Kewa Pueblo Health Corporation, Inc. Board of Directors

Talking Points

Joint Meeting with State Legislative Health and Human Services Committee

And Indian Affairs Committee

October 5, 2015

Introduction:

We are nearing 2 years of Centennial Care that began on January 1, 2014 with services provided by four managed care organizations (MCOs) – Presbyterian Health Services; Blue Cross/Blue Shield of NM; Molina; and United Health Care. These services include physical health, behavioral health, and long-term care and community benefits. Basically, the Centennial Program means that the State passed on the responsibility of administering Medicaid to four private entities. Historically, this has not worked well for Indian people and as sure as we're sitting here today, that remains true today.

In 2012, NM Tribes vehemently opposed the State's 1115 Waiver that included mandatory enrollment of Native Americans into a managed care program. After Centers for Medicare/Medicaid Services (CMS) consultation with NM Tribes, CMS agreed that the waiver will not impose any new requirement for Native Americans to enroll in managed care. As result, Native American Medicaid beneficiaries have an opportunity to voluntarily opt-in to managed care, i.e. a choice. Except! Native American beneficiaries who meet nursing facility level of care or who are dually eligible are required to enroll in managed care as was the case a few years ago under the Coordination of Long-Term Services (CoLTS) Program.

Today, as part of Centennial Care, long-term care services for the elderly are provided through a program entitled Community Benefit. Community Benefit's suite of services are specifically chosen to help the elderly remain living in their homes or "in the community". Today our focus is on those Native Americans that qualify for long-term care benefits under the Medicaid Program. We're here to tell you that despite the enormous amount of resources available to the four MCOs, there remains significant deficiencies in coordination of care detrimental to the individual.

As such, we continue to oppose the mandatory enrollment of Native American members and will pursue legislation that give all a "choice".

Continuing Negative Impact of Mandatory Enrolled Long-Term Care Tribal Members:

Recent quarterly reports provided to members of the Native American Technical Advisory Committee (NATAC), from the four MCOs on care coordination, indicated that deficiencies exist in care coordination and persist in their organizations. The object of these reports was to "...ensure that Native American members have access to care are receiving needed services." However, the information in these reports was vague, inconsistent and simply unacceptable. Specifically, for care coordination services, the following was reported by the four MCOs:

Blue Cross/Blue Shield:

> "Of the 474 transition Native American members, 52% did not have an HRA completed."
>
> "Of the 969 new Native American members 54% did not have an HRA completed."

"Of the 226 Transition Native American members, 41% did not have a CNA completed."

"Of the 447 new Native American members, 68% did not have a CNA completed."

Molina:

"Of the 6,510 Transition Native American members, 56% did not get an HRA completed."

"Of the 1,576 new Native American members, 69% did not have an HRA completed."

"Of the 1,658 Transition Native American members, 33% did not have a CNA completed."

"Of the 184 new Native American Members needing a CNA, 40% did not have a CNA completed."

Presbyterian:

No data entered concerning Transition Native Americans and HRA completion.

"Less than ½ of the members had completed their HRAs."

No data entered concerning transition Native American members and CNA completion.

"All CNAs were completed"

United Health Care Corporation:

"Completion rate higher but still lacking outreach to all members."

"Completion rate lower than expected. There is still a need to do more outreach to clients."

"A greater number of CNAs were completed. Numbers indicate higher identification of Level 2 clients."

"Not many new members have a CNA. Of those who have a CNA only 1 client was completed."

The State's response was equally disappointing. The State marked the box to indicate that escalation was not required. In the comments section, the State commented - "no further action required at this time"; "no further comments"; or simply left the comment section blank. Clearly, there is no concern or accountability on part of the State and the MCOs. The quarterly reports are a mere formality.

We hope this raises concerns, but from a patient's perspective, the lack of care coordination to an already vulnerable population, we hope stirs up some emotions as much it has with us. As we know, there are far more real life stories in the lack of MCO care coordination, but here are at least two:

1. A young man, 40 years old, on Molina Medicaid (not long term yet) who injured himself while at work. He didn't know he had diabetes and overtime a wound developed on his foot. As he worked, fluid from collecting trash got into his shoe, leaked into the foot wound, creating an infection, and eventually, the infection spread to his brain. He was admitted at St. V's for several days. During his admission, our staff applied for short-term disability on the patient's behalf and at the same time enrolled him in Molina Medicaid (his choice). However, he quickly realized the need to change because he was not receiving the care he needed. Specifically, he needed durable medical equipment (DME) such as a boot, shower chair, and a scooter. He repeatedly called Molina and the case worker did an assessment who promised that the DME would be delivered but he's still waiting. As more time passed, family members had to step in and ended up buying the DME themselves. Frustrated, he tried to drop Molina and was told

that he could not for 12 months - which is entirely not true. Knowing this, we switched the patient to Medicaid Exempt effective the following month (November 2015). But our efforts may be empty because he may have a long term disability and will be subsequently forced to mandatorily enroll in an MCO anyway. Our fears are that he's diabetic, has high blood pressure, and the foot wound is still healing and the MCO, whoever that may be, will not step up and see to his needs and the State will be equally unaccountable. But that's okay, we'll be there for this patient, insurance or not.

2. Patient had a stroke, is on long-term disability with United Health Care, has a care coordinator assigned, but speech therapy has not been ordered but necessary after the stroke. It's been several months since her stroke and receives only 4 hours of PCO care but actually needs 8 hours. We say this because when she's alone she vulnerable to falls. Unfortunately, we were right and she fell but we don't know how much time passed by the time her husband found her because she can't speak. She's tries to write but it's illegible. During the stroke time, United Health Care dropped her because she was "over-income". However, her income did not change and it was a mistake. However, it was our staff that worked to get her back on United Health Care which took about a month. The patient had to re-do the whole health assessment and application just to get back on. What remains to be seen is whether UHC will be in picture.

What's missing from both the State and the MCOs is the intent to meet the patient's needs today – as reflected in the quarterly reports. The State pays MCOs a per member per month capitated rate. In my limited understanding of the capitated rate, it is based on a three-tiered system of risk – low, medium and high to put it simply. We are assuming that MCOs receive the highest capitated rate for Native Americans as they are statistically proven as "sicker" when compared to all other US populations.

A Native American in long term care is estimated to have a capitated rate of $3,700 per month/$44,400 per year. This amount is 2.7 times the annual income level of a single Medicaid recipient and is more than the average monthly premium for private insurance. The State insists these rates are necessary because the MCOs assume all the risk of caring for the patient is nature of managed care. On the contrary, Tribes and IHS provide care to more Native American beneficiaries than MCOs and assume additional risk because we serve all Native Americans despite funded at 45% level of need. Tribes and IHS collect reimbursement on actual services provided to the insured patient, not before.

New Mexico is one of the top three states with the greatest concentration of Native American members in the US. Questions regarding equity and common sense accountability remain unaddressed. There is a lot to be said about this fact alone but we understand, although absurd, it is beyond our influence to try to change Medicaid managed care entirely but we can change a small part of it.

As much as we want to complain, we are ending on a positive note. The CMS is moving in the direction of changing regulations that will apply 100% FMAP for Native Americans seen in non-IHS/Tribal facilities. This means that the State can no longer argue that it is necessary to mandatorily enroll any Native American in managed care. Period. Should this change in regulation take place we anticipate increased opportunities to address long-term care and improve care coordination of our Native American members.