly with CMS; tribes may request that CMS deny any waiver request from NM Medicaid that diminishes tribal sovereignty or attempts to limit federal law.