

WRITTEN TESTIMONY

To: Senate Committee on Indian Affairs

Oral Presentation by: Carmelita Skeeter, Executive Director
Indian Health Care Resource Center of Tulsa, Inc.

Re: Section 512 Oklahoma Demonstration Projects Indian Health Care Improvement Act Reauthorization

July 16, 2003

Good day, Senators, Ladies and Gentlemen. I am Carmelita Skeeter, Executive Director of Indian Health Care Resource Center of Tulsa (IHCRC). Our Urban Indian Clinic is one of the two national Urban Demonstration Projects – our counterpart is the Oklahoma City Indian Clinic.

The Board of Trustees of our nonprofit Urban Indian health organization supports the reauthorization of the Indian Health Care Improvement Act (IHCIA) with language in Section 512 that assures our organization will retain its current ability to manage its own affairs and provide locally directed health care services. As an Indian Health Service Urban Demonstration project, our organization has steadily grown and offers a comprehensive program of outpatient care. Our Urban clinic provides medical, dental, optometry, pharmacy, mental health and substance abuse treatment. What we seek in the renewal of the Indian Health Care Improvement Act is an assurance that our organization can continue to provide health care within the legal structure of the very successful Urban Demonstration delivery system. Last year, our urban clinic received the Outstanding Program award from the National Council of Urban Indian Health.

The Oklahoma Urban Demonstration clinics have proven ourselves to be effective projects and want to continue to operate in the future in the same way that we have functioned since we became Demonstration programs in 1987. **I urge retention of the existing language of Section 512 of the IHCIA Reauthorization Act, which maintains the current status of the two Oklahoma Urban Demonstration Projects as direct care service unit components** of an integrated model of health care within the Indian Health Service delivery system. **I also urge retention of IHCIA Reauthorization Act language that continues to protect the Oklahoma Urban Demonstration programs from the tribal compacting and contracting provisions** of the Indian Self-Determination and Education Assistance Act (ISDEA).

Let me provide a little background and history about the two Oklahoma Urban Demonstration programs. The Indian Health Service provides partial funding to 32 nonprofit Urban Indian clinics and to the two Oklahoma Urban Demonstration clinics. The Indian Health Care Improvement Act enacted in 1976, included the basic Title V authorization for Urban Indian health programs. Nationally, the enactment of Title V was vitally important to the evolution of Urban Indian health care, for it provided an effective means for IHS to partner with community-

based organizations to more effectively serve the basic health care needs of the Urban Indians who comprise over 60% of the nation's American Indian and Alaska Native population.

Due to the instability and inadequacy of Title V funding for Urban Indian Clinics throughout the 1980s, and the overwhelming unaddressed health care needs of Oklahoma's large Indian population, the Tulsa and Oklahoma City Urban Indian health programs advocated for special status as Indian Health Service Demonstration projects. This effort was successful in 1987 when the Interior Appropriation Act moved the funding for the Tulsa and Oklahoma City Urban Indian centers from Title V Urban program to the IHS Direct Care Program (Line Item 01 for Hospitals and Clinics of the IHS annual budget). This action established the Tulsa and Oklahoma City Urban clinics as the only two Urban Demonstration Projects for IHS in the nation.

Since the creation of the Oklahoma Demonstration Projects, the Indian Health Service and Congress have provided a series of incremental interpretations and statements to more clearly define the nature of the Urban Demonstration program and its operations. The two urban health programs do not neatly fit within the IHS/Tribal/Urban framework. Although they came into existence through the Title V Urban Health program, they have moved beyond this origin. When Congress established the Oklahoma Demonstration projects it created a "hybrid," unlike any other in the IHS clinical delivery system. We are independent nonprofit corporations and are not a federal IHS facility. **Our Demonstration status within the I/T/U system has had a positive effect on the level of IHS service unit funding received and the expanded scope of services we are able to provide to Indians in Tulsa and Oklahoma City** and has led to better integration of the Urban programs with the operation of other IHS facilities and programs.

From a tribal perspective, urban clinics, including the Oklahoma Demonstrations are not affiliated with any single tribe – rather, the Urban Demonstration projects maintain an open door to serve members of all tribes. Like all of the Title V Urban clinics, **the designation of the Tulsa and Oklahoma City clinics as Demonstration programs kept in force the Title V language which guarantees the nonprofit corporate independence of all Urban Indian Clinics from the potential of being compacted or contracted** under the provisions of the Indian Self-Determination and Education Assistance Act (ISDEA).

Urban Indian funding was developed by the federal government to provide a means to fill in gaps between Tribal and federal programs. In 1992 Congress enacted P.L. 102-573 stating the following:

The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to assure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to affect that policy. (underline added for emphasis)

Returning to the current situation we face today regarding the reauthorization of the Indian Health Care Improvement Act, extended roundtable discussions were held by the Indian Health Service, Tribal and Urban (I/T/U) system partners for the past three years to consider appropriate language and changes to IHCIA. As you know, these discussions were far-ranging, yet

throughout the process there was strong and clear agreement among the I/T/U roundtable participants that the two Oklahoma Urban Demonstration projects –

- 1) should be made permanent programs in the IHS direct program;
- 2) should continue to be treated as Service Units in the allocation of resources and coordination of care while still being treated as a Title V Urban program;
- 3) should not be subject to the Section 638 Tribal compacting and contracting provisions of the Indian Self Determination and Education Act.

These three provisions were agreed upon nationally by the I/T/U partners and were concretely expressed in the draft Section 512 IHCA language contained in the 2002 S 212 bill. The Section 512 language of the current IHCA S 556 bill remains unchanged from last session's S 212 bill.

Today I am here to reiterate the need to keep all three of these components of Section 512 in place as originally agreed upon. **The two Oklahoma Urban projects strongly urge retention of the Section 512 language of S 556 as it was introduced. We absolutely cannot support the language like or similar to the H.R. 2440** which would make the Oklahoma Urban projects “subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.” To make the Demonstration programs projects subject to compacting and contraction would risk compromising and stressing the entire system of care provided to Oklahoma Urban Indians. Compacting and contracting could result in undermining the stability of the Demonstration programs if the tribes were to pull out the base IHS service unit funding from the Demonstration projects.

The Oklahoma Demonstration Projects operate in a unique manner within the Oklahoma I/T/U delivery system. Because the entire state of Oklahoma is designated as a “Contract Health Service Delivery Area” (CHDSA), Oklahoma Indians (including members of non-Oklahoma tribes living in Oklahoma) have the right to receive services from any IHS, Tribal or Urban clinic. The two centrally located clinics operated by Oklahoma's two Urban programs are the most efficient means to serve the diverse intertribal population living in the state's two major Urban areas. The Tulsa metro area has one of the nation's largest concentrations of Native Americans – in the 2000 Census over 86,000 Oklahomans living in the five-county Tulsa MSA responded as American Indians or Alaskan Natives.

The Demonstration status and the corresponding enhanced baseline service unit funding that two Oklahoma Urban Indian clinics receive (as compared being funded at the much lower Title V Urban clinic funding level) has enabled the Tulsa and Oklahoma City Urban Demonstration projects to:

- Construct new clinical facilities, expand clinical services and improve quality of care; the Tulsa Urban clinic has been accredited by the Accreditation Association of Ambulatory Health Centers (AAAHC).

- Maintain continuity of care for a steady stream of patients and clients who move to Urban cities from the rural towns – enabling these patients to transfer their care from rural tribal and IHS health facilities;
- Coordinate care for Urban Indians who access health care at the Urban clinics and at the IHS direct care and Tribally-controlled health programs; we serve as patient advocates to help patients access IHS contract health care and other health services not available at our Urban ambulatory clinics.
- Assist Native Americans qualify for Medicaid and Medicare so they can access additional health care through non-IHS health providers and insurance networks;
- Bill for third-party Medicaid reimbursement as an IHS outpatient clinic at the OMB “all-inclusive” rate generating additional program income to expand services.
- Grow our overall operating budgets. In Tulsa, the Demonstration baseline service unit funding has enabled us to expand our operating budget by more than two and a half times our base IHS funding through grants, contracts and third party insurance billings. As documented in IHCRC’s FY 2002 audited annual report, we received \$2,672,055 in IHS base funding of our total annual revenue budget of \$6,773,763.

The Urban clinics are partners with the federal government and a wide range of community partners. By definition, the contractual partnership which the Urban clinics have with the federal government to deliver health care services requires the Urban clinics to coordinate care with Tribal health programs, as well as IHS controlled health services. Although the Urban clinics operate as partners with the federal and Tribal governments, they operate independently of their direct control. IHCRC and the Oklahoma City Urban clinic are private nonprofit, non-stock membership corporations. IHCRC is a community-based corporation with a local Board of Trustees who are elected by the membership of Indian patients who utilize the clinic’s services. Elected Tribal representatives are eligible and have served on the IHCRC Board of Trustees. **The health care our clinic provides to tribal members is provided at no cost to the tribe .**

Establishing Demonstration status, with a corresponding increase in service unit funding, has enabled the two Oklahoma Urban organizations to grow. The two Oklahoma Urban clinics have constructed new facilities through lease/purchase agreements. Although the base IHS funding is helping to finance these new facilities, the principal source of funding that enabled services to be expanded has been through billing for Medicaid reimbursement of services using the OMB rate. Last year, the IHCRC Urban Indian clinic billed nearly \$2 million in Medicaid billings. Billing for Medicaid reimbursement under the OMB rate only became possible after the Oklahoma Urbans were designated as Demonstration programs and were recognized as service units within the IHS system. Similarly, for Medicare, Demonstration status allows the two Demonstration programs to receive the cost-based rate available for Federally Qualified Health Centers (FQHCs).

The base IHS service unit funding the Tulsa Urban project (IHCRC) receives represents less than 40% of the annual operating budget of the organization – however it is the core funding that is gives stability of the entire clinical operation. IHCRC has a long track record of success in using the base IHS funding to leverage additional contracts and grants. Private philanthropic and corporate donations were used to help furnish the new IHCRC clinic. In order to receive state substance abuse funding for Indians, IHCRC has served both Indians and non-

Indians for over a dozen years as a state-certified substance abuse contractor. Keeping a patchwork of 10-15 grants in place on an ongoing basis requires organizational stability and maintenance of good relations with the funding sources.

IHCRC has very real concerns that the success of its current business and clinical operations would be threatened if it were to become an object of Tribal politics. IHCRC expanded operations depend on prudent management to maximize Medicaid revenues, to maintain state grants and contracts and to competitively compete for other grants. **If the Tribes compacted IHCRC and “pulled the IHS funding out” of the Urban clinic, this action would unravel the entire financial structure and operation of the organization.**

We believe the tribes and the Urbans need to be respectful and supportive of each other’s health programs. Indian people do ourselves a disservice when we create divisions that hamper and impede our collective ability to address the health needs of Indian people. One promising example of ongoing cooperation is a six-year partnership in which our Urban clinic, eight Oklahoma tribes and the State Health Department are collaborating. Through a CDC “Racial and Ethnic Approaches to Community Health” (REACH) health disparities grant, each of the Indian partners receives funding to conduct physical activity programs for Indian youth to reduce the lifetime risk of diabetes and cardiovascular disease. Another example – the Cherokee Nation has conducted the WIC nutrition and food program for moms and children in our clinic for over 25 years. Additional information that documents our extensive collaborations with tribes and community partners is attached to my written testimony.

All of us within the I/T/U system need to work together to improve the Indian care health care delivery – and ultimately – to improve the health of our Indian people. Recently, the Oklahoma I/T/U system of 41 health facilities operated by the Indian Health Service, Tribes and Urban organizations has been given an opportunity by the Oklahoma Health Care Authority and the federal Centers for Medicaid and Medicare Services (CMS) to develop a model Medicaid program for Oklahoma Indian people. A concept paper describing an expanded partnership between the state Medicaid agency and I/T/U has been submitted to CMS in anticipation of a full revision to the Oklahoma 1115 Medicaid waiver. This waiver will provide a special opportunity to further grow and develop the Oklahoma’s I/T/U delivery system into a more integrated system of care through OMB Medicaid reimbursement available to I/T/U programs. Indian Health Care, in its role as Urban Indian Demonstration program, looks forward to being an active participant in making this proposed statewide Indian Medicaid 1115 Demonstration waiver a success.

Since 1995, when Oklahoma initially implemented its Medicaid managed care delivery system, the I/T/U programs and the Oklahoma Health Care Authority have worked to adapt to challenges and changes of the managed care delivery systems and to maneuver the regulations required both for the Medicaid program and the I/T/U facilities. Indian clients have had perhaps the biggest challenge in navigating through these systems to receive Medicaid services. The proposed Oklahoma I/T/U Medicaid waiver has great potential to streamline the Medicaid program for Indian people and offer improved access to an expanded set of desperately needed health care services within the I/T/U network of IHS, tribal and Urban health facilities.

In closing, the Tulsa and Oklahoma City Urban Clinics believe the health care of Indian people is best served by a Indian health delivery system that ensures the continued presence of the federal Indian Health Service programs and initiatives, Tribal health services and Urban programs operated by locally-controlled Urban Indian nonprofit organizations. Indian Health Care Resource Center functions both as a major provider of I/T/U services and as a key local provider of essential safety net health care services within the general Tulsa community.

The health care needs of Oklahoma Indians are too critical to risk the operation of the Oklahoma Urban Demonstration Projects to the uncertainties of Tribal politics. The health needs of vulnerable Tulsa and Oklahoma City Indian people should not be allowed to be caught in a struggle among Oklahoma tribes.

Conclusion

I urge the Senate and Congress to reauthorize the Indian Health Care Improvement Act with the language of Section 512 in the “as introduced” version of Senate Bill 556, which would make permanent the current “Demonstration” status of IHCRC and its Oklahoma City Indian Clinic counterpart, protecting the two Oklahoma Urban clinics from tribal control and guaranteeing they continue to receive their fair share of IHS service unit funding for the population they serve. It is also very important that the Oklahoma Demonstration Projects continue to be able to provide care to patients with Medicaid and Medicare insurance coverage and receive appropriate OMB and FQHC reimbursement.

* * *

IHCIA SECTION 512 – LANGUAGE RECOMMENDATION

The Oklahoma Urban Demonstration Projects strongly support the language of S. 556, SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

(a) TULSA AND OKLAHOMA CITY CLINICS – Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic Demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an Urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

The Oklahoma Urban Demonstration absolutely cannot support the language of H.R. 2440, SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

TULSA AND OKLAHOMA CITY CLINICS – Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic Demonstration projects shall –

- (1) be permanent programs within the Service’s direct care program;
- (2) continue to be treated as Service Units in the allocation of resources and coordination of care; and
- (3) shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.”

Brief IHCRC History and Background

Indian Health Care Resource Center (IHCRC) was founded more than 27 years ago in order to give Indians living in Tulsa more convenient access to health care – previously they had to travel 30 miles to receive care at the Claremore Indian Hospital. Through the years, IHCRC has steadily grown to become a major medical clinic with a wide range of services. In 1999, the IHCRC Board developed a lease/purchase funding package that enabled the clinic to move from its former cramped and deteriorating location to a modern, much larger facility. The new medical facility and clinical operation is accredited by the Accreditation Association for Ambulatory Health Care.

The comprehensive health care offered at Indian Health Care is truly impressive. It includes medical, prenatal and dental care, pharmacy, optometry, Indian family services, behavioral counseling and substance abuse treatment. Other services include lab, x-ray, mammography, cardiovascular and diabetes care, health education, preventive care and WIC nutritional foods. Indian Health Care Resource Center serves over 15,000 active patients from more than 150 tribes.

***Mission:** The mission of Indian Health Care Resource Center is to provide quality, comprehensive health care to Tulsa area Indian people in a culturally sensitive manner
That promotes good health, well being and harmony.*

***Vision:** Indian Health Care Resource Center is committed to the elimination of health disparities, the expansion of innovative family-focused practices and the promotion of an embracing approach to care that strengthens physical, mental, emotional and spiritual wellness within the Indian community.*

Oklahoma Indian Health Status

Oklahoma has an estimated 391,419¹ Native Americans, the second largest Native American population in the nation. As with other populations of color, Native Americans face a disproportionate share of health problems compared to the general population, including:

- Oklahoma's Native American population has a smoking rate of 33%² and rate of obesity 66%³, which are two contributors to heart disease, the leading cause of death for Indians in Oklahoma.
- The rate of diagnosed diabetes is 2.6 times higher in Native Americans than non-Hispanic whites.
- Diabetes complications⁴:
 - The rate of end state renal disease is six times higher in Native Americans than the general population.
 - Amputation rates are 3-4 times higher
 - Rate of diabetic retinopathy is 24.4% in Native Americans.
- The proportion of Native American women with no prenatal care⁵ in first trimester was 31.2 in 1998, which is 2.6 times higher than white non-Hispanics (12.1).
- The Breast Cancer⁵ age-adjusted death rates increased from 9.9 in 1990 to 19.3 in 1998.
- The Lung Cancer⁵ age-adjusted death rates increased from 19.6 to 25.1 in 1998.

¹ United States Census, 2000.

² Oklahoma State Health Department, 2002 State of the State's Health Interim Report.

³ Kaiser Family Foundation State Health Facts Online.

⁴ Diabetes Among Native Americans, American Diabetes Association Webpage.

⁵ Keppel KG, Percy JN, Wagener DK. Trends in racial and ethnic-specific rates for the health status indicators: United States, 1990-98. Healthy people statistical notes, no. 23. Hyattsville, Maryland: National Center for Health Statistics. January 2002.

IHCRC Cooperative Activities with Tribes and the Community

Tribal Collaborations

- In Fall 2002, the Cherokee Nation and the Muscogee Creek Nation behavioral health and substance abuse departments met with IHCRC to conduct strategic planning with an objective of expanding treatment services, including opportunities to collaboratively and collectively compete for grants in federal minority health, education, juvenile justice, substance abuse and mental health arenas. The group met with Terry Cline, the Director of the Oklahoma Department of Mental Health and Substance Abuse Services, to discuss approaches for the State and Indian organizations to partner in efforts to develop a continuum of mental health and substance abuse services.
- IHCRC provides Substance Abuse treatment services to the Creek Nation Sapulpa Indian Clinic
- For more than 25 years, IHCRC and has maintained a contract for the Cherokee Nation to offer WIC services in our clinic.
- Another example of ongoing tribal cooperation is a six-year partnership in which our urban clinic, eight Oklahoma tribes and the State Health Department are collaborating. Through a CDC REACH health disparities grant, each of the Indian partners receives funding to conduct physical activity programs for Indian youth to reduce the lifetime risk of diabetes and cardiovascular disease.
- The Oklahoma I/T/U system of 41 health facilities operated by the Indian Health Service, Tribes and Urban organizations are working together with the Oklahoma Health Care Authority to develop a model Medicaid program for Oklahoma Indian people that will be submitted as an amendment to the Oklahoma 1115 waiver.

Community Collaborations

IHCRC is an active partner in a wide variety of community and state public health partnerships. A brief summary of these collaborations follows.

- IHCRC is an active participant in Oklahoma's Turning Point initiative that links local community activism to raise consumer awareness about the need for individuals to take greater personal responsibility for their health.
- IHCRC is a Healthy Start contractor in a community partnership to reduce infant mortality that includes smoking cessation and anti-depression programs.
- In addition to working with local and state health departments, our agency also works closely with other community health and social services agencies to address major public health concerns including the perinatal health, immunizations, AIDS, tuberculosis, chronic diseases, drug abuse, homelessness and domestic violence. IHCRC is an active member of the Native American Diabetes Coalition, Oklahoma Primary Care Association, the Tulsa Family Health, the American Red Cross, the Homeless Services Network, the Tulsa Immunization Coalition, and the Tulsa Community Aids Partnership.
- For eight years IHCRC has been part of Community HealthNet, a community consortium of Tulsa's nonprofit providers of primary health care with the goal of increasing access to health care for persons without health insurance or on public assistance. Last year, Community HealthNet received a substantial (\$880,000) federal HRSA Community Access Program (CAP) infrastructure development grant. The CAP grant is being used to establish internet-based client referral and case management system that will help integrate and coordinate patient care among the community's multiple agencies that provide health and human services.
- IHCRC recently assisted Community HealthNet and other community partners apply for HRSA Bureau of Primary Care Section 330 funding for a new community health center and designate a new Medically Underserved Area in collaboration with the State Health Dept. Office of Primary Care.
- IHCRC's Behavioral Health Department recently established a graduate psychology student internship program, which collaborates with area universities.

Specific Collaborations between the Cherokee Nation and Indian Health Care Resource Center of Tulsa, Inc.

Indian Health Care Resource Center (IHCRC) was established in 1976 as an outreach program of the Native American Coalition of Tulsa. IHCRC was formally incorporated in 1978 as a separate nonprofit organization with a community-based board.

- In 1976 the Cherokee Nation established a satellite WIC nutrition program in IHCRC's clinic. This operation has continued in operation continuously to date.
- Cherokee tribal members, including elected Cherokee Tribal Council members, have served on the IHCRC board throughout the years. Currently, Cherokee tribal members comprise more than half the IHCRC Board of Trustees.
- The Cherokee Nation and IHCRC collaborated with seven other Oklahoma tribal nations and the State Health Department to establish the Oklahoma Native American REACH 2010 Coalition partners. Funded at \$1 million/year for six years, this grant program promotes physical activity to reduce lifetime risks of diabetes and cardiovascular disease. The other participating tribes in the Oklahoma Racial Equality Achievement in Community Health (REACH) 2010 Coalition are the Absentee-Shawnee, Cheyenne-Arapaho, Chickasaw, Choctaw, Pawnee, Seminole, and the Wichita and Affiliated Tribes. Sponsored by the Centers for Disease Control, the REACH program is intended to eliminate health disparities among minority people and the nation.
- For many years, IHCRC has made its clinic available as a community location for tribal enrollment.
- IHCRC provides its clinic as a community polling place for members of the Cherokee Nation to conduct its tribal elections.
- IHCRC provides its clinic as a community location to hold tribal press conferences for the Tulsa media.
- IHCRC is currently providing clinic space for a tribal representative to market its HUD home improvement grant program.
- Recently, IHCRC was an active participant in the Cherokee Nation 15-Year Health Plan.
- Cherokee Nation has provided a letter of support to IHCRC affirming that the Tulsa Urban program addresses critical Indian health needs and that the Tulsa program should continue to be governed as a nonprofit organization with an elected community board.
- As requested by the Cherokee Nation, IHCRC has provided Letters of Support to the Tribe for grant applications.
- IHCRC and the Cherokee Nation are coordinating their two federal Substance Abuse and Mental Health Services Administration (SAMHSA) community planning FY 2002 grants to improve the availability of comprehensive substance abuse treatment services.
- On a routine basis, the Cherokee Nation and IHCRC coordinate clinical referrals between the two health organizations, including substance abuse referrals to the Cherokee Nation's Jack Brown substance abuse residential treatment facility for Indian youth.
- On a routine basis, the Cherokee Nation and IHCRC coordinate referrals for the Cherokee Indian Child Welfare and the Oklahoma Department of Human Services (DHS).