Joint Legislative Committee on Access to Health Care and Medicaid Expansion

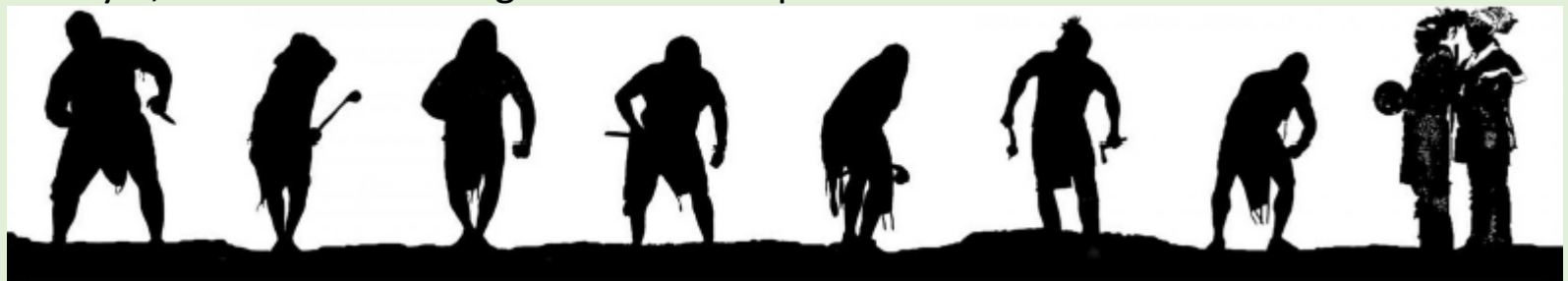
Casey Cooper, CEO
March 15, 2022

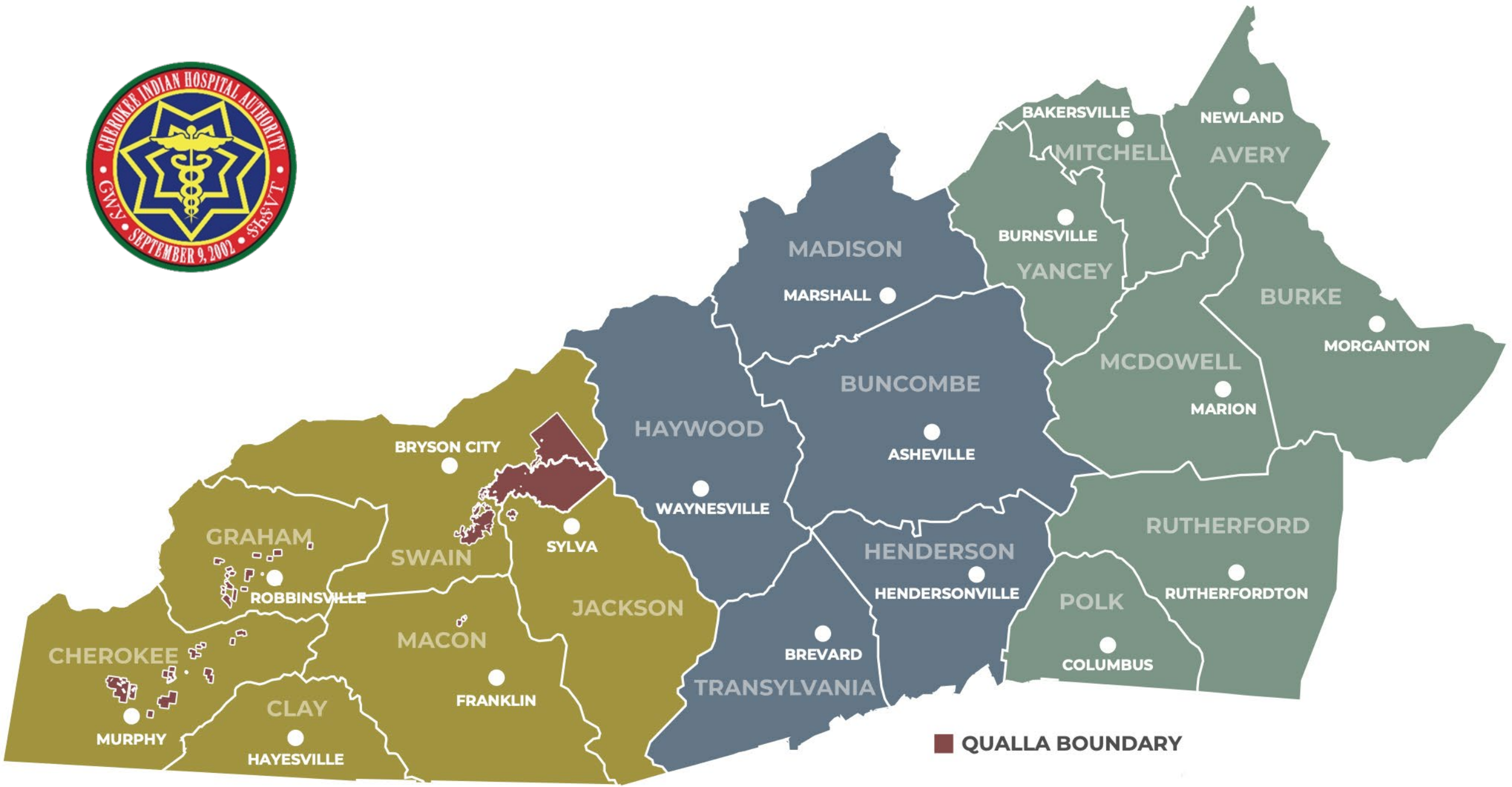
CHEROKEE INDIAN HOSPITAL AUTHORITY


Teen Miss Cherokee 2015

Eastern Band of Cherokee Indians (EBCI)

- Descendants of the Cherokee Nation and the Oconaluftee Cherokee of 1817 and 1819
- Duly incorporated in 1889 under a corporate charter
- Located on 56,000 acres in 5 of the western most counties known as theQualla Boundary
- Enrollment today is approximately 16,500 and is at this time the only federally recognized tribe in NC
- Approximately 12,500 American Indian/AlaskanNatives (AI/Ans) are considered active users of the Tribal Health System referred to as the Cherokee Indian Hospital Authority
- Diabetes, Depression, and Substance Use Disorders (SUD) are the top three priorities for the Tribe
  - At least 3,000 members have been diagnosed with Diabetes
  - Approximately 4,000 have been diagnosed with Depression and or SUD




BAKERSVILLE
NEWLAND
MITCHELL
AVERY
BURNSVILLE
MADISON
YANCEY
MARSHALL
BURKE
MORGANTON
MCDOWELL
BUNCOMBE
MARION
HAYWOOD
ASHEVILLE
BRYSON CITY
WAYNESVILLE
RUTHERFORD
GRAHAM
SYLVA
HENDERSON
SWAIN
HENDERSONVILLE
RUTHERFORDTON
ROBBINSVILLE
JACKSON
POLK
MACON
BREVARD
CHEROKEE
COLUMBUS
TRANSYLVANIA
FRANKLIN
CLAY
MURPHY
HAYESVILLE
QUALLA BOUNDARY

Overview: Failing to address the "Coverage Gap" could be disastrous for the Indian Health Service (IHS) and Tribally managed health systems.

- American Indian and Alaska Natives have a **unique political relationship** with the United States that is not based on race
- The provision of health Care for AI/ANs is the **legal and moral obligation** of the United States Government
- Indian Health is among the **most underfunded** federal health systems in this Country
- **Medicaid is used to supplement the underfunded** system and to help cover the cost of fulfilling the US responsibility for providing health care to AI/ANs
- Failing to expand Medicaid and creating unnecessary barriers to enrollment for AI/ANs is inconsistent with the legal and moral obligation of the United States

Adverse Childhood Experiences (ACE)

- Physical, emotional, sexual abuse; mentally ill, substance abusing, incarcerated family member; seeing mother beaten; parents divorced/separated

  --Overall Exposure: 86% (among 7 tribes)

	Non-Native	Native
Physical Abuse-M	30%	40%
Physical Abuse-F	27	42
Sexual Abuse-M	16	24
Sexual Abuse-F	25	31
Emotional Abuse	11	30
Household alcohol	27	65
Four or More ACEs	6	33

Am J Prev Med 2003;25:238-244

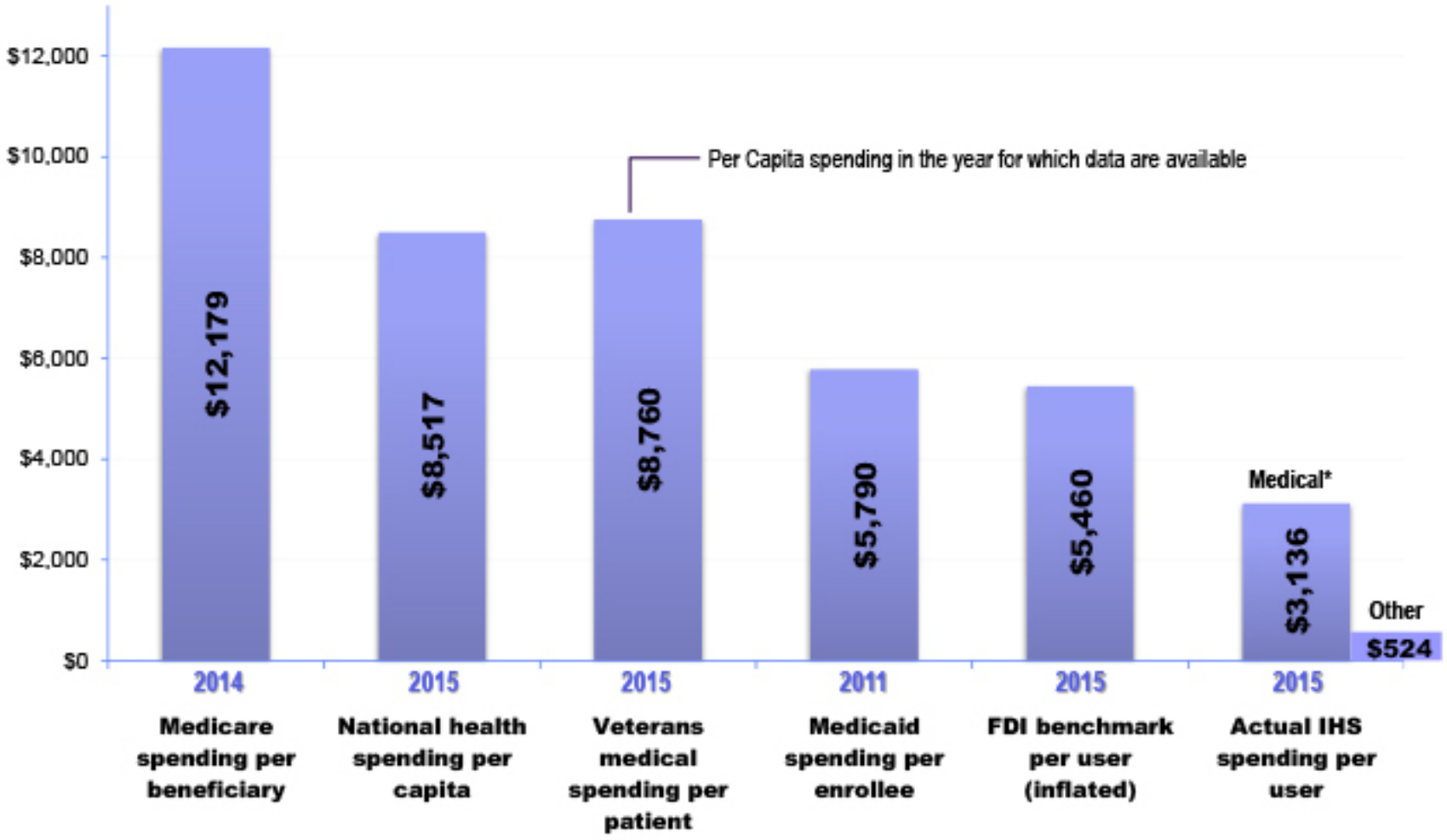
American Indian/Alaska Native Health Disparities

American Indians are more likely to die from certain diseases than general population

Alcoholism	514% Higher
Tuberculosis	500% Higher
Diabetes	177% Higher
Mosaic Variegated Aneuploidy (MVA) Syndrome	229% Higher
Accidents	140% Higher
Suicide	92% Higher
Pneumonia, influenza	52% Higher

Source: Ihs.Gov

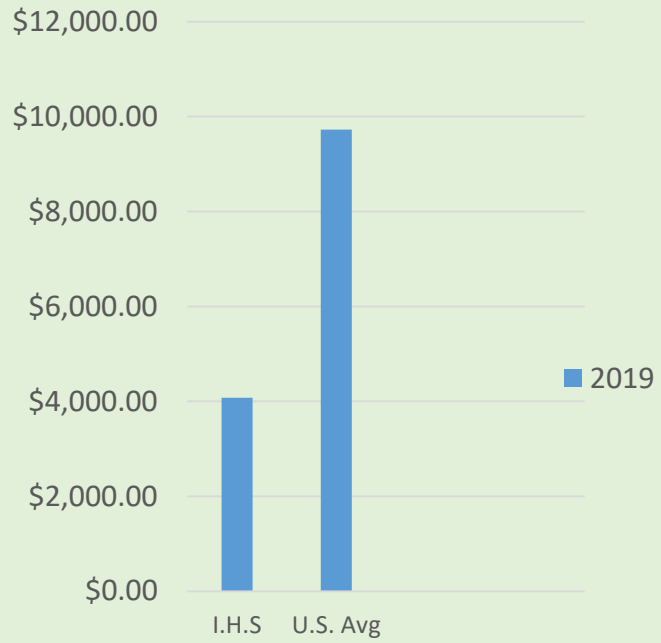
2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*See page 2 notes on reverse for sources. *Payments by other sources for medical services provided to AIANs outside IHS is unknown.*

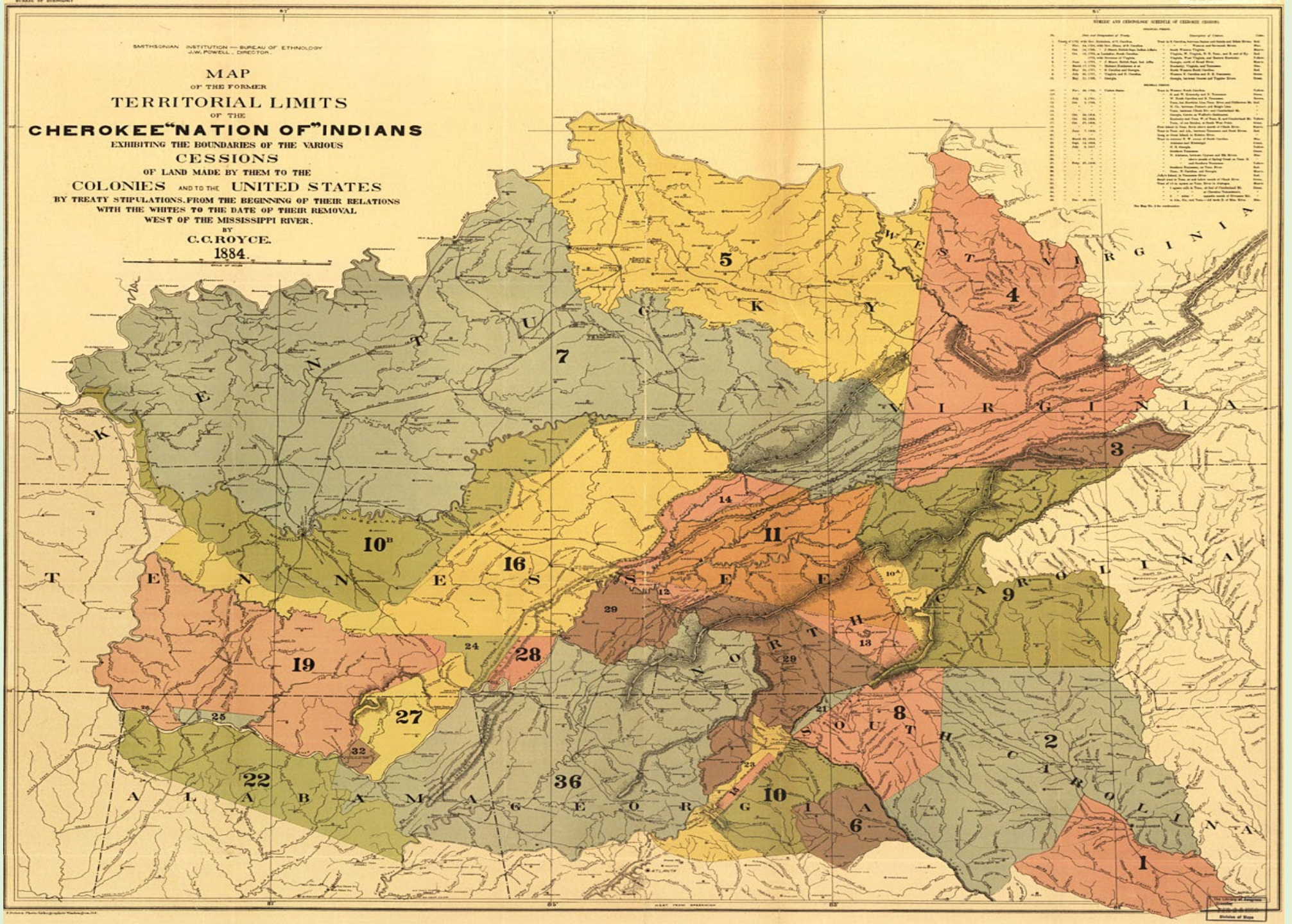
12/29/2015

Updated per IHS website



Unique History of Indian Health Care:

- AI/ANs have a unique political relationship with the US founded in treaties predating the origin of the US
- AI/ANs were forced into treaties resulting in the loss of millions of acres of land
- In more than 22 of the treaties with the US from 1778 to 1871, the Government obligated to provide health services as recompense for the forced surrender of land
- In the late 1880s, AI/ANs lost even more land during the allotment error, and by the early 1900s, communicable disease and starvation were the leading causes of death among AI/ANs according to the Meriam Report in 1928
- **The Snyder Act of 1921** is the founding authorization for provision of health services to Indians
- **Indian Reorganization Act of 1934** allowed tribes that had formally been terminated to reorganize and regain their sovereign status because the Removal and Allotment policies had decimated the social and economic structures of Tribes, leaving them in horrific conditions
- **Public Law 568, A transfer Act by Congress** in 1954 formally transferred the responsibility of managing hospitals and health services for Indians, from the Department of the Interior to the Public Health Service in the Department of Health Education and Welfare


SMITHSONIAN INSTITUTION — BUREAU OF ETHNOLOGY
J.W. POWELL, DIRECTOR.
MAP
OF THE FORMER
TERRITORIAL LIMITS
OF THE
CHEROKEE NATION OF INDIANS
EXHIBITING THE BOUNDARIES OF THE VARIOUS
CESSIONS
OF LAND MADE BY THEM TO THE
COLONIES AND TO THE UNITED STATES
BY TREATY STIPULATIONS. FROM THE BEGINNING OF THEIR RELATIONS
WITH THE WHITES TO THE DATE OF THEIR REMOVAL
WEST OF THE MISSISSIPPI RIVER.
BY
C.C. ROYCE.
1884.
TENNESSEE
KENTUCKY
WEST VIRGINIA
VIRGINIA
NORTH CAROLINA
SOUTH CAROLINA
GEORGIA
ALABAMA
1
2
3
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10A
10B
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32
36

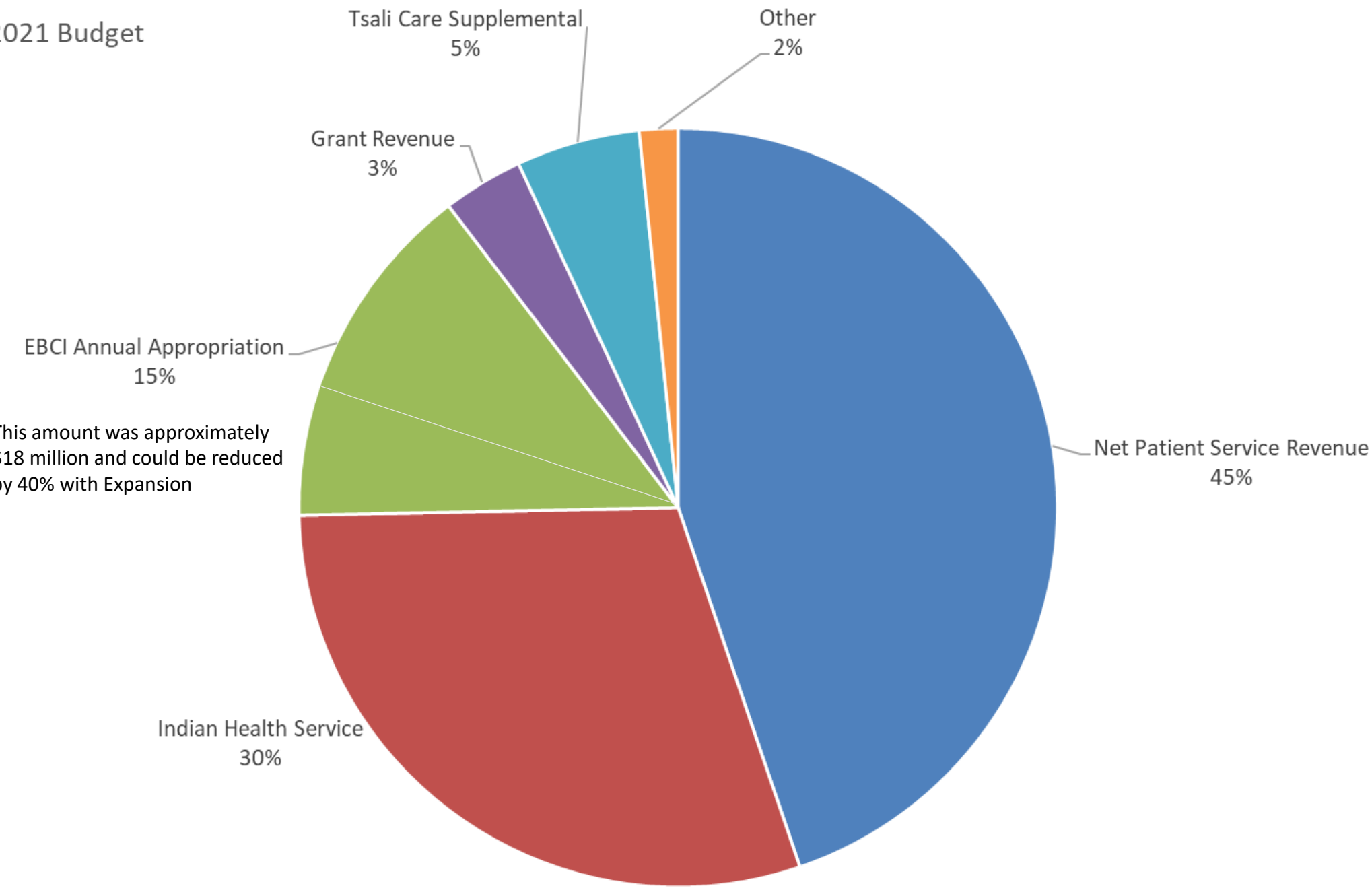
Unique History of Indian Health Care:

- In 1965, the Social Security Amendments created Medicare and Medicaid
- **Indian Self-Determination and Education Assistance Act of 1975,** which was later amended in the 1980s, allowed tribes to take control of the federal programs that were being provided to them by the US in carrying out its trust responsibility
- **The Indian Health Care Improvement Act (IHCIA) of 1974** provided more authority for funding Services and Facilities and authorized the Indian Health Services to collect third party payments as a means to supplement the underfunded system
- Congress enacted **Section 1911 of the Social Security Act** authorizing Indian Health Services to collect payments from the Medicaid program to supplement funding to IHS
- In 1976 Congress **amended 1905 (b) of the Social Security Act** to allow for 100% Federal Medical Assistance Percentage (FMAP) to states
- In 1997 Congress authorized IHS and tribal services to collect payments from Children's Health Insurance Program (CHIP)
- In the **American Recovery Act of 2009,** Congress authorized more Indian specific provisions to protect the ability to collect Medicaid Revenue recognizing how vitally important it is to supporting the grossly underfunded Indian Health System

CHEROKEE INDIAN HOSPITAL AUTHORITY

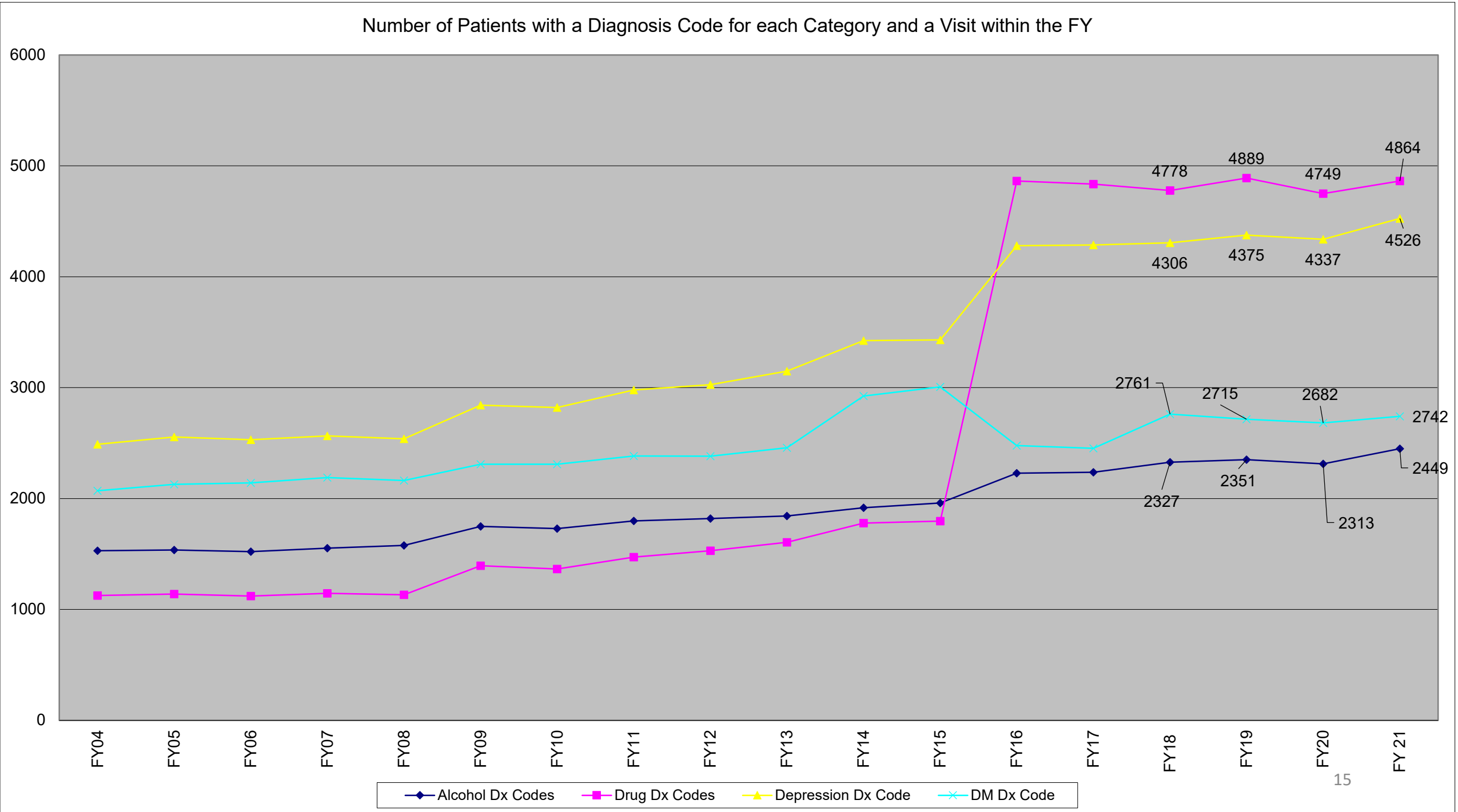
- Title V Health System since 2002
- Tribal sub-unit created by the EBCI
- Annual Operating Budget roughly $110 million
- Approximately 750 employees
  - 100 credentialed members of the medical staff (2 psychiatrist)
  - 100 dedicated Behavioral Health staff
- Services include:
  - Adult and Pediatric Primary Care
  - Inpatient Medical
  - Inpatient Behavioral Health/Substance Use treatment
  - Dental
  - Ophthalmic
  - Procedure Suite
  - Lab
  - Radiology
  - Pharmacy
  - Physical therapy
  - Psychiatry
  - Respiratory Therapy
  - Complimentary Medicine
  - Comprehensive Continuum of Behavioral Health and Substance Abuse Services
- History of Clean Financial Audits

2021 Budget



This amount was approximately $18 million and could be reduced by 40% with Expansion

Percentage of Patient and Visits Per Age Group FY 2018-2021 Total Pts=24516 Total Visit=1142217


Number of Patients with a Diagnosis Code for each Category and a Visit within the FY
6000
5000
4000
3000
2000
1000
0
FY04
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY14
FY15
FY16
FY17
FY18
FY19
FY20
FY 21
4778
4889
4749
4864
4306
4375
4337
4526
2761
2715
2682
2742
2327
2351
2313
2449
Alcohol Dx Codes
Drug Dx Codes
Depression Dx Code
DM Dx Code

Crisis Stabilization Unit

CHEROKEE INDIAN HOSPITAL AUTHORITY

Analenisgi Outpatient

- Individual, family, and group therapy
- Supervised medication Administration
- Opioid replacement therapy
- Targeted Case Management
- Adult and Pediatric Behavioral Health
- Psychiatry
- Intensive Outpatient Treatment
- Residential Services Care Management

CHEROKEE INDIAN HOSPITAL AUTHORITY

Analenisgi Inpatient

- 14 Bed Secured Inpatient Unit
  - 4 medical beds for Detox and treatment of Comorbidities
  - 1 Infectious disease/Isolation room
  - 2 group therapy rooms
  - Gym
- 4 high Acuity Psychiatric beds

Kanvwotiyi is a residential treatment center located in the Snowbird Community of Graham County, NC. In 2015, the EBCI Tribal Council approved funding and directed Cherokee Indian Hospital to develop a comprehensive system of care—a recovery community for Cherokee people struggling with addiction and other challenges.

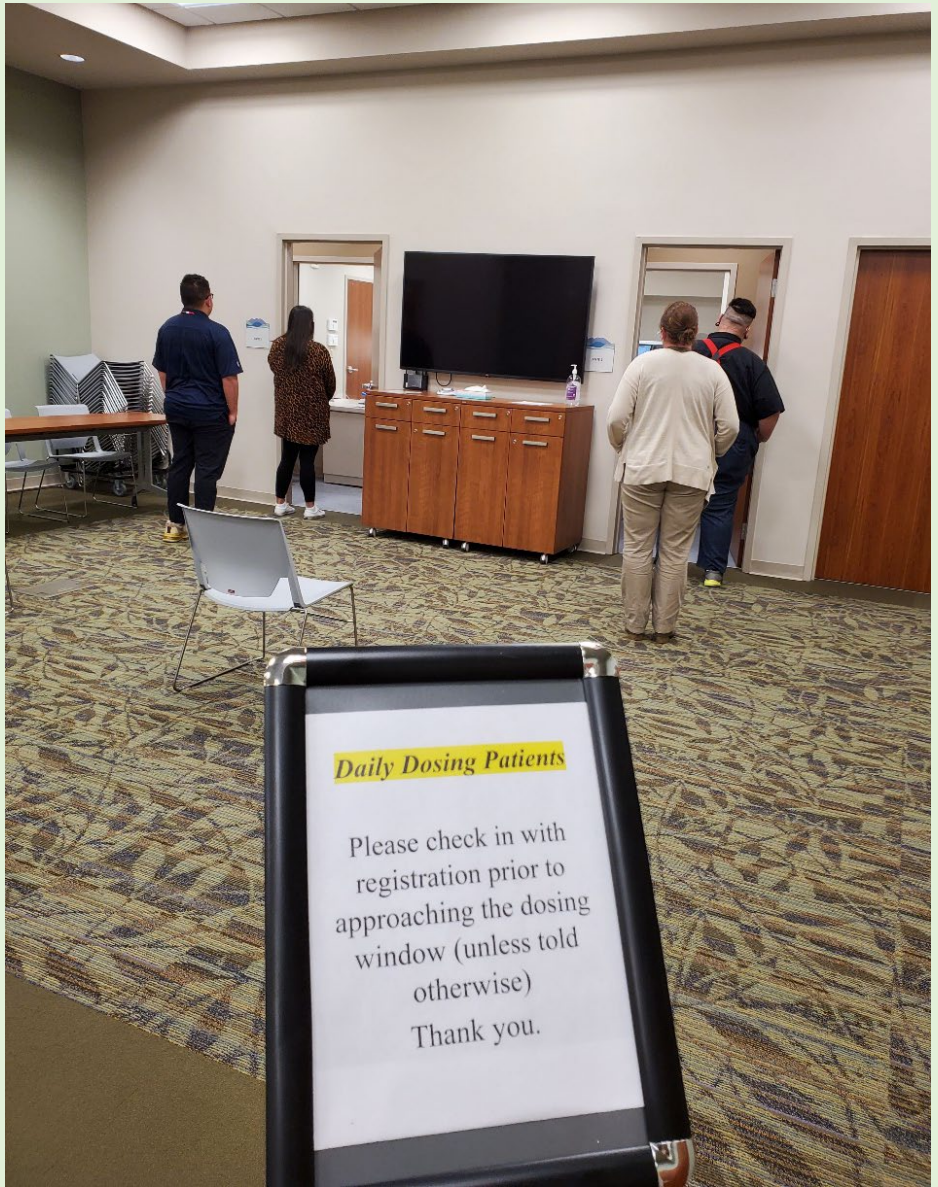
The **Analenisgi Recovery Center** is a safe, comfortable and non-judgmental place where clients participate in activities that support a personal recovery journey.

The Recovery Center is staffed with 5 Certified Peer Support Specialists who are members of the community and surrounding areas with lived experiences of addiction and mental health struggles but who now live a life in long term recovery.

Classes available:

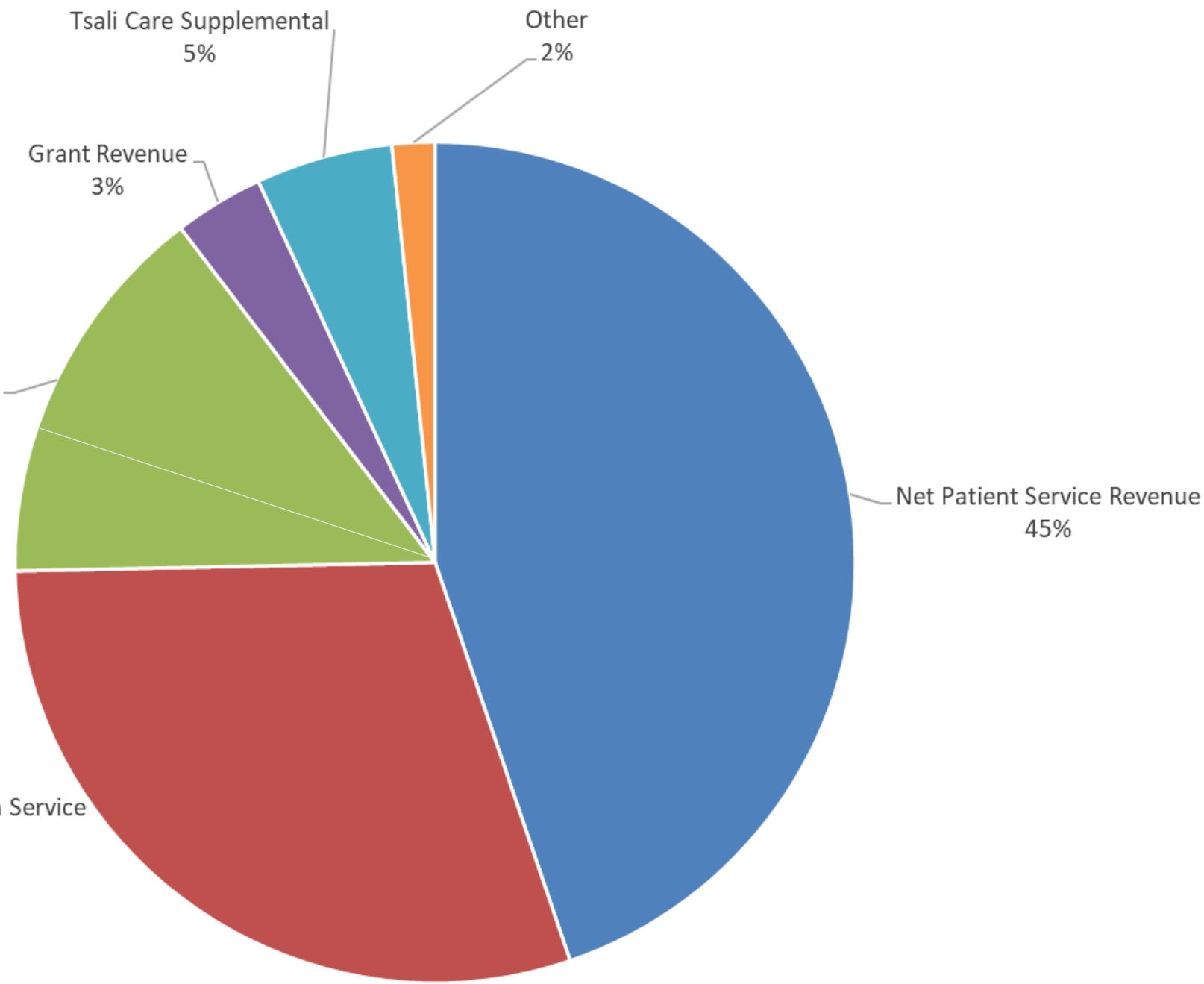
- Anger Management
- Depression & Anxiety Group
- Creative Writing
- To-hi, CIHA's second Guiding Principle which means "A state of peace and balance"
- Meditation/Relaxation techniques
- Let it go – skills and practices of forgiveness
- Sounds of Recovery – musical therapy

Medication Assisted Therapy



Women and Children's Home

2021 Budget



This amount was approximately $18 million and could be reduced by 40% with Expansion

Indian Health Access | Medicaid Program

- Section 1911 of the Social Security Act, 42 U.S.C. §1396j
  - Access to Medicaid for IHS and tribal health facilities
- Section 1905(b) of the Social Security Act, 42 U.S.C. §1396d(b)
  - 100 percent FMAP for services received through IHS and tribal facilities
- Section 401(d) of the IHCIA, 25 U.S.C. § 1641(d)
  - Authority for tribal health programs to directly bill for Medicare and Medicaid services
- Section 401(a) of the IHCIA, 25 U.S.C. § 1641(d)
  - Medicare and Medicaid funding to supplement IHS funding

Medicaid| Critical Third Party Resource

- Access to Medicaid is intended to act *"as a much-needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian."*
- Medicaid authorization was provided by Congress *"to enable Medicaid funds to flow into IHS institutions."*

- H.R. REP. NO. 94-1026, pt. III at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2796

Medicaid| Indian 100% FMAP Rule

- States are eligible for 100 percent Federal Medical Assistance Percentage reimbursement for Medicaid services received through the IHS or tribally operated program. SSA 1905(b); 42 U.S.C. § 1396d(b).
- CMS State Health Official (SHO) Letter #16-002 allows States to receive 100 % FMAP for services provided by non-IHS providers if they have a care coordination agreement with an IHS Provider.

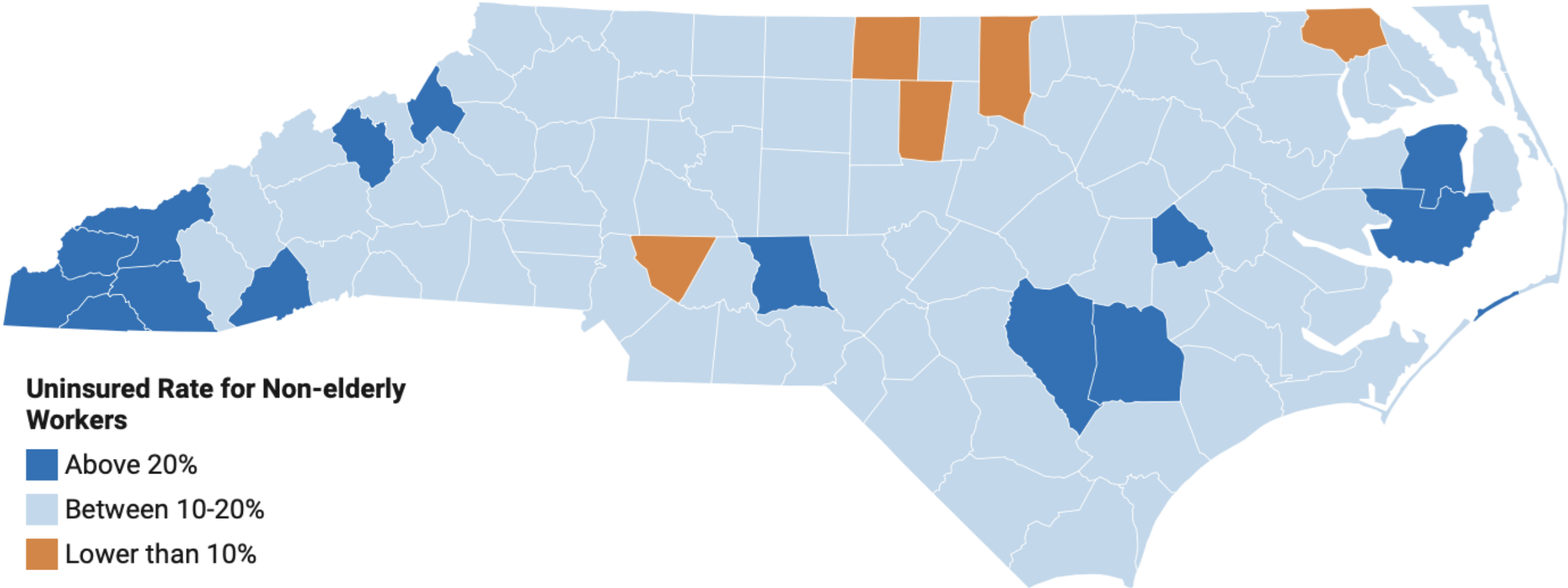
Significance of Medicaid Cherokee

- Approximately 4,000 patients have Medicaid, and CIHA is the Patient Centered Medical Home (PCMH) to them
- Reimbursement from third party payers now represents approximately 45% of the annual operating revenue

Closing the Coverage Gap in NC

- The EBCI estimates between 1,000 and 1,400 patients are below 138% of he Federal Poverty Level (FPL) and do not have coverage
- The EBCI estimates the opportunity cost for failing to close the coverage gap to be more that $7 million annually
- Because of the 100% FMAP, the cost to expand would cost the State nothing, yet failing to expand is extremely detrimental to the EBCI and is inconsistent with the US trust responsibility
- Barriers to enrollment do not decrease demand, utilization, and cost for Indian Health Systems
- Failing to expand adversely affects employment opportunities, economic development, and housing development, and competes with funding for education
- Statewide Expansion is needed to build a healthier ecosystem in WNC, where Natives and non-Natives synergistically co-exist

Which parts of the state have higher proportions of uninsured workers?



Note: Includes all workers ages 19-64 regardless of income or citizenship status.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2015-2019 Table DP03.

Counties where More Than 20% of Workers are Uninsured

County	Uninsured Rate
US	**11.0%**
North Carolina	**13.8%**
Avery	27.2%
Tyrrell	26.6%
Graham	26.1%
Hyde	26.0%
Cherokee	25.1%
Duplin	23.9%
Clay	23.2%

The counties with the highest uninsured rates for non-elderly workers are all rural.

Swain	22.9%
Greene	22.4%
Sampson	22.2%
Yancey	22.1%
Macon	21.7%
Transylvania	20.5%
Montgomery	20.4%

Figure includes all workers ages 19-64 regardless of income or citizenship status.
Camden County suppressed due to small sample size and low-reliability.
Georgetown University Center for Children and Families analysis of US Census Bureau American Community Survey (ACS) 2015-2019 Table DP03.

Closing the Coverage Gap Keeps Health Care Affordable and Accessible

- When uninsured people need care, they often turn to the emergency room. An emergency room visit leads to high medical bills that patients cannot pay, and the hospitals often have to absorb the cost.
    - Hospitals then try to offset lost revenue by **"cost-shifting"**, meaning that they charge higher premiums to everyone that uses health care. *-The Commonwealth Fund, 2020*
- Covering more uninsured people improves providers' and hospitals' bottom lines and saves all patients money. *-The Commonwealth Fund, 2020*

82% of rural hospital closures nationwide in the last five years have been in non-expansion states. - *UNC Sheps Center, 2018*

- **Six rural hospitals** in North Carolina have **closed** since 2010, and several others are at high risk of financial distress. *-NC Rural Health Leadership Alliance, 2020*
- States that have already closed their coverage gap have seen a **62% decrease** in likelihood of rural hospitals **closing**. *-NC Rural Health Leadership Alliance, 2020*
- North Carolina delaying the enactment of a solution to close the coverage gap puts many rural hospitals at risk and deprives them of necessary resources. *-NC Rural Health Leadership Alliance, 2020*

SPOTLIGHT

SPONSORED BY north carolina JUSTICE CENTER

1 in 4 rural hospitals are at risk of closing - 7 in NC have already closed

Tags: sponsored, hospitals, healthcare, N.C. Justice Center

Posted June 12, 2021 5:00 a.m. EDT

1 man injured, another dead in apparent shooting suicide in Jackson County

Public Safety Benefits to Closing the Coverage Gap

- Reduce crime, save counties money
- Fiscal year 2014-2015, North Carolina spent $6,922 per inmate on health care

that have health insurance coverage under Medicaid are 14 percentage points more likely to receive treatment for their opioid use disorder.

Questions?