



Position Statement  
Tribal Support for Permanent Legislation  
To Prohibit Mandatory Enrollment of Native Americans  
in Managed Care Programs  
July 2013

Mandatory enrollment of Native Americans into a Medicaid managed care plan remains a significant threat to not only the individual Native American but to the healthcare delivery systems operated by Indian Health Service/Tribes/Urban Indian Organizations (I/T/Us). In the past two years, the State Health Services Department (HSD) sought to gain approval from the Centers of Medicare/Medicaid Services (CMS), through Section 1115 of the Social Security Act, to waive Federal law prohibiting the mandatory enrollment of Native Americans into a managed care organization (MCO), without ANY ability to opt-out. The 1115 Waiver was submitted without tribal consultation and written notification which CMS required the State HSD to withdraw its waiver application and to re-submit after written notification to the tribes.

The waiver was then re-submitted but again without meaningful tribal input. As a result, NM Tribes demanded consultation with CMS which occurred on two occasions. CMS eventually weighed in and communicated to HSD that any waiver will not impose any new requirements for Native Americans to enroll in managed care. Native Americans, as they do today, will continue to have the opportunity to voluntarily enroll in a managed care plan if they so choose. However, this is a partial victory in the sense that 1) it excluded Native Americans who qualify for long-term care as they must be mandatorily enrolled into an MCO and 2) this does not prevent the State HSD from pursuing additional waivers in the future. In addition, any Native American who enrolls in an MCO is locked in for a year after the 90-day enrollment period that will begin October 1, 2013. The tribes want permanent state legislation that is consistent with Federal law and fully values tribal sovereignty.

In February 2013, Representative Roger Madalena introduced House Bill (HB) 376 to amend the Public Assistance Act to remove Native Americans from mandatory enrollment in Medicaid managed care. HB 376 is codified Federal Law in exempting Native Americans from Mandatory Managed Care; is consistent with current state Medicaid regulations that affords eligible Medicaid recipients who identify as Native American the option of enrolling in a Medicaid managed care or medical fee for service program NMAC 8.305.4.10(C) (2009); grants Native Americans a monthly opportunity to enroll or dis-enroll in either an MCO or fee for service (as this provision stands today); and there was and remains widespread majority support for the bill by tribal communities, health care providers, and leadership.

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The tribes of the state of New Mexico worked together to remain unified in opposition to the provisions of the Centennial Care Plan that would significantly and negatively impact the individual Native American and the I/T/Us. Specifically, NM tribes worked with the NM Chapter of the National Indian Council on Aging, IHS, and the NM Center on Law and Poverty to develop and communicate a holistic view and opinion of the impact of the provisions of Centennial Care.

Permanent legislation that will specifically prohibit any mandatory enrollment of Native Americans for any Medicaid service would further support the historical and newly authorized provisions of the Indian Health Care Improvement Act. For example, the Indian Health Care Improvement Act gave authority to I/T/Us to provide long-term care services if they so choose. I/T/Us desiring to provide long-term care services such as the Pueblo of Jemez and other NM tribes would be at a significant disadvantage today because Native Americans are mandatorily enrolled in the state's Coordination of Long-Term Services (CoLTs) managed care program. This means that any long-term care services provided by an I/T/U would continue to face significant challenges on several levels as long as Native Americans are required to be enrolled in the CoLTs managed care program. These challenges include securing reimbursement in a timely manner or at all for that matter; care coordination because the I/T/Us today have to include CoLTS MCO in its health care delivery/care coordination process which has proved to be a complete failure not to mention completely unnecessary.

MCO's cannot duplicate the local level involvement of IHS and/or tribally operated health and human services in the community. IHS and tribally operated organizations already provide extensive care and benefits coordination and will continue to provide it indefinitely. As for the Pueblo of Jemez, its comprehensive health center is AAAHC accredited and certified as patient-centered medical home. Benefits coordinators, social services and CHRs coordinate care with several programs within the Pueblo and external facilities. Case management in Indian country is complex and requires a high level of trust, constant attention and intense commitment to a successful outcome from all individuals involved in care coordination. It includes sophisticated comprehension of the cultural landscape of health care delivery in Indian country. In New Mexico alone, there are 19 Pueblos, big Navajo and the three smaller bands of the Navajo Tribe, and two Apache Tribes. I/T/Us know that a corporate organization cannot duplicate this amount of effort or expertise. Again, I/T/Us find it more than reasonable to pursue permanent legislation that will eliminate inherent and anticipated barriers to care or delays in care for the Native American individual.

The current enrollment of Native Americans in an MCO today remains at 15% which includes the 7% of Native Americans who are mandatorily enrolled in the CoLTS Program managed by two long-term care MCOs for the entire state of NM. With the advent of Centennial Care, the I/T/Us do not anticipate any significant increase in enrollment of Native Americans into an MCO for many reasons. Historically I/T/Us are pioneers in coordinating patient care from the depths of the Grand Canyon or from the frozen Alaskan frontier. Care coordination will continue to exist under a Fee-for-Service Program.

The State contends that Native Americans who are in the Fee-For-Service will not benefit from the value-added services the MCOs will offer. The value-added services are no match to what the I/T/Us already have in place. For instance, I/T/Us already provide what MCO's consider "value-added" such as a car safety seat program, smoking cessation programs, weight loss and management program, assistive devices such as shower/grab bars, traditional medicine, medical social services home visits, prenatal classes, dental care for pregnant women, obesity management, etc. These

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value-added services are merely a gimmick for MCOs to increase enrollment but these are core services in I/T/U systems of care.

The State HSD is of the opinion that I/T/Us have little impact on the health of Native Americans and I/T/Us need to be replaced by the state's Medicaid managed care plan who claims to do a better job. On the contrary, I/T/Us are key contributors to improved health outcomes of Native Americans despite chronic underfunding, old facilities and equipment, cramped conditions, limited housing, harsh environments, for a population that is largely uninsured. I/T/Us are also subject to recent Federal sequestration so our need to secure third party reimbursement in a timely manner just went into hyper-drive. Compare those realities with these corporate MCOs that have large budgets, are not subject to sequestration, beautiful facilities, state of the art equipment, highly paid staff, sophisticated IT systems, etc. yet the health outcomes or specific data on the 15% Native American Salud! members is not captured.

In closing, you can surmise that the Pueblo of Jemez is pleased to support HB 376 and find it completely necessary considering the smoke and mirrors and broken promises/assurances from state officials. The Pueblo of Jemez is confident that other NM tribes remain in their support for the passage of HB 376. Thank you for time.

#### ADDENDUM:

The State HSD continues to minimize or dismiss the importance of tribal consultation. It created the Native American Task Advisory Committee for the sole purpose of obtaining committee input, comment and advice on Medicaid issues. However, the State HSD released two recent documents to the public that promoted Centennial Care without seeking comment from neither the Native American Task Advisory Committee nor the larger Medicaid Advisory Committee. The FAQ document and now the new "Centennial Care" brochure are getting widely distributed now. These two documents make no mention of the fact that Native Americans do not have to sign up for managed care. Moreover, the brochure states that adults can start applying for the new Medicaid expansion category starting January 1, 2014. But actually, by law, Medicaid has to start taking applications by October 1, 2013 with coverage going into effect on January 1, 2014.

Officials from HSD have both said that people can start applying by October 1st, but that the HSD doesn't want to put this in the brochure. HSD officials don't see why it matters because people can't enroll until January anyway. But it does matter. People have a right to accurate information so they can make the decision for themselves about when to enroll. A person might need coverage right away starting Jan. 1st that will be delayed if they don't apply until then, or they might want to apply early so they can get Exchange coverage if it turns out they don't qualify for Medicaid. First, HSD needs to give out accurate information about Medicaid Centennial Care and the Expansion application date (not withhold it) – people have a right to know what is happening. By giving out misinformation, HSD is hurting its own credibility and trust with the public. There are clear outreach and enrollment issues concerning Medicaid expansion and HSD's deliberate attempts to keep Medicaid expansion low-key are very troubling.

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**PUEBLO of JEMEZ**

Talking Points

Welcome	
<p>Chairman, Members of the Committee, we thank you for the opportunity to host the State's Legislative Health and Human Services Committee. Not only is this an honor for the Pueblo of Jemez, this is a perfect example of promoting the gov't to gov't relationship between the State and a tribe.</p>	<p>However, today you will hear from our Director regarding our continued challenges with the State's existing Medicaid managed care Salud! programs and the upcoming Medicaid managed care Centennial Care program and the reasons why we and other NM Tribes support permanent legislation that prohibits the mandatory enrollment of any Native American into a managed care program.</p>
<p>We hope today that the presentations from the Pueblo of Jemez's Health and Human Services Department will provide insight and appreciation for the hard work and the variety of services our staff provides to our community as well as the challenges we face on a day-to-day basis.</p>	<p>Over the course of 40 years, tribes, on a national level, fought hard to preserve tribal sovereignty and its right to define and manage its own health care delivery systems. As a result, several federal laws and regulations were created that authorizes I/T/Us to provide a wide array of health services to Native Americans but also promotes self-determination of who will provide said services – IHS? A Tribe? An Urban Indian Program?</p>
<p>Nearly 15 years ago, the Pueblo of Jemez decided to contract its tribal shares from the Indian Health Service. As a result, we have grown in size and in scope and you will soon see our operations as we tour the Jemez Health Center.</p>	<p>If time permits, the Pueblo of Jemez is more than happy to provide information regarding the following: Anticipated enrollment for expansion and the exchange: Projected Workforce Needs and Challenges; Opportunities for Outreach and Enrollment; Payment of Premium Payments by Tribes for Patients</p>
<p>After the tour, you will hear from our Director of our Health and Human Services Department regarding how the Pueblo has benefitted from the new provisions of the Indian Health Care Improvement Act.</p>	<p>Most importantly, you will hear our position regarding our opposition to mandatory enrollment of Native Americans under any circumstances and thus our support of House Bill 376. I know personally that the Pueblo of Jemez worked hard during the last legislative sessions to pass HB 376 that passed many House and Senate committees and died at the Senate Finance Committee over HSD's desperate and unsubstantiated claims of increased administrative burden and costs.</p>

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IMPLEMENTATION OF CERTAIN INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS

BY THE PUEBLO OF JEMEZ

PROVISION	PUEBLO OF JEMEZ
SEC. 124 EXEMPTION FROM PAYMENT OF CERTAIN FEES.	Ex. Personnel and Tribe exempt from paying DEA registration fees.
SEC. 201 INDIAN HEALTH CARE IMPROVEMENT FUND.	Allows greater flexibility in spending 3 <sup>rd</sup> Party Revenue
SEC. 205 OTHER AUTHORITY FOR PROVISION OF SERVICES. (1) ASSISTED LIVING SERVICE. (2) HOME- AND COMMUNITY-BASED SERVICE. (3) HOSPICE CARE (4) LONG-TERM CARE SERVICES.	The POJ provides services 1-3.
SEC. 206 REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.	The POJ has issued letters to all insurance companies that have denied payment for services provided to their members – i.e. non-network provider.
SEC. 222. LIABILITY FOR PAYMENT.	Letters are issued to providers and collection agencies that they are prohibited from pursuing the patient for CHS payment when the POJ has authorized payment for contract health services.
SEC. 402. PURCHASING HEALTH CARE COVERAGE.	The POJ pays insurance premiums for patients when not eligible for other alternative resources but cannot afford to purchase insurance.
SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.	The POJ uses this provision for various reasons to show that we do not need a State license to operate and nor do our providers need to be licensed in the state of NM to practice.
SEC. 813 HEALTH SERVICES FOR INELIGIBLE PERSONS.	The POJ is the first tribe in the nation to invoke Section 813 to provide care to non-Indians.

IMPLEMENTATION OF CERTAIN INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS

BY THE PUEBLO OF JEMEZ

SEC. 124 EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by a Federal agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees.

SEC. 201 INDIAN HEALTH CARE IMPROVEMENT FUND.

(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—(1) eliminating the deficiencies in health status and health resources of all Indian tribes; (2) eliminating backlogs in the provision of health care services to Indians; (3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate; (4) eliminating inequities in funding for both direct care and contract health service programs; and (5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

(B) Preventive health, including mammography and other cancer screening.

(C) Dental care.

(D) Mental health, including community mental health services, inpatient mental health Services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

(E) Emergency medical services.

(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

(H) Home health care.

(I) Community health representatives.

(J) Maintenance and improvement.

SEC. 205 OTHER AUTHORITY FOR PROVISION OF SERVICES.

(a) DEFINITIONS.—In this section:

(1) ASSISTED LIVING SERVICE.—The term “assisted living service” means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—(A) shall not be required to obtain a license; but (B) shall meet all applicable standards for licensure.

(2) HOME- AND COMMUNITY-BASED SERVICE.—The term “home- and community-based service” means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

(3) HOSPICE CARE.—The term “hospice care” means—(A) the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and (B) such other services as an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of that care.

(4) LONG-TERM CARE SERVICES.—The term “long-term care services” has the meaning given the term “qualified long-term care services” in section 7702B(c) of the Internal Revenue Code of 1986.

SEC. 206 REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—(1) such services had been provided by a nongovernmental provider; and (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

SEC. 222. LIABILITY FOR PAYMENT. (a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services. (b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services. (c) NO RECOURSE.—Following receipt of the notice provided under

subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.

SEC. 402. PURCHASING HEALTH CARE COVERAGE. (a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a contract health service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner.

SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES. (a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.— (1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program. (2) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State. (b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.— (1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian. (2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian. (3) FEDERAL HEALTH CARE PROGRAM DEFINED.— In this subsection, the term, “Federal health care program” has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian tribe, tribal organization, or urban Indian organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).

SEC. 813 HEALTH SERVICES FOR INELIGIBLE PERSONS. (a) CHILDREN.—Any individual who— (1) has not attained 19 years of age; (2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and (3) is not otherwise eligible for health services provided by the Service, shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency. (b) SPOUSES.— Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(c) HEALTH FACILITIES PROVIDING HEALTH SERVICES.—(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service unit and who are not otherwise eligible for such health services if—(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and (B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians.

(2) ISDEAA PROGRAMS.—In the case of health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. The provisions of section 314 of Public Law 101–512 (104 Stat. 1959), as amended by section 308 of Public Law 103–138 (107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph.

(3) PAYMENT FOR SERVICES.—

(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual

cost of providing the health services. Notwithstanding section 207 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or children's health insurance program reimbursements under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq.), shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individuals....