MANDAN, HIDATSA & ARIKARA NATION

Three Affiliated Tribes * Fort Berthold Indian Reservation
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Tribal Business Council

Office of the Chairman
Mark N. Fox

HOUSE BILL 1012
HOUSE APPROPRIATIONS COMMITTEE
JANUARY 28, 2021

TESTIMONY OF CYNTHIA MONTEAU
MANDAN, HIDATSA AND ARIKARA NATION

Mr. Chairman and members of the Committee, my name is Cynthia Monteau, I am here today on behalf of the Three Affiliated Tribes of the Mandan, Hidatsa and Arikara Nation (MHA Nation). I come before you today as a Proponent of House Bill 1012, a bill that eliminates the Managed Care Organization (MCO) managed care model and ensures that there is no longer mandatory enrollment of Medicaid eligible Native Americans.

North Dakota Medicaid sought and received a 1915(b) Waiver for Managed Care Enrollment of the Medicaid Expansion to permit the State to furnish services through a Managed Care Organization (MCO). This authority allows mandatory enrollment for all eligible Medicaid Expansion individuals, including Native Americans, into the MCO plans. The State advance pays MCOs for members in their plans. The advanced payment is based on a capitated rate which is basically an all-inclusive rate. MCOs receive a higher capitated rate for high-risk populations they intend to serve. Native Americans are identified as high-risk populations due to their health status. This means that MCOs are guaranteed a higher per capita rate for their Native American members who are auto enrolled into the MCO. This is regardless of whether the patient utilizes or has access to the MCO's services. In contrast, North Dakota currently does not pay a capitated fee for traditional Medicaid members.

The MHA Nation formally opposes auto enrollment of Native American Medicaid Expansion eligible patients in the North Dakota MCO. The MCO Managed Care model limits access to Health Care for Native Americans as many live in rural areas where MCO's that are delivering Medicaid services either do not have local offices or local providers to properly and efficiently serve tribal people. When MCO's do not have offices or providers near tribal communities, their staff cannot become acquainted with the clients and the community. This limits the MCO's ability to provide the required care coordination. The use of the MCO does not result in significant cost savings to the State for health care to Native Americans. Even tribal facilities that regularly serve Medicaid Expansion eligible patients only receive a fee-for-service payment- not the capitated rate given to MCOs.

Further, MCOs deliver a treatment model that fails to consider culturally appropriatness to the Native American population of this State. To properly treat tribal people, any organization must review health outcome date from every source, including the tribal or IHS run health systems prior to developing the treatment model. We have seen no evidence that either the state or the MCO examined health data related to the high risk tribal patient population. As a result, critical health data was not passed onto MCO's and is not reflected in the service delivery plans designed by the MCO's to treat tribal people. Without this engagement with tribal health delivery systems, tribes have no confidence that the MCO's can train their care coordinators to properly respond to tribal patient and community needs in an effective manner.

For these reasons, the MHA Nation supports House Bill 1012.

Thank you, Mr. Chairman.