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Cherokee Nation Perspective on National Health Care Reform

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The Cherokee Nation has been highly engaged in discussions at the state level regarding health care reform and has identified several areas where the Indian health system can play an active role in national reform. The Cherokee Nation participates on the Oklahoma State Coverage Initiative (SCI) and the Oklahoma House Speaker's Task Force on Healthcare Reform. Both initiatives have enabled the Cherokee Nation to develop an understanding of efforts in various states which will likely serve as a blueprint for national health care reform. The manner in which the national health care system is reformed is under considerable debate[1]. However, the most viable option in the United States appears to be a mix of government (federal, tribal, state, and local) and private sector participation.

While reducing the number of individuals without health insurance and increasing the number of health care providers is vital to health care reform, it does not by itself translate into improved health. However, both efforts are a critical first step in establishing the financial and human resource infrastructure for health care reform.

Other common themes associated with health care reform, such as information technology advancements, improve the quality of care using evidenced-based protocols, pricing transparency, supporting prevention and chronic care management, emphasizing personal responsibility, etc. are equally as important. However, the successful implementation of such themes relies heavily on the availability of funding (health coverage) and qualified health providers.

How does the Indian health system fit into the conversation? The same reforms being discussed at the national level are equally important to the Indian health system. While national health care reform is being discussed, it is vital that the Indian health system is a part of the discussion and can fully participate in any reforms implemented. Additionally, efforts should be included to encourage collaboration between Tribal and non-Tribal sectors (IHS, other federal agencies, state/local government, private entities) for the purpose of promoting patient-centered health care, interoperability of health information systems, developing health industry clusters,

[1] It is important to note that the recommendations offered by the Cherokee Nation pertain to anticipated legislation for national health care reform. While Congress will take up reauthorization of the Indian Health Care Improvement Act, it is vital that Indian Country be engaged in the larger health care reform discussion.

establishing specialty care in rural communities, reducing duplication of services, leveraging of resources, etc.

Priority 1 – Addressing the Uninsured

In Oklahoma, over 600,000 residents are without health insurance, which includes approximately 106,000 AI/ANs. The Cherokee Nation has identified approximately 46,980 AI/ANs within the 14-county service delivery area without health insurance. Because the Cherokee Nation and other tribally operated health systems have the authority to seek third party resources through private insurance, Medicare, and Medicaid, the Cherokee Nation actively supports efforts to increase access to health insurance.

As previously stated, increasing health coverage alone does not necessarily equal reform. However, the lack of health coverage serves as one of the largest barriers to seeking health care. Because the Indian health system is able to access 3rd party payment sources, the Indian Health Service and Tribal Nations have a vested interest in increasing the number of American Indians/Alaska Natives (AI/AN) with health insurance. Additionally, Tribal Nations desire to increase the number of insured individuals throughout the U.S. that are unable to access the Indian health system due to geography and other factors.

Individuals not familiar with the Indian health system, including many users of the system, often have a misperception that eligibility to access care through the Indian health system equals health coverage. However, due to inadequate funding and limited access, it does not equal health coverage. It is important to note that, according to the U.S. Census Bureau's Current Population Survey (CPS), individuals who report Indian Health Service (IHS) eligibility and no other coverage are classified as uninsured.

As a first step, various government (primarily federal and state) programs already exist to address the high number of uninsured individuals, but not all eligible individuals participate. In some instances, no additional funds are necessary because funding has already been established through dedicated revenue streams. A prime example exists in Oklahoma, where two existing programs are currently under utilized and could reduce the number of uninsured by 125,000, or 20%. Efforts associated with outreach and education efforts must be undertaken to ensure existing programs are serving all that are eligible to participate. Outreach and education is especially important for the AI/AN population as many do not participate in Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and private insurance because of the misperception that participation is not necessary due to IHS eligibility. Additionally, many would participate, but are unable/unwilling to pay the associated costs of such coverage, which is the purpose behind several efforts to encourage AI/AN participation in all eligible programs.

In 1976, the Indian Health Care Improvement Act (IHCIA), Public Law 94-437, authorized Medicare and Medicaid payments for services delivered in Indian Health Service facilities and Tribally operated facilities.

The purpose of the authorization under the IHCIA was to ensure American Indians and Alaska Natives can access federal entitlement programs in the same manner as other U.S. citizens.

Without such authorization, otherwise eligible American Indians/Alaska Natives receiving care through the Indian Health system would not be able to participate in Medicare and Medicaid.

In addition to ensuring participation of all eligible U.S. citizens in Medicare and Medicaid, the IHCIA authorization also promotes governmental efficiency as it integrates two federal functions; the federal trust responsibility to provide health services to American Indians/Alaska Natives and federal entitlement programs. The federal government dedicates substantial resources to streamline activities, reduce waste, improve program interoperability and compatibility, etc. and the IHCIA provides an excellent example that has been successfully in place since 1976.

While the ability of Indian Health Service (IHS) facilities and Tribally operated facilities to receive payments for services provided under Medicare and Medicaid may appear to represent accessing multiple federal sources for one activity, thus taking advantage of the federal government, it is not the case. Even with the ability of IHS facilities and Tribally operated facilities to receive payments for services provided under Medicare and Medicaid, the Indian Health system remains woefully underfunded.

Legislative efforts should continue to remove barriers to AI/AN participation in the above mentioned programs. Recently enacted provisions in the American Recovery and Reinvestment Act of 2009 that protect AI/ANs from certain premiums/cost sharing and excluding certain assets from consideration when determining Medicaid eligibility are a positive start. While some may hold the view that the Indian health system receiving payments for services provided under Medicare and Medicaid represents accessing multiple federal sources for one activity (double dipping), it is merely integrating two federal functions; the federal trust responsibility to provide health services to American Indians/Alaska Natives and federal entitlement programs. For instance, national health reform legislation should include language that will allow Indian Health Service/Tribally-operated Programs/Urban Indian Health Organizations (I/T/U) expenditures to apply toward Medicare Part D True Out-of-Pocket Expenses (TROOP).

Another legislative effort that would greatly improve the ability of the Indian health system to access private insurance resources is automatically classifying services provided within the Indian health system as “in-network” for purposes of payment.

Priority 2 – Increasing Access to Healthcare Services (workforce, rural needs, etc.)

It is important to note that Cherokee Nation health services are delivered in a primarily rural setting, which experiences a more difficult time recruiting and retaining health professionals compared to urban settings. The Cherokee Nation is committed to cultivating health professionals from local communities and keeping them in their local communities. Because the Cherokee Nation is able to integrate and collaborate among its various programs, the Cherokee Nation is working with schools, colleges/universities, workforce development entities, and others to address current and future healthcare workforce demands.

While Cherokee Nation Health Services has dedicated much time and effort in recruiting and retaining qualified health professionals, it remains a challenge, especially in light of the future shortages expected in Oklahoma:

- The number of patient care doctors per 10,000 people is about 22 for the country as a whole; more than 30 in Massachusetts, New York, Maryland, and Connecticut; and just 15 in Mississippi, Alaska, Oklahoma, Wyoming, and Iowa.
- According to the U.S. Census Bureau, Oklahoma ranks 49th in state rankings for physicians per 100,000 population.
- In 2006, national statistics indicated an average of 807 nurses per 100,000 population. However, in Oklahoma, the rates are substantially lower, 691 per 100,000.
- Oklahoma is expected to have a shortage of more than 3,000 nurses, 500 lab technicians, 400 physical therapists, 300 surgical technologists and 200 occupational therapists by 2012.
- Statewide surveys of hospitals conducted by the Oklahoma Hospital Association from 2001-2005 indicate Oklahoma hospitals' greatest needs for clinical employees included the following: nurses, respiratory therapists, imaging technologists, pharmacists, medical and laboratory technologists, physical and occupational therapists and scrub/surgical technicians.
- On a national basis, the Indian Health Service faces difficulties in filling health care provider positions as noted by the following vacancy rates:
    - Physicians 18%
    - Nursing 19%
    - Dentists 32%
    - Pharmacists 11%

In order to address the impending healthcare workforce crisis, efforts must be made to both increase the workforce and make the current workforce more accessible to the rural population.

The Cherokee Nation supports the appropriate expansions of the quantity and quality of health care professionals and workers, and support practices that allow this workforce to operate at "the top of their licenses."

While it may not be practical to construct full-time, dedicated clinics in remote areas, efforts can be undertaken to utilize existing infrastructure such as schools, places of business, retail establishments, etc. to host health provider sites. The flexibility to allow the Indian Health Service and Tribally-operated health systems to carry out such efforts is critical.

For the Indian health system specifically, targeted programs already exist to ensure a pipeline of health care providers to meet the health needs of the AI/AN population. Unfortunately, it is woefully underfunded and adequate funding will enable the Indian Health Service and Tribal Nations to address the high vacancies that currently exist. In FY 2008, the Indian Health Service Scholarship program only 101 (or 5.3 %) of the over 1,900 new applications were able to be funded. Of that figure, only 15 will train to become physicians, 8 will train to become nurses, and only 2 will train to become dentists. It is apparent that the IHS Scholarship Program is an

attractive program designed to both meet the needs of the Indian health system and enable qualified individuals to pursue health careers and adequate funding will

National health reform should also include specific language to ensure Tribal facilities operated by a Tribe or Tribal organization authorized by Title I or III of the Indian Self-Determination and Education Assistance Act, aka ISDEA (P.L. 93-638, as amended) are eligible to participate in the National Health Service Corp (NHSC).

Lastly, facilities in Indian Country continue to be desperately needed. The IHS Joint Venture (JV) program demonstrates the shared commitment of Tribal Nations and the federal government in providing additional health facilities within the Indian health system and the staff necessary to support the facilities. The JV program is a proven success in leveraging resources to construct and build critically needed health facilities, making federal funds go farther. Unfortunately, the JV program has been funded on a sporadic basis and Tribal Nations wishing to participate must submit a proposal to the IHS and then seek appropriations through Congress to fund the project. The JV program would greatly benefit from funding on an annual basis; including contract support costs funds, and adequate operational funds.

Priority 3 – Improving Information Technology Capacity

While most of the U.S. enjoys reliable and prompt internet connectivity, Indian Country lags far behind and is hampered in its efforts to update its technological capacity. While some opportunities exist through the American Recovery and Reinvestment Act of 2009 (ARRA) to improve the information technology capacity in Indian Country, Tribal Nations will still need assistance in developing Universal Enterprise Network Systems to build internetwork connectivity and operability.

An investment in the technological capacity of Indian Country will enable the expedited implementation of electronic health records, telemedicine, health information exchange, etc. in an efficient, secure, and user-friendly manner. The Cherokee Nation has been very active in improving technological capacity, including health information exchange.

Oklahoma is among nineteen states that received funds though the Agency for Healthcare Research and Quality (AHRQ) to develop a broad scale health information exchange organization. Named SMRTNET, the expandable network has been developed over a two-year period by a team of over sixty people and several national experts. Initial partners included the Oklahoma State Department of Health, Oklahoma Department of Mental Health and Substance Abuse Services, Cherokee Nation, Tahlequah City Hospital, Northeastern Oklahoma Community Health Center, W.W. Hastings Indian Hospital, and Northeastern State University.

The SMRTNET personal health record provides a private, comprehensive, longitudinal, portable record that enables consumers to store personal health information. The foundation of SMRTNET solutions is its ability to enable consumers to better manage their own health, and the health of their family members, with regards to allergies, medical conditions, surgeries, medical tests, measurements, immunizations, medications, and claims. The mission of SMRTNET is to create an Internet-based healthcare community that connects persons and healthcare providers

and also offers storage for critical health information within a PHR, enabling individuals to better manage their own health. By providing the right tools, consumers have access to the most current health information.

Priority 4 – Improving Patient Care

The Cherokee Nation has a demonstrated commitment to improving patient outcomes through the use of effective care management and evidence-based medical protocols with an emphasis on cost effective preventive and chronic disease care. The Cherokee Nation follows the patient centered medical home concept.

Cherokee citizens and other users of the Cherokee Nation health system enjoy a seamless health system that allows its providers to follow and track individual patient care in one health system. For example, a patient can be under the care of the same physician at both the clinic and hospital level, including certain specialists. Additionally, providers have the ability to instantly access patient information within the Cherokee Nation's health system regarding allergies, medical conditions, surgeries, medical tests, measurements, immunizations, medications, and claims is crucial for patient care. Patient record sharing avoids the need for health providers to order duplicative tests, as well as reduce the risk for errors associated with drug allergies, patient conditions, etc. It is a patient-centered concept that serves as a model for other health systems in the U.S.

The Cherokee Nation fully embraces the principle that good health encompasses not only health services, but also education, career development, social services, elder programs, cultural enrichment, and a host of other opportunities. The Cherokee Nation has witnessed a great deal of success in supporting personal responsibility and behavioral health and firmly believes health care reform should include both.

Additionally, in order for health care reform to be effective, preventive health must be considered on the same level as health coverage, access, information technology, etc. Building and sustaining healthy communities is a strategic priority for the Cherokee Nation and the Nation recognizes the relationships between people, their social networks and environment have a substantial impact on making lifestyle decisions. The Cherokee Nation has made tremendous strides in supporting wellness activities, farmers' markets, building safe communities, improving worksite wellness, and school exercise programs.

Conclusion

As the Committee is well aware, health care reform is a major topic before Congress and much discussion will take place as to the impact and integration of the Indian health system. The Cherokee Nation urges the Committee to ensure that the Indian health system remains intact and reforms are integrated into the Indian health system rather than dismantling it. While many health reform proposals have been discussed recently, much of the discussion has focused on privatization, increasing health care coverage, increasing the number of health providers, collaboration between government and the private sector, health information technology

improvement, etc. The Indian health system encompasses all of these areas, it just lacks the resources necessary to properly implement.

The Cherokee Nation has built a solid reputation as a responsible, successful, and responsive government, which also extends to its health system. As a result, Cherokee Nation Health Services (CNHS) is recognized as a "provider of choice" in northeastern Oklahoma and Cherokee citizens and other American Indians prefer to access health care at CNHS sites. Therefore, it is critically important that any health care reform efforts protect the ability of eligible beneficiaries to access CNHS, as well as other Indian health systems throughout the United States.

Attached please find further information on the following topics:

- Data Needs in Indian Country
- Concerns Related to Competition and Unnecessary Duplication of Services
- Privatization of the Indian Health System
- Examining Indian Health Service (IHS) Eligibility Criteria

Data Needs in Indian Country

Question posed – If the federal government were to have the capability to produce all of the necessary data to better address the health disparities facing AI/ANs, what areas for data collection should be targeted?

Response –Some specific areas of focus should include:

- Quantification of Chronic Disease prevalence (e.g., cancer, heart disease, diabetes) and associated risk factors (e.g., obesity, diet, physical activity) through sustained support of prospective studies among AI/AN populations
- Chronic disease risk factor reduction
- Intentional and unintentional injuries
- Hypertension – evaluating methods to improve awareness and treatment of hypertension
- Stroke Prevalence/Prevention
- Methamphetamine Prevalence/Prevention
- Evaluation of the use of emerging technology (such as telemedicine, electronic health records, health information exchange, etc.) for the provision of care
- Health Services Research (such as utilization of prenatal care; preventable hospitalizations, emergency room utilization, etc).
- Auto Immune Disorders
- Suicide Prevention

In addition, efforts should be made to develop data that attempts to understand exposure to risk and vulnerability over the lifespan to AI/AN health due to social determinants such as social exclusion, marginalization and inequality. Research should address the complex interactions between health determinants and long term exposure to risk unique to AI/ANs as an indigenous population.

Additionally, one of the most beneficial improvements would be the establishment of single data sources. As an example, the federal government maintains several AI/AN data sources through IHS, Bureau of Indian Affairs, Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, National Institutes of Health, Substance Abuse and Mental Health Services Administration, U.S. Census Bureau, and several others. A single, integrated internet accessible website with data available to calculate simple statistics, such as incidence and prevalence rates etc. would assist in identifying areas of focus within AI/AN communities. Additionally, the resource could provide access to published data as well.

Concerns Related to Competition and Unnecessary Duplication of Services

A cursory observation of the healthcare system in Oklahoma, including the interrelation between the Indian health system and the non-Indian health system, might indicate that some areas of the state have facilities in close proximity that provide similar services to two different populations indicating an inefficient use of health resources. An often cited example is in Tahlequah, where the W.W. Hastings Indian Hospital (WWH) and the Tahlequah City Hospital are located in close proximity and provide similar services.

A closer examination would demonstrate that both facilities are vital to not only to Cherokee County residents and counties throughout the region as well, but are also vital to each other. Since the October 1, 2008 assumption of WWH by the Cherokee Nation, the facilities have built an even closer relationship and actively collaborate to address the health needs of the region in an effective and cost-efficient manner. The facilities have also developed a "shared services" committee to carry out such activities and as a result of this effort; the timely and appropriate use of primary care services has reduced unnecessary emergency room utilization.

Another issue that has been raised previously is the notion that the growth of the Indian health system has a negative impact on non-Indian health providers by reducing the pool of patients in the area that the providers could serve. However, that is not the case and within the Cherokee Nation, the Indian health system is viewed as a complimentary health provider as the current health care workforce cannot meet the demand. Often, rural providers are unable to accept new patients, thus leaving those in need of health care to travel long distances for care or forego health care until emergency room utilization is necessary. The presence of the Cherokee Nation health system is especially important for maternal/child and elderly health care needs.

Collaboration Between Public and Private Sectors

In order to achieve a healthier population, the Cherokee Nation has placed an emphasis on collaboration with Oklahoma state agencies, local governments, and the private sector. However, governmental rules/regulations often impede collaboration. Building partnerships and removing unnecessary impediments should be addressed as part of this and other health reform efforts. Despite the impediments, the Cherokee Nation has a proven track record of collaboration. A few examples include:

Cherokee Health Partners – Cherokee Health Partners, LLC, is a partnership between the Cherokee Nation Comprehensive Care Agency and Tahlequah Hospital Authority and is located within the Tahlequah City Hospital. The partnership was created to allow both Tribal and non-Tribal patients to get necessary testing locally instead of traveling to distant locations. Examples of services offered include cardio imaging and nuclear medicine testing. The partnership has been very beneficial to the elderly population, especially those residing in retirement facilities and those unable to travel long distances.

EagleMed – EagleMed is an air ambulance service in Tahlequah. EagleMed was the result of a joint effort between the Cherokee Nation, Tahlequah City Hospital and Hastings Indian Medical Center.

Addressing the health care and social services needs of the elder population in northeastern Oklahoma – In August 2008, the Cherokee Nation began operating the first Program of All-Inclusive Care for the Elderly (PACE) program in the United States located in a Tribal, as well as rural, community. PACE is offered through the Centers for Medicare and Medicaid Services (CMS). Cherokee Elder Care provides and coordinates a variety of both medical and non-medical services for frail elders. Services are provided both in the participants home and though the Cherokee Elder Care Facility. Services are provided by the Elder Care team which includes a physician, nurses, therapist, social workers, home care providers, and transportation specialists.

Cherokee Elder Care serves both Tribal and non-Tribal elders from a facility based in Tahlequah with the goal of allowing elders to remain living safely in their home and community. The cost of the Cherokee Elder Care Program is covered for most participants through a combination of Medicare and Medicaid resources. The Tahlequah Cherokee Elder Care facility has the capacity to serve 150 elders. In addition to the Tahlequah facility, future plans include additional sites in Stilwell, Muskogee, and Claremore.

Northeastern State University – Cherokee Nation Health Services operates an agreement with the School of Optometry at Northeastern State University for the provision of optometric services throughout the Cherokee Nation. Optometry students in their fourth-year residency, under the clinical direction of optometry practitioners and professors, provide services to Tribal members throughout Cherokee Nation clinics, and W.W. Hastings and Claremore Indian hospitals. Additionally, the Cherokee Nation collaborates with Northeaster State University and other local educational institutions to increase the number of educational opportunities for nursing, clinical sciences, etc.

University of Oklahoma, Tulsa Campus – Given the high incidence of cancer and diabetes in Oklahoma, the Cherokee Nation and the University of Oklahoma, Tulsa Campus (OU-Tulsa) have developed a partnership to identify areas of collaboration for the prevention, treatment, and research of diabetes and cancer.

Oklahoma State University College of Medicine – The Cherokee Nation and the Oklahoma State University College of Medicine have recently begun discussions to identify areas of collaboration regarding telemedicine, workforce development, and rural health.

Northeastern Oklahoma Healthcare Industry Development – The Cherokee Nation is currently engaging external partners to participate in a strategic planning effort to facilitate the growth of the northeastern Oklahoma health care industry, including supportive services, to develop a comprehensive, long-term industry growth plan. The external partners are involved to: 1) provide expert guidance and perspective; 2) to identify and foster partnerships/collaborations; and 3) discuss possible ideas for action.

Entities participating include the Oklahoma Hospital Association, Oklahoma Health Care Authority, Blue Cross/Blue Shield, Hillcrest Healthcare System, Tahlequah City Hospital,

City/County Health Departments, Community Health Centers, Oklahoma Workforce Development, OU-Tulsa, Oklahoma State University Center for Rural Health, and others.

To date, the five areas of focus identified include:

1. Develop Clearly Defined Centers of Excellence. (Opportunity Focus)
2. Grow New Businesses and Jobs in Healthcare. (Opportunity Focus)
3. Acquire Required Strategic Investment Capital. (Resource/Asset Focus)
4. Build the Health IT Infrastructure. (Resource/Asset Focus)
5. Grow the Regional Healthcare Workforce. (Resource/Asset Focus)

Privatization of the Indian Health System

The Cherokee Nation is aware of recent proposals to explore "privatizing" Indian health services by providing American Indians/Alaska Natives with a voucher or credit to seek health care in the private sector. The primary question that must be addressed is whether health services could be provided more effectively and efficiently through the private sector. Based on the current per capita funding level for IHS users in Oklahoma ($976 annually, $81.33 monthly), funding is woefully inadequate to purchase comparable health services in the private sector. The Cherokee Nation recently reviewed similar efforts at the state and federal level.

Discussions at the State level – In 2006, the State of Oklahoma attempted to launch a pilot project which would determine average Medicaid beneficiary spending and provide the amount to Medicaid beneficiaries to purchase coverage through available private plans. The State of Oklahoma determined that it spends an average of **$3,453** per capita annually on Medicaid beneficiaries within the pilot project area. Following the determination, the State of Oklahoma published a request for information (RFI) to determine the interest and feasibility of commercial health plans providing coverage. Only two commercial health plans responded and neither indicated that coverage could be provided for the amount of funding available and instead offered several suggestions/alternatives that would be necessary to make the pilot project feasible for commercial health plans. The pilot project has essentially been tabled.

Discussions at the Federal level – In FY 2003, the federal government expended **$5,200** per capita annually for patients within the Veterans Health Administration (VHA) system. When discussions have taken place regarding the possibility of privatizing the VHA system, the resounding response has been that privatization is unfeasible due to the level of funding available, despite the VHA having over two times the amount of resources provided for American Indians and Alaska Natives.

The IHS Pawnee Service Unit in Oklahoma essentially privatized its hospital operation in the 1980s, by issuing "Pawnee Benefit Package" cards to its patients and closing the hospital. The program resembles a "contract health-like" operation and the resulting care level, while conducted by private hospitals and physicians, is severely rationed and experiences a high level of denials of care.

The Cherokee Nation has concluded that the level of funding provided by the federal government for IHS beneficiaries is not adequate to seek coverage through the private sector. While the level of funding for the Indian health system remains woefully underfunded, tribally operated health systems have done a tremendous job in maximizing and leveraging available resources.

Another aspect that the Cherokee Nation reviewed is patient choice. In 2001, a Cherokee Nation comprehensive long range plan was developed to meet the needs of tribal citizens for health care in the 14-county tribal jurisdictional service area. Consumers preferred to have Cherokee Nation operate health facilities rather than purchasing services from the private sector.

Privatization = Lost Opportunities – One of the most valuable aspects of the Indian health system that would be lost if the system were to be privatized is the contribution and involvement of Tribal Nations. Some specific examples include:

- **Patient-centered care** – Cherokee citizens and other users of the Cherokee Nation health system enjoy a seamless health system that allows its providers to follow and track individual patient care in one health system. For example, a patient can be under the care of the same physician at both the clinic and hospital level, including certain specialists. Additionally, providers have the ability to instantly access patient information within the Cherokee Nation's health system regarding allergies, medical conditions, surgeries, medical tests, measurements, immunizations, medications, and claims is crucial for patient care. Patient record sharing avoids the need for health providers to order duplicative tests, as well as reduce the risk for errors associated with drug allergies, patient conditions, etc. It is a patient-centered concept that serves as a model for other health systems in the U.S.

- **Integration of other Tribal services** – the Cherokee Nation fully embraces the principle that good health encompasses not only health services, but also education, career development, social services, elder programs, cultural enrichment, and a host of other opportunities. Privatization of the health system prevents the Cherokee Nation and other Tribes from providing a highly integrated system to build a happy and health citizenry. A prime example within the Cherokee Nation is the development of innovative methods to improve health promotion/disease prevention (HP/DP). While HP/DP funds are sorely lacking in Indian Country, Tribes have the ability to develop and fund programs that incorporate HP/DP and traditional practices, inter-generational interaction, etc.

- **Ability to supplement patient care funds –** Due to inadequate federal funding for the Indian health system, Tribal Nations have been placed in a position of trying to locate resources to address deficiency. Examples include supplementing the IHS Contract Health Services (CHS) Program, creating new programs depending on the particular health needs of the Tribe, facility construction/expansion, etc.

Examining Indian Health Service (IHS) Eligibility Criteria

During the February 5, 2009 Senate Committee on Indian Affairs (Committee) hearing on advancing Indian health care, Chairman Byron Dorgan indicated some Members of the Committee are interested in examining Indian Health Service (IHS) eligibility criteria in order to reduce the number of IHS eligible beneficiaries and thus increase per capita expenditures. Should the Committee examine this issue, the Cherokee Nation urges the Committee to review eligibility criteria in a manner that upholds the government-to-government relationship between the United States and federally recognized Tribal Nations. Additionally, rather than examining methods to reduce the number of IHS eligible beneficiaries, Congress has a real opportunity to better utilize the Indian health system, which has demonstrated the ability to provide efficient and effective health care, even with inadequate resources.

Government-to-Government Relationship

It is a well settled principle that the government-to-government relationship between the United States and federally recognized Tribal Nations provides the foundation for the federal trust responsibility to carry out various programs and services for Tribal citizens.

Just as the United States has the inherent and absolute right to determine citizenship, so does the Cherokee Nation. By virtue of citizenship in the Cherokee Nation, an individual should have equal access to all programs and services carried out by the federal government as part of the federal trust responsibility. Eligibility for such programs and services is based on this unique legal and political status rather than a racial category.

Unfortunately, the federal government has been inconsistent in determining eligibility for such programs and services resulting in a blurred line between Tribal citizenship and race. The inconsistency has lead to a great deal of confusion in the administration of federal programs and services, as well as legal challenges.

A prime example is Indian Health Service (IHS) eligibility. IHS criteria for determining eligibility is found in the IHS Manual at Section 2.1.2, as well as the Code of Federal Regulations (CFR) at 42 C.F.R. § 136.12, which codifies provisions of the Indian Health Care Improvement Act (P.L. 94-437). Additionally, the eligibility criteria is typically incorporated into compacts and funding agreements with the IHS. The criteria are very subjective, is interpreted on a facility by facility basis, and thus inconsistently applied. For uniformity and objectivity, the Cherokee Nation recommends eligibility criteria be based on citizenship in a federally recognized Tribal Nation.

Indian Health Service (IHS) User Population

As mentioned previously, the basis for examining IHS eligibility criteria is to increase per capita expenditures by reducing the number of IHS eligible beneficiaries. While it was not stated during the February 5th hearing, the assertion is to limit IHS eligibility to individuals with what the federal government deems to be an acceptable American Indian/Alaska Native blood quantum.

The whole premise is reminiscent of federal paternalism and the federal government's attempt to retreat from obligations from the 18th century to the present. Additionally, it diverts attention from the real issue; the failure of the federal government to fulfill its responsibility to Tribal Nations.

From a practical standpoint, the Cherokee Nation urges the Committee to take into consideration that, according to the 2000 Census, American Indians and Alaska Natives (AI/AN) numbered 4.1 million, or 1.46% of the total U.S. population. However, in FY 2001 the IHS provided health services to only 1.3 million, or 0.46 % of the total U.S. population. Using 2000 Census figures, even if every eligible AI/AN accessed the IHS system, the federal fiscal impact is negligible compared to the 37.7 million Medicare enrollees, 29.2 million Medicaid enrollees, and the 8.4 million accessing services through the Veterans' Health Administration and Department of Defense (VA/DoD).

It is well documented that the per capita personal health care expenditures for users of the Indian health system are significantly less than those participating in Medicare, Medicaid, VA/DoD, as well as the general population. In 2003, consequently the last time the IHS made the information available, the federal government spent only $1,914 per capita, compared to national average of $5,085. For Oklahoma Tribes, the disparity is even greater as only $976 per capita is expended, which represents only 44% of the actual need according to the Federal Disparity Index.

In summary, the AI/AN population represents only a small segment of the overall population and the Indian health system has consistently demonstrated the ability to provide quality care with miniscule resources. During this period of reforming the health care delivery system in the United States, the Committee should champion an effort to fully implement the framework of the Indian health system in order to increase the services for current patients and improve access for those unable to utilize the system.

Mandating Participation

While health coverage reform efforts in some states have included mandatory participation for individuals, based on the numerous meetings convened in Oklahoma over the past several years concerning increasing health coverage, mandating participation in Oklahoma has little support and many other states would likely follow suit. Should a proposal move forward at the federal level with a mandatory participation provision, the Cherokee Nation believes that the American Indian/Alaska Native (AI/AN) population not be allowed to "opt-out" of the health insurance program solely based on an individual's status as a Tribal citizen.

The rationale for the Cherokee Nation's position is that while the Indian health system should meet all of the health needs of American Indians/Alaska Natives, the reality is that it does not. The lack of adequate funding, sparsely located facilities, and limited services have created a situation where American Indians/Alaska Natives do not have access to health care. For this reason, the U.S. Census Bureau's Current Population Survey (CPS) has determined that individuals who report Indian Health Services (IHS) and no other coverage are classified as uninsured. Therefore an exemption from mandatory participation would have a negative affect on the health of AI/ANs and the Indian health system.

Allowing the AI/AN population to "opt-out" would increase the high number of AI/ANs without health coverage, create a class of U.S. citizens without health coverage that would then utilize the Indian health system and the Indian health system would have to provide health care services to the AI/AN population utilizing only Indian Health Service appropriations and essentially eliminate third party payment sources, which are a substantial revenue stream for the Indian health system

For any employer mandates that are proposed, the Cherokee Nation agrees that Tribal Nations should not be subject to such requirements.